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Humanum

Issues in Family, Culture & Science

HEALTH AND MEDICINE

Catholicism and the Future of Medicine

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Catholicism and the Future of Medicine

This issue is the fruit of an ongoing dialogue between the CCPR and a group of doctors at the Mayo clinic concerning the nature of medicine, the nature of the human body, and of the necessary link between health and the religious dimension of the human being.

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FEATURE ARTICLE

Appendix: Catholicism, the Mayo Clinic, and the Future of Medicine

ALLEN J. AKSAMIT JR.

Medicine as a profession has been regarded since the time of Hippocrates as a vocation rather than an occupation. The values that define this vocation have been referred to as “medical professionalism” (Mueller, 2009). Professionalism, however, takes its root for the Christian physician in the Christian ethic, as a derivation of the gifts of the Holy Spirit. Strong parallels can be drawn between the description of medical professionalism and Christian virtues. However, current radical changes are occurring in the practice of medicine that are not driven by either professionalism or virtue, but rather by medical economics, at least in the United States.

Medicine as it is practiced in the United States is undergoing a cultural, governmental, and economic revolution. We have changed from a primary fee-for-service system to a heavily governmental-influenced payment system. The government has borne the brunt of recent economic difficulties, and in turn the government payment system, which pays for medical practice in hospitals in the United States, has created pressure on those institutions. The relationship between the patient and doctor is no longer the prime focus, and has been co-opted by the influence of third-party payers, and now increasingly the United States government.

This economic reality has strongly challenged the cultural and Christian character of many healthcare institutions. The last four years have brought the challenges of the Affordable Care Act, with the Health and Human Services Mandate additionally being in conflict with medical professionalism and Catholic practice in both inpatient and outpatient institutions. This is particularly so in Catholic hospitals.

These decisions have taken place essentially as a business transaction between Mayo Clinic and the Sisters of Saint Francis. This serves as an example of the lost influence of Catholic culture on one of the prominent medical institutions of our

The Mayo Clinic has been a prominent influence in American medicine for more than a hundred years. The evolution of the interface between professionalism, the practice of medicine at the Mayo Clinic, and its interface with Saint Marys Hospital, its principal Catholic in-patient hospital for more than 100 years, are being played out in real time in 2013. The changes that occurred in March 2013 at Mayo Clinic and Saint Marys Hospital serve as a significant example of changes in American culture, medical economics, and the decline of Catholic religious influence on medicine (Mayo Clinic News Center, March 25, 2013).

As economic background to this specific example, the latest figures from 2012 showed that Mayo Clinic reported annual revenue of 8.8 billion dollars. It finished with 395 million dollars of net income from activities with an operating margin of 4.5%. It employs in Rochester, Minnesota, 34,223 people (Mayo Clinic News Center, Feb 28, 2013). Much of the payment for medical services provided by Mayo Clinic originates from government reimbursement. More than 40% of Mayo Rochester's revenue originates from care for patients supported by the Medicare system. The proportion of over 65-year-old patients is expected only to grow with the aging of the baby-boomer generation that has now reached that age threshold.

Mayo Clinic, as a healthcare organization, has reacted to the changing tides of the financial stress. Although it is a not-for-profit foundation, the need to remain cutting edge, and offer its patients innovation and technological advances in all areas of medicine, creates great expense and challenges for an institution operating on a narrow margin. Mayo Clinic also regards itself as a medical economic steward for southeastern Minnesota. As healthcare has become more costly, charity care for the poor and disenfranchised, which has been a hallmark of Catholic healthcare, has become more challenging. This, in concert with societal changes and trends toward secular cultural influences, challenges Catholic influence on the practice of medicine at Mayo Clinic. This will have far reaching consequences in dealing with medical decisions and controversies now and in the future.

Historical Beginnings

The Mayo Clinic, a secular institution, has had a close relationship with a Catholic Franciscan-run Saint Marys hospital since their respective origins in the late 19th century in Rochester, Minnesota. The relationship serves as a unique example of collaboration that is now disappearing in the context of economic and cultural change. The story of Mayo Clinic and its relationship to the Franciscan sisters has been tested in the past, and now approaches irrelevance in the context of economic realities, growth of the secular components of the medical institution, and the decline in numbers of religious women in the Franciscan order.

To be specific, the Catholic identity of Saint Marys hospital is disappearing. More than a hundred years ago, Mayo Clinic and the Sisters of Saint Francis in Rochester, formed a unique, altruistic partnership, which has been sustained up to the present time. The current economic climate challenges Mayo Foundation with economic bankruptcy, and the dwindling numbers of religious women challenge the Sisters of Saint Francis to maintain their values that served to influence the Saint Marys Hospital and Mayo Clinic relationship.

It is worth exploring in some detail the historical origins of Mayo Clinic and Saint Marys hospital, to put in context the deep roots that are now in a state of upheaval. William Worrall Mayo, father of the founders of Mayo Clinic, was born in northern England in 1819, and

emigrated to the United States in 1845. His yearning for the frontier first caused him to learn the trades of pharmacy, then medicine at Indiana Medical College where Dr. Mayo received his MD degree in 1850.

By 1851 he was married, and by 1854 he is recounted by Helen Clapsattle as saying, as he hitched his horse and buggy, because of personal illness and malaria in southern Indiana, “I am going to keep on driving (west) until I get well or die” (Clapsattle, 1969). He moved on to see the Mississippi River and subsequently Minnesota, initially establishing himself in Saint Paul. In order to find his own way, he initially moved to Le Sueur, Minnesota, with his family to work as a plains doctor, also working as a justice of the peace, veterinarian, and newspaper publisher. The American Civil War in 1863, however, led to his nomination as an examining surgeon for the Union Army, whose headquarters were in Rochester, and Dr. Mayo moved his family there in 1864.

Even as a frontier physician, he was regarded as a man of science and famously mortgaged his home to buy a new microscope to help care for his patients. His sons, William J. Mayo and Charles H. Mayo, were born in 1861 and 1865 respectively. Their upbringing was under a “horse and buggy country doctor.” Will and Charlie, as they were affectionately called, were quoted as saying that they were “not geniuses. We were hard workers. We were reared in medicine as a farm boy is reared in farming. We learned from our father” (Clapsattle, 1969).

Maria Moes, founder of the Sisters of Saint Francis of Rochester, was born in 1828 in Remich, Luxembourg. She came to the United States at the age of twenty-two in 1851 and was described by her companions as “strong willed, confident, sometimes headstrong” (Whelan, 2002). She sought the frontier in the United States and followed Bishop John Martin Henni of Wisconsin. Maria Moes became Sister Alfred Moes. It was she who broke off from the Mother House in Joliet, Illinois, and eventually moved a convent of sisters to Rochester in 1877 with the principle mission of teaching (Whelan, 2002).

A tornado struck Rochester in 1883. There was no formal hospital, and the injured and dying were transferred to an improvised hospital. William Worrall Mayo was placed in charge, and several local women volunteered as nurses. “At once, Dr. Mayo saw the need for better organization of the nursing staff. The volunteers were willing enough, but they had homes and families to look after. It was urgently necessary to find nurses who could give their entire time to the job. The next morning, Dr. Mayo appeared early at the convent and said to Mother Moes in his offhand way, "There ought to be a sister down there to look after those fellows." Agreeing at once, Mother Alfred appointed two Sisters to the task and from then on the Sisters supervised the nursing” (Whelan, 2002).

Mother Alfred Moes’ personal characteristics produced a convincing personality. She made the argument that a hospital was needed in Rochester. Within a short time, Mother Alfred approached Dr. William W. Mayo with her idea about a new hospital. Dr. Mayo gave this account of the conversation when he spoke at a hospital addition ceremony in 1894: "The Mother Superior came down to my office and in the course of her visit, she asked, 'Doctor, do you think a hospital in the city would be an excellent thing?' I answered, 'Mother Superior, this city is too small to support a hospital.' I told her, too, that the erection of a hospital was a difficult undertaking and required a great deal of money and, moreover, we had no reassurance of its success even after a great deal of time and money had been put into it. 'Very well,' she persisted, 'but if you promise me to take charge of it, we will set the building before you at once. With our faith and hope and energy, it will succeed.' I asked her how much money the Sisters would be willing to put into it. Her reply was, 'How much do you want?' 'Would you be willing to risk $40,000?' I said. 'Yes,' she replied, 'and more if you want it. Draw up your

plans and it will be built at once'" (Whelan 2002).

That idea, sealed with a handshake, concluded that Dr. William W. Mayo and his medically educated sons, new graduates of mid-western medical schools, would staff the hospital. Saint Marys opened in 1889 as a surgical-only hospital, with exclusively the brothers Mayo and their partners as the staffing physicians. The Sisters of Saint Francis, self-trained in administration and nursing with the help of the physicians of the burgeoning Mayo Clinic, took on the responsibility of running a Catholic hospital. Many years later, Dr. Will Mayo reflected that much of the success was due to the time at which he and his brother entered medicine. He referred to surgical developments of antisepsis and asepsis that yielded unprecedented opportunity. Indeed, Saint Marys Hospital had the good fortune of opening during a new surgical era.

Despite the diversity of their backgrounds, mutual associations significantly helped the Mayos and the Franciscans bridge their differences. Most importantly, they shared a common goal – Saint Marys Hospital's success. Financially speaking, the Mayos, particularly Dr. Will Mayo, were pleased that the hospital paid its own way. The Mayos wanted the hospital to be fully self-supporting. They adopted the policy of telling patients to pay the Sisters' bill first and their bill for professional services second. The hospital underwent unprecedented growth, driven by the expertise of the Mayo brothers with their growing reputation, and the reputation of the hospital (Whelan, 2002).

Sister Whelan, in her historical recount, describes the religious challenges of the day. "The Mayos' dominance of healthcare in Rochester did not go unchallenged. Dr W.A. Allen, the Mayos' homeopathic rival in Rochester, saw the advantage that Saint Marys Hospital gave the Mayos, and began making plans for a hospital of his own. He formed a partnership with another homeopathic physician, hired a trained nurse, and rented a remodeled house. The new hospital, called Riverside Hospital, opened for patients in November 1892. Sentiment rose high enough in Rochester to put the "American Protective Association" planks against Catholic institutions into state political platforms. Local Protestants renewed their opposition to Saint Marys Hospital, and pointed to the rival Riverside Hospital as an institution that Protestants and patriots would enter without doing outrage to their convictions by furthering an agency of the "hated and alien Catholic Church." Dr. Allen saw his chance and made a bid for more business by inviting local physicians, who were not homeopathic, to use the Riverside Hospital.

At this juncture, two important members of the Presbyterian church fell ill and were taken to the Riverside Hospital. They called on the doctors Mayo to attend them. The Mayos faced an important decision. On one hand, to refuse to attend patients at Riverside Hospital cemented their alliance with the Catholic Saint Marys Hospital and made them a target of abuse by their fellow Protestants. On the other hand, to accept patients at Riverside divided their practice between the two hospitals and would have been disastrous for Saint Marys Hospital, because most of their patients would choose the non-Catholic hospital. After deliberating, the Mayos refused to attend patients or operate in the Riverside Hospital. The biographer, Helen Clapsattle, says about their decision, "The Mayos were wise enough to see the advantages of centralizing their practice in one hospital under one staff, particularly a hospital and staff they controlled. Moreover, the Mayos felt a strong moral obligation to the Sisters of Saint Francis who had just lately decided to put all of their eggs in the Mayo basket and were now adding to their investment. And finally, the Mayos were not men inclined to knuckle under to public clamor or the pressure of opposition" (Whelan, 2002).

As anticipated, the Mayos' decision brought censure from a segment of the Protestant

community. In the midst of these contentious times, the Mayos quietly focused on their practice. When critics attacked them and waited for a response, they chose to ignore the abuse and appeared unperturbed by it. Indeed during the height of their controversy, Dr. Charlie Mayo married Miss Edith Graham, one of the first professional nurses at Saint Marys Hospital on April 5, 1893. The Riverside Hospital had been in operation for more than two years when, in September 1895, Dr. Allen said he was leaving his practice in Rochester and moving to Saint Paul. The Riverside hospital closed. The Mayos' decision to centralize their surgical practice became a primary factor in Saint Marys success (Whelan, 2002).

In 1897, the Mayos performed 915 operations. By 1906, 5,000 operations were performed at Saint Marys Hospital, more than half of them intra-abdominal. It was the Mayo brothers who recognized, because of the burgeoning practice, that they could not be skilled in all aspects of medicine. They began to bring on associates, some of whom were nonsurgical, and who could help with the medical management, care, and assessment of patients presurgically. By the turn of the century, the Mayo medical roster numbered eight doctors, including among them Henry Plummer and Edward Starr Judd. Pathologist Louis Wilson joined the staff in 1905. William McCarty, from Johns Hopkins, joined the staff and refined the diagnostic value of histology applied to surgical pathology (Clapsattle, 1969).

As the Mayo brothers' skill and reputation grew, they were invited to speak as celebrities in the medical field. In a famous speech given at the 1910 Rush Medical College commencement, Dr. Will Mayo captured the essence of the Mayo Clinic, "As we grow in learning, we more justly appreciate our dependence upon each other. The best interest of the patient is the only interest to be considered, and in order that the sick may have the benefit of advancing knowledge a union of forces is necessary" (Mayo, 2000). The primacy of the patient welfare, altruism, competence, and teamwork became the Mayo Clinic's primary values derived from this very statement. "The needs of the patient come first," and the Mayo Clinic's mission, "Mayo will provide the best care to every patient every day through integrated clinical practice, education, and research," reflect the institution's history, primary value, and mission, and is used as a guide to the current day (Mueller 2009).

Scientific advances during the first decade of the twentieth century made major contributions to surgery. In 1913, surgeon Dr. Franklin Martin of Chicago organized the American College of Surgeons to maintain the highest ethical and professional standards. Members of the college elected Dr. William J. Mayo president of the organization and Dr. Charlie H. Mayo to the first Board of Regents.

The American College of Surgeons chose Catholic hospitals to begin their reform programs for two reasons. First, half of US hospitals were Catholic institutions. Second, experience told them that hospitals supported by civic communities strongly resisted admitting flaws in the institution they built. By contrast, they perceived Catholic institutions as more homogeneous, less tied to local community control, and potentially more open to reform. Dr. Martin reflected on the decision, "The Catholic hospitals, many of them the oldest in the United States and Canada, contain more than 50% of all beds on the continent. As we viewed it, hospital standardization to succeed must be looked on as a spiritual as well as an educational movement." Directors of the Surgeon's College believed that a national Catholic hospital organization would offer a resource for reform (Whelan, 2002).

Father Charles B. Moulinier SJ, a member of the Marquette University School of Medicine in Milwaukee, was selected to head the new Catholic Hospital Association. In less than one year, Father Moulinier convened the first convention of the Catholic Hospital Association in 1915. Sister Joseph Dempsey OSF, of the Sisters of Saint Francis of Rochester, was appointed and

acted as chairman for the business meeting. She served as the first chairperson of the organization. Sister Joseph was the “famous Supervisor of Surgery at Mayo Clinic” (Whelan, 2002).

The American College of Surgeons met in April 1918. That summer, during its convention, the Catholic Hospital Association officially resolved to support the program for reform. Members agreed that a resolution be sent to Dr. William J. Mayo, President of the American College of Surgeons, to read as follows: “Be it resolved that we, the Catholic Hospital Association of the United States and Canada, now assembled in Chicago in our third annual convention, approve the work being done by the American College of Surgeons for the standardization of hospitals, and assure the College of our full cooperation in its endeavor for the betterment of hospitals and the resultant increased welfare of mankind.” This resolution pledged almost 600 hospitals to standardization (Whelan, 2002).

Early in 1914, the medical faculty of the University of Minnesota, which had been recently consolidated from several medical schools, began to make plans for instituting graduate work in clinical medicine. President George E. Vincent suggested, when approached by the Mayo brothers, that they might be able to form a corporate foundation to handle the education and research phases of their work in Rochester. Dr. Will Mayo immediately agreed. On February 8, 1915, Dr. Mayo and his partners executed articles incorporating the Mayo Foundation for Medical Education and Research. The next day, doctors Will and Charlie endowed it by transferring to three trustees, securities amounting to $1.5 million. This was to be administered by individuals within the University of Minnesota, but this was met with resistance by local medical societies from Minneapolis and Saint Paul. This eventually went to the Minnesota legislature; and when the legislature convened in 1917, opponents became vocal in their opposition to linking the University of Minnesota to Mayo Clinic (Clapsattle, 1969).

Dr. Will Mayo was asked to appear for legislative hearings about the impending bill allowing association between the University of Minnesota and Mayo Clinic. The speech given that day is one of the lost orations of the Mayo Clinic; however, small sections were recorded in local newspapers. It was recorded that Dr. Will Mayo said, “Every man has some inspiration for good in his life. With my brother and I, it came from our father. He taught us that any man who has physical strength, intellectual capacity, or unusual opportunity holds such endowments in trust to do with them for others in proportion to his gifts. We want this money to go back to the people from whom it came, and we think it can best be given back to them through medical education” (Clapsattle, 1969).

Quoting from Lincoln, “that these dead shall not have died in vain,” Dr. Will Mayo said, “that line explains why we want to do this thing. What better could we do than help young men to become proficient in the profession so as to prevent needless deaths?” Objections were overruled, and the association between Mayo Clinic and the University of Minnesota was established. That was in March 1917. America declared war against Germany on April 6, 1917. Articles making the affiliation permanent were signed September 17, 1917 (Clapsattle, 1969).

Later, quotes in news accounts included, “What we want to do is make the medical experience of the past generation available for the coming one and so on indefinitely so that each new generation shall not have to work out its problems independently but may begin where its predecessors left off. This Foundation, its fund, and all that goes with it are the contribution of the sick of this generation to prevent sickness and suffering in the next and following generations” (Clapsattle, 1969).

Endowing the Mayo Foundation wiped out the brothers’ personal savings; but as the principle

partners in the Foundation, they still retained ownership of the properties and the capital of the partnership. However, their next step was to ensure that the trust would contribute to the advancement of medicine and be held in perpetuity for advancement of medical education and research. In October 1919, the Mayo brothers transferred the ownership of all of the properties of the Mayo Clinic, from the buildings down to the last test tube, case record, and pathological specimens, along with all accumulated cash and securities. By 1925, the properties were valued at $5 million and the securities amounted to $5.5 million more. The administration of the Mayo Foundation was vested in a Board of Governors made up of the former partners, Mr. Harry Harwick, and two members chosen from the staff. The supervision of the professional activities was entrusted to the Executive Committee of the five members appointed by the Board of Governors from a list of fifteen nominated by the staff (Clapsattle, 1969).

Before 1922 Saint Marys Hospital was exclusively a surgical hospital, because the surgical demand left no hospital rooms available for patients with exclusively medical problems. A major expansion occurred in 1922. Within the year, renovations in the older part of the building provided facilities and patient beds for the Departments of Medicine, Pediatrics, and Obstetrics. The sisters borrowed $2 million to complete the task.

In honor of the 1922 expansion, Dr. William Osler, who is considered the father of Internal Medicine, contacted his friends the Mayos. Now residing at Oxford University after spending many years at Johns Hopkins, he noted the change and hailed it with joy. “The surgeons have had their day, and they know it! The American Saint Cosmas and Saint Damian, the Mayo brothers, have made their Clinic today as important in medicine as it ever was in surgery. Wise men! They saw how the pendulum was swinging” (Clapsattle, 1969).

The depression of the 1930s, however, created a markedly different environment. Whereas the 1920s had been bountiful, widespread prolonged unemployment made people reluctant to come to Saint Marys Hospital for treatment. Those who came often had no money to pay their bills. In 1931, patients numbered 6,527, less than half the number recorded three years earlier. The next year, hospital registrations sank to 40% of capacity (Whelan, 2002).

Struggling to keep financially afloat, the congregation of the Sisters of Saint Francis looked to Saint Marys Hospital for its lifeline. Earlier, Sister Joseph had established a fund for building a larger chapel. The Chapel Fund offered a source of immediate revenue. Between September 1932 and January 1933, the congregation borrowed more than $50,000 from the fund to cover financial obligations. Hospital monies would continue to play a vital role in meeting the congregational debt The congregation’s broker, hired to administer repayment of the debt notes, had misused the Sisters’ money for his own purposes. The congregation lost $350,000. The newly elected Mother Superior, Aquinas Norton, appointed Sister Adele O’Neill as congregational treasurer. Since eighty percent of the creditors were from Chicago, Sister Adele sought assistance from a large Chicago bank. As she put it, “We made friends with the Continental Bank of Chicago and found the vice president to be very helpful” (Whelan, 2002).

The year 1939 was a difficult one for Mayo Clinic. Both Dr. Charlie Mayo and Dr. Will Mayo died in that year. The collaboration between the Mayos and the Sisters of Saint Francis, however, was thriving. Sister Joseph Dempsey, who was the principal administrator for Saint Marys Hospital, also died in 1939 of an acute respiratory infection (Whelan, 2002). These giants created the collaboration between Saint Marys Hospital and Mayo Clinic. Ironically, at the time of their deaths, that collaboration was thought to be cemented in perpetuity.

Prior to 1968, the collaboration between the Sisters of Saint Francis and Mayo Clinic thrived

symbiotically based on the mutual agreement. The agreement that established Saint Marys Hospital was created by a handshake, not by a contract. The governance of Saint Marys Hospital was by the Sisters of Saint Francis, who controlled finances, operations, and administration. Mayo Clinic physicians collaborated with the Sisters by overseeing surgical services and inpatient medical care (Whelan, 2002).

The Evolution of Catholic Identity for Saint Marys Hospital

The first ethical and religious directives (ERDs) from the United States Conference of Catholic Bishops (USCCB) were published in 1948, creating for the Catholic Health Association (CHA, formerly the Catholic Hospital Association formed so many years before), the basis for hospital uniformity of Catholic identity (USCCB, 2009). Changes subsequently precipitated by the Second Vatican Council by 1968 led to reformulation and reconsideration of many of the initial recommendations. This social change, coupled with the decrease in the number of religious sisters committed to religious life, changed the workforce available for Catholic hospitals. At Saint Marys hospital, Sister Mary Brigh Cassidy, the Saint Marys Hospital administrator in 1968, established the Board of Trustees comprised of Sisters and public members.

A “Philosophy of Sponsorship” document was created by the Sisters of Saint Francis in 1973. This document sought to provide practical guidance to both sisters and lay individuals regarding the day-to-day operations at the hospital. In 1983, the Saint Marys Hospital Board of Trustees appointed their first Franciscan Sponsorship Coordinator. The role of this person was to ensure that the values articulated in the “Philosophy of Sponsorship” documents were upheld. As the Saint Marys Hospital Board of Trustees continued to operate as a separate entity, the Sisters of Saint Francis occupied a one-over-half majority on that board (Swetz *et al*., 2013).

With increasing growth of Mayo Clinic, and dwindling numbers of Sisters of Saint Francis, the Sisters and interested stakeholders recognized the importance of maintaining the Catholic and Franciscan identity of Saint Marys Hospital. Eventually, because of changes at Mayo Clinic and an increasing need for Mayo to be involved with the governance of Saint Marys Hospital, the Sisters of Saint Francis turned Saint Marys over to Mayo Clinic. The sisters and Mayo created the “Sponsorship Agreement” executed on May 28, 1986. This was a formal written agreement between the Mayo Foundation, Saint Marys Hospital, and the Sisters of Saint Francis. The document formally created the Saint Marys Sponsorship Board. The Mayo Clinic, through the Mayo Foundation, with a common governance and management structure, took over the day-to-day operations of Saint Marys Hospital but agreed to continue to operate it as a Catholic hospital. In order to maintain that designation, Mayo Clinic agreed to several contingencies. First, was to continue to follow the ethical and religious directives (ERDs) under the diocese of Winona and the bishop (USCCB, 2009). Second, the Philosophy of Sponsorship document would continue to provide guidance regarding the overall day-to-day workings of Saint Marys Hospital. Finally, a philosophy and mission statement of Saint Marys Hospital promoting the common goals and values of the Sisters of Saint Francis was set against the backdrop of the Mayo Foundation. The Sponsorship Agreement insured the Catholic identity of Saint Marys Hospital, beyond outward signs and symbols. The goal of sponsorship was defined as collaboration between the Sisters of Saint Francis and Mayo Clinic to promote and preserve key values the founding Franciscan Sisters and Mayo physicians embraced (Swetz *et al*., 2013).

The question, “What makes a hospital Catholic?” has been addressed in publications during the last 30 years (Swetz *et al*., 2013). The Catholic Health Association (CHA) published guidelines

regarding this in their 1980 publication “Evaluative Criteria for Catholic Health Care” (CHA, 1980). This was shortly followed by the United States Conference of Catholic Bishops’ pastoral letter on “Health and Health Care,” which described challenges Catholic hospitals faced (USCCB, 1981). These documents, along with successive iterations of the ERDs, have provided guidance to Catholic institutions for operationalization of these goals (USCCB, 2009).

However, the Saint Marys Sponsorship Board has not exercised operational control of the hospital assets since 1986. Rather, these are controlled by Mayo Clinic. The Sponsorship Board, however, has been responsible for influencing the fiscal policy of the organization, particularly at Saint Marys Hospital, so that resource allocation occurs in an appropriate fashion, in alignment with the ERDs. Regarding the beginning of life, all reproductive care at Mayo Clinic Rochester is provided at Rochester Methodist Hospital where abortions and in vitro fertilization programs reside, separate from Saint Marys Hospital. This model has been described as a “carve out” where Saint Marys Hospital has no supervisory, financial, or direct involvement in issues that would violate Catholic ERDs. However, end-of-life palliative care is readily available at Saint Marys Hospital and follows the ERDs. The issues at the beginning and end of life are monitored by the Ethics Consultation Service of Saint Marys Hospital in conjunction with the Sponsorship Coordinator. The Winona diocese and Bishop, or his appointee, is consulted on an ad hoc basis if issues arise that require further scrutiny. The close link between Mayo’s institutional values, the Franciscan values, and Catholic healthcare values are supported by this sponsorship agreement. This governance mechanism of “influence” has been in place for over 25 years.

The Sponsorship Agreement created a variety of concerns for the future. First, the Sponsorship Board does not have a direct financial or asset control in order to insure ERDs are followed at Saint Marys Hospital. Financial pressures are to consolidate services in a single hospital entity. Second, secular cultural influences of “inclusion” may create medical practices that violate the ERDs. Third, the Sponsorship Board, which is under the influence of the Sisters of Saint Francis, can only “influence” fiscal policy. This happens only indirectly, and there is no direct Franciscan presence on the Mayo Board of Governors, which actually determines the policies for Mayo Foundation. Finally, the Sisters of Saint Francis of Rochester are dwindling in numbers. This reduction creates an inevitability of reduced influence by the Sisters of Saint Francis on the policies of Mayo Clinic as carried out at Saint Marys Hospital. This will certainly have an impact on reproductive services and end-of-life ethical issues in the future.

The USCCB has expressed interest in “forming new partnerships with healthcare organizations and providers.” There has been, however, no embracing of this initiative by Mayo Clinic, its Board of Governors, and particularly no interest by the governance of Mayo Clinic to deal with controversies challenging the ERDs. This has been played out by the silence of Mayo Clinic Board of Governors during the discussion of the assault on Catholic health care by the Health and Human Services mandate recently.

The Sisters of Saint Francis have tried to expose Mayo Clinic personnel to Franciscan values by providing for and guiding an annual Franciscan Leadership pilgrimage since 1997 for Mayo administrators to Assisi, Italy. This is to create an influence of both Franciscan and Catholic values in the governance of Mayo Clinic. The concrete manifestations of this influence however are not readily apparent to most Mayo Clinic staff physicians who routinely work at Saint Marys Hospital. Indeed many are not cognizant of the existence of the Sponsorship Board, and its role in influencing the governance of Saint Marys Hospital.

Conclusion

At Mayo Clinic, “the needs of the patient come first” is soundly grounded in the historical and operational activities of the institution. The 25th Anniversary of the Sponsorship Agreement was celebrated in 2011. However, the collaboration with the Sisters of Saint Francis has changed, and the Catholic identity of Saint Marys Hospital is ending because of the waning influence of the Sisters in the operations of the hospital. Concerns among lay physicians who work in Saint Marys derive from the uncertainty about the future, and the concerns about the consistency of the Mayo Foundation in following those agreements initially articulated in the Sponsorship Agreement in 1986. The Catholic identity of Saint Marys Hospital is left in doubt. The question for the Mayo Foundation and the Sisters of Saint Francis is “Where do we go from here?” The hope for the future of Catholic influence may be with the lay faithful of the hospital, to maintain the Catholic identity of Saint Marys. However, no provision to empower them has been created to bring about this end.

Epilogue

In a memo and news release March 25, 2013, originating from the Mayo President and Chief Executive Officer John H. Noseworthy, MD, and Vice President and Chief Administrative Officer Shirley A. Weis to the staff and public, Mayo Clinic announced its intentions:

“Effective next January (2014), Saint Marys and Methodist hospitals on the Rochester campus will become a single licensed hospital under the name Mayo Clinic Hospital – Rochester. We are making this change in licensure and legal status of the hospitals to reflect our integrated hospital practice, ensure accurate reporting of data, and reinforce our ability to prove the value of Mayo Clinic care to patients and payers.”

“Mayo Clinic currently has a single integrated hospital practice divided between two hospital licenses and two legal entities. Regulations require separate reporting for the two hospitals, which has led to an increasingly incomplete and incorrect picture of our care. Reporting as one hospital will ensure that regulatory agencies, payers, and patients have accurate information about Mayo Clinic.

“The change in legal status means that Saint Marys Hospital will no longer be an official Catholic health care institution. However, the history, values and connections that have shaped the hospitals and Mayo Clinic will remain. The Academy of Our Lady of Lourdes Board, comprised of leadership from the Sisters of Saint Francis, approved the change in legal status.

“Even though the hospital name is changing, the Franciscan Mission and Founders’ Values will remain. Patients, families, staff, and the public will continue to see widespread presence of the Franciscan Mission and Founders’ Values throughout Saint Marys Hospital. Saint Marys chapel will continue the current worship schedule, worship broadcast, and reservation of the Eucharist. The chaplaincy services at the hospitals will remain the same. The convent on the current Saint Marys Hospital campus will remain. The Sisters of Saint Francis presence at the hospital will remain unchanged. Sponsorship Board activities will continue through a new structure that is being jointly developed by the Franciscan Sisters and Mayo Clinic” (Mayo News release, March 25, 2013).

These decisions have taken place essentially as a business transaction between Mayo Clinic and the Sisters of Saint Francis. This serves as an example of the lost influence of Catholic culture on one of the prominent medical institutions of our time.

Dr. Will Mayo's comments from a 1932 faculty meeting may sum up the current concerns well:

"Admitting that rules and regulations may be necessary to conduct the affairs of the Clinic, we hope that too many rules and regulations will not be instituted…*it is necessary to have a liberal attitude towards those who are responsible for the care of the patients, and to see that necessary rules and regulations do not needlessly interfere with the initiative of members of the staff. We know only too well the necessity for efficient management, but there is a spiritual as well as a material quality in the care of sick people, and too great efficiency in material details may hamper progress" (Beck, 2000).*

Where will this spiritual influence come from?

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Beck, C.S., "Mayo's Spiritual Heritage," Mayo Clinic Proceedings, 2000: 75, pp. 1111-12.

Catholic Health Association of the United States, Evaluative Criteria for Catholic Health Care.

Facilities: A Working Document for Self-Renewal (St Louis: The Catholic Health Association of the United States, 1980).

Clapsattle, H., The Doctors Mayo (Rochester, MN: Mayo Foundation for Medical Education and Research, 1969, fifth printing 1990).

Mayo Clinic News Center, "Saint Marys and Rochester Methodist Hospitals to become single licensed hospital," March 25, 2013.

http://newsletters.mayo.edu/newscenter/shield_updates/practice/DOCMAN-0000144783

Mayo Clinic News Center, "Mayo Clinic reports solid 2012 financial performance at news conference," Feb. 28, 2013.
http://newsletters.mayo.edu/newscenter/shield_updates/leadership_messages/DOCMAN-0000143009

Mayo, W.J., "The necessity of cooperation in medicine," Mayo Clinic Proceedings, 2000: 75, pp. 553-56.

Mueller, P.S., "Incorporating Professionalism into Medical Education: The Mayo Clinic Experience," Keio Journal of Medicine, 2009: 58 (3), pp. 133–43.

Swetz, K.; Crowley, M.E.; Maines, T.D.; "What Makes a Catholic Hospital 'Catholic' in an Age of Religious-Secular Collaboration? The Case of the Saint Marys Hospital and the Mayo Clinic," HEC Forum. Published online January 6, 2013 (DOI 10.1007/s10730-012-9207-8).

United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services (fifth edition, November 2009).
http://www.usccb.org/about/doctrine/ethical-and-religious-directives/

United States Conference of Catholic Bishops, Health and Health Care (1981).

http://old.usccb.org/sdwp/national/HEALTH.PDF

Whelan, E., The Sisters' Story: Saint Marys Hospital – Mayo Clinic, 1889 to 1939 (Rochester, MN: Mayo Foundation for Medical Education and Research, 2002).

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FEATURE ARTICLE

Meeting Suffering

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In his Apostolic Letter *Salvifici Doloris* ("On the Christian Meaning of Human Suffering"), Blessed Pope John Paul II wrote: "The theme of suffering… is a universal theme that accompanies man at every point on earth: in a certain sense it co-exists with him in the world, and thus demands to be constantly reconsidered."[1] We all know that suffering is a common experience; we have each of us suffered in some way in our lives, we know others who have suffered and we are also, thanks to the media, acutely conscious of widespread suffering throughout the world. As John Paul II put it: "in whatever form it takes, suffering seems to be, and is, inseparable from man's earthly existence…. man walks in one manner or another on the long path of suffering."[2] It is on this "path of suffering" that medicine meets man, and it is the nature of this meeting which is our present topic of discussion.

What Is Suffering?

At the outset of this discussion, and in order to keep in mind the depth of the question before us, it is worthwhile asking the question: "What exactly *is* suffering?" We might speak of it in terms of pain, whether that is physical, emotional, psychological, spiritual, or social; and we might discuss pain in terms of neurotransmitters and nerve pathways or emotions and feelings. Yet suffering seems to be something that encompasses all these experiences and reaches still deeper within us.

A search for synonyms for the word suffering gives words such as "anguish," "distress," "affliction," "misery." We can say, with John Paul II, that "man suffers when he experiences any kind of evil."[3] This explanation rings true from the way we speak about suffering as something "bad," or "not right." But if suffering is an experience of evil then it naturally prompts the question, "What is evil?"

In the Judeo-Christian tradition, evil has always been understood as a lack, limitation, or distortion of good. In this way we can say that man suffers because of a good in which he does not share; for example, when we are sick we are suffering because we do not share in the good that is health. This truth is also reflected in the basic human response to suffering which is to try and alleviate it, to restore the good that is missing. Suffering is a scandal to us; it is something that we intuit *should not be.* Phrases we often hear in situations of suffering such as:

"It is not fair…" or "She does not deserve this…" reflect our attempts to make sense of suffering, and it is this struggle that is particular to man's experience of suffering.

The fullest response to the "why?" of human suffering, then, comes not through words or explanations, but through gesture, through presence. To remain, even when there appear to be no more answers, is itself the beginning of an answer.

What makes suffering a *human* reality, we can say, is the fact that man *knows* he is suffering and wonders why. "Within each form of suffering endured by man… there inevitably *arises the question: why?* It is a question about the reason and the purpose of suffering, in brief a question about its meaning."[4] We suffer most intensely when we do not have an answer to this question.

Suffering, then, provokes in us deep questions: Why am I suffering? Why is there evil in the world? Who am I? Behind which lie deeper questions still: What is man? Who is God? Does God even exist? And it is in virtue of these questions, particularly the question "why?," that suffering becomes a place in which man reaches beyond himself, since in asking "why?" he is ultimately addressing God himself. As John Paul II wrote, "…what we express by the word 'suffering' seems to be particularly *essential to the nature of man.* Suffering seems to belong to man's transcendence: it is one of those points in which man is in a certain sense 'destined' to go beyond himself, and is called to this in a mysterious way."[5] Suffering reveals man's relationship with the transcendent; it is a moment in which we can discover again our foundational openness to God as we turn outwards in search of answers.

The Suffering Body

This call to reach beyond ourselves, this search for meaning that suffering brings about in our lives, is rooted in the body. After all, it is only possible for us to suffer at all because we *are* bodies and in the concrete experience of physical suffering we are specifically reminded of our corporeality.[6] Our bodies immerse us in the physical world, without any prior choice on our part; we experience pain and limitation. It is this very experience of our *physical* limits that causes us to search for something more, to question, to wonder, to reach beyond ourselves, to ask "why?"

If suffering is rooted in the body then it is worthwhile taking time to explore the experience of physical suffering to discover what, if anything, the body reveals about the question of suffering itself. To do so is to follow in the footsteps of the many thinkers who see that it is man's experience of life which points him towards meaning, but in particular to work within the framework of John Paul II's powerful *Theology of the Body*, which accepts a synthesis between the corporeal and the spiritual. It is that which allows us to speak of a "language of the body." [7]

John Paul II proposes that the body reveals three "original experiences" in God's plan for man – "original solitude," "original unity," and "original nakedness" – and that these interrelated moments stand at the foundation of every human experience. It will be proposed here that the dynamics at work in a moment of bodily suffering correspond with the truths of man's original experiences, and so allow man's search for meaning to begin to take shape. This is a worthwhile exploration for medicine in particular, since medicine's point of entry into the

whole “world of suffering” is the human body; each patient we meet is in the midst of experiencing this “language of the body.”

The primary experiences that come to the fore when we suffer physically are those of vulnerability and dependence. In a moment of sickness, our bodies remind us of our fragility and the precarious nature of our existence; they stir in us (whether this is explicitly conscious or not) the realization that we do not hold ourselves in being; we are not the source of ourselves; they cause us to question, to wonder; and this is what makes human suffering unique. This experience corresponds with “original solitude” in which John Paul II expresses how man discovers himself as unique in creation; he is a being capable of wonder, capable of a relationship with God. Suffering is a moment that makes it possible for us to rediscover this foundational openness to God.

A second moment in the experience of physical suffering is that we come face to face with our need for others, whether that is our need for the skills, expertise and care of our physicians and nurses, or the love and support of our families; we cannot escape the fact that we depend on others. We are broken open as it were from the inside, and in discovering our dependence on others we learn that we exist, not as isolated individuals, but in relation. This discovery is encompassed in what John Paul II calls “original unity,” in which he saw how the creation of humanity is only complete in the unity of the two, male and female; and so the human person discovers himself already existing in relation to another and can only fully understand himself in such a relation of unity and difference.

What is more, the nature of this relation is also revealed in a third element at play in suffering, which is the response of those around the one who is suffering – the environment in which he is received. Since the only truly human response to suffering is one of com-passion, in which we reach out and care for the one who is suffering, and even choose to suffer-with him, this relation should emerge as one of love. This corresponds with John Paul II’s concept of “original nakedness,” by which he understands the body to reveal the nature of man’s relation to the other and to God as one of love, since the male and female bodies are ordered towards a mutual self-giving that is fruitful.

As José Granados writes in his article entitled *Towards a Theology of the Suffering Body*, “What is revealed about the body in suffering is its openness to the world in the form of vulnerability. This openness guides us to solidarity with our fellow men: the body becomes a place of communion, by means of compassion (from the Latin *compati*, ‘to suffer with’).”[8] Suffering draws us into community, and the response of this community to the spectacle of suffering mediates meaning to the one who is suffering. For, if our dependence and vulnerability are met with genuine compassion and care, we can realise that we still are valued because, even in our brokenness and frailty, we have an innate dignity and worth.

It is possible to explore this “language of the body” further through one particular response to suffering that appears in palliative care, and to propose, not just a “language of the suffering body,” but also a “language of the dying body.” Such an exploration is greatly enhanced by the work and writings of Dr. Cicely Saunders, pioneer of palliative care and founder of the modern hospice movement. Saunders has a particular voice in any discussion about medicine and suffering and a contribution of considerable weight, because she chose to live alongside the most vulnerable and dependent patients we can meet: the dying.

Saunders once asked a dying man what it was he needed from those caring for him. He replied, “I look for someone to look as if they are trying to understand me.”[9] In searching to do just this, Saunders found that all suffering, but perhaps the suffering of the dying more than

any other, can bring us to a place of darkness, of abandonment, where there seems to be no answer to the question "why?" She wrote, "However much we can ease distress, however much we can help patients to find new meaning in what is happening, there will always be the place where we will have to stop and know that we are really helpless."[10] And yet, it is precisely in this place that the response of those close to the suffering person becomes crucial. "Even when we feel that we can do absolutely nothing, we will still have to be prepared to stay."[11]

The fullest response to the "why?" of human suffering, then, comes not through words or explanations, but through gesture, through presence. To remain, even when there appear to be no more answers, is itself the beginning of an answer. For in remaining we are acknowledging the goodness of the suffering person's very being, we are receiving them just as they are, we are saying simply, "You matter because you are you and you matter to the end of your life."[12] And from *within* this response of presence, of being received, it becomes possible for the suffering person to face the deepest truths that the experience of suffering brings to the fore.

The dying person, more concretely than any other, is faced with the fact that we do not hold ourselves in existence. Yet, when we are held in a community that continues to value us and to reflect to us our worth, our existence continues to have purpose and meaning. As Granados observes, "This movement of compassion is a new revelation for the suffering person. Someone cares for him in the midst of his pain; even more, someone wishes to suffer with him. This compassion reawakens in him the sense of his own dignity; it is the beginning of the answer to his question to God regarding the meaning of suffering."[13]

In this way the discovery that I am not source of myself can be transformed into the discovery that there is One who *is* my source. The paradox of the language of the dying body is that just as life seems to be being taken away, it is possible to discover that it was given in the first place. And if life is given, then there must be a Giver – One who stands at the foundation of life and to whom we can return the gift of life as an act of gratitude. This means that man has an origin, and so he has a destiny: he is a being-from (God and others) and a being-for (God and others). The whole hermeneutic of gift that John Paul II proposes in *Theology of the Body* is laid bare.

Therefore, we can say that the concrete experience of bodily suffering, and in particular that of the dying body, points us towards fundamental truths about the human person which offer us a way of living with the "why?" of suffering. Granados speaks of suffering as a "boundary experience" which allows us to glimpse again the original truths of creation.[14] In this way, those of us fortunate to serve those who are suffering find ourselves to be the ones who are receiving, and the patients are giving to us. For, if we take on board the truths about the human person that the suffering and dying body reflects to us, our own experience of living is transformed and enriched. In this way, we can glimpse what Saunders meant when she said, "We need the dying person as much *and more* than they need us."[15]

Medicine's Challenge

Medicine, then, as the discipline directly engaging with the question of physical suffering, unavoidably participates in all the questions revolving around the experience of suffering, and does so directly through the body. In one way, this places medicine in an advantageous position, because it always has before it the witness of the suffering body, which points to fundamental anthropological truths. However, we have to ask whether modern medicine, permeated as it is by the secular anthropology of Western civilization, is capable of

recognizing this witness of the body or of hearing the language of the suffering body.[16]

We do not expect medicine to *solve* the mystery of suffering, but we do need it to respect the truths reflected to us by the *experience* of suffering, and to work within a framework that corresponds to that experience. Do we find such a correspondence within contemporary medicine? Without it, put simply, medicine will not be able to meet suffering and this, in turn, will contribute to an intensification of suffering.

In an attempt to open up this question of suffering for continued discussion, and without claiming to address all the anthropological issues involved, three main areas will be briefly proposed for exploration. These have been chosen because they come to the fore within the clinical setting, and they give a clear illustration of principles of secular anthropology at work in contemporary medicine, which directly impact how medicine engages with the reality of suffering.

1. The Body

The first of these is how medicine approaches the body. It is immediately evident that medicine operates according to mechanistic principles when it deals with the human body. The body is conceived of as an intricately connected collection of parts or organs, which can be treated separately, or even taken out to be fixed and replaced. The body in effect is a machine, an artefact, in which the whole is simply a group of parts whose unity is a matter of organization.

This mechanistic attitude is reflected in the way we separate and divide the disciplines within medicine, so that different parts of the patients' bodies are treated by different teams, the priorities of which can often be very different, or even in conflict. Mechanism is also reflected in our language. An extreme example of this, but one that is brutally honest in a way, is when we hear healthcare professionals referring to patients according to their diagnosis or dysfunctional organ: "The mitral valve in Bed 8…" or "I've got a fractured femur to do before lunch…"

The difficulty is that this approach to the body, in which it becomes a machine or a tool we employ in order to exist, stands in direct conflict with the experience of the body that the patient is going through. It is precisely when we are suffering that the usual "transparency" of our bodies is obscured and we become acutely aware that we do not *have* a body, we *are* our bodies. We know that we never meet a body, we meet a person; we never see an organ, it is always *someone's* organ. This might seem obvious, and we could say that if we are healthcare professionals worthy of the name we would always seek to promote person-centred care that respects this reality. The question we need to ask is why is it a *struggle* to do that in our modern healthcare system?

Moreover, if we are serious about the unity implied in a true "person-centred care," then we should follow this through and explore the fact that human biology is always a *personal* biology – which is to say that the unity between the body and soul is radical; the soul is informing the body from within. Such a discussion would be extremely difficult in modern medicine, because materialistic principles mean that the body must be nothing but matter, and matter cannot have any meaning. The patient's experience of suffering can have no unity.

2. Health

The second area necessary to any discussion about medicine and suffering is the question of health, since in seeking to relieve suffering, medicine aims to restore health. Traditionally,

health has been understood as wholeness; the word comes from the same Indo-European root as the words “heal,” “whole,” or “holy.” So *healing* is about restoring unity and relation in something that is broken or divided. However, if the body is just a collection of parts inside parts, then health has simply to do with the organization of these parts. A purely technological approach to health cannot see that health is a harmony that is not produced by the interaction of mechanical parts manipulated by a physician’s activities.

What is more, modern medicine, by approaching the body as a collection of parts inside parts, in fact imitates dis-ease, which is itself characterized by division and disintegration.[17] We separate the person from fundamental relationships which have an integral part to play in their wholeness, in their health: fresh air, good food, sound sleep, family, and friends. This might be necessary for a time, for some technical reason, but we have to accept that this will not lead to healing.

As the writer Wendell Berry so astutely observes, “The modern hospital, where most of us receive our strictest lessons in the nature of industrial medicine, undoubtedly does well at surgery and other procedures that permit the body and its parts to be treated as separate things. But when you try and think of it as a place of healing – of reconnecting and making whole – then the hospital reveals the disarray of the medical industry’s thinking about health.”[18]

Patients themselves articulate this reality to us in phrases such as, “I need to get home to get well,” or “I’ll get some rest when I get home.” This should lead us to ask, is “healing” in the fullest sense a realistic aim for modern medicine? Should we not acknowledge that the most we can offer is to “fix” people? And if this is so, we must acknowledge that suffering is a much greater question than medicine can address, and perhaps medicine has something to learn from suffering?

3. The Person

The third area is how medicine approaches the person. This too reflects the reductive mechanism at work in our anthropology. Just as we treat organs or diseases in isolation, so we treat the person as an isolated individual within a community. We attempt to (re)construct relations, while at the same time prizing independence and a self-sufficient autonomy above all else. In Wendell Berry’s phrase, we are “fanatically individualistic.”[19]

This isolation of the person is one of the biggest challenges of our time, and crystallizes around the question of suffering. We have discussed how the experience of suffering forces us to face our need for others and our dependence. Each patient we meet is in the midst of this experience, and is going through that in an environment and a system that, at every level, has no recognition of “relation.” There is frequently poor communication between the diverse teams dealing with patients’ different symptoms or organs. We are taught to stay “professional” and not become too involved with our patients. In the acute setting, patients feel this isolation from relation at a practical level in visiting times needing to be strictly limited and facilities for families and friends not being a priority. On-going financial aid, care structures in the community and rehabilitation programs focus solely on the individual in isolation.

A young mother (known to this writer) paralyzed by a spinal injury, and immersed in our modern medical system for seven months, found eventually that in order to articulate to those working with her towards rehabilitation at home the way she wished to live family life with her husband and her children, she needed to say, “I do not want to be independent. I want to

be inter-dependent." The key to living with suffering, as this mother found within her very profound experience of dependence, comes in relation, in community. Suffering is only intolerable when no one seems to care.

By approaching the person as an isolated individual we should ask: does medicine in fact leave people alone in their suffering? And if so, does it thereby make their suffering worse?

Suffering

How then, in the light of all these points for discussion, *does* contemporary medicine understand suffering?

Suffering is experienced as something that challenges and threatens our existence. We have discussed how it draws us into the fundamental questions about reality ("Who am I?" "Who is God?" and most significantly "Why am I suffering?" and "What does this *mean*?") – how it may offer a moment of transcendence. Contemporary medicine attempts to respond to that moment according to a reductive and secular anthropology that excludes the question of God and the transcendent from the outset. This has a number of interrelated consequences for its understanding of and engagement with the question of suffering, and we meet these consequences in our clinical practice.

Within a framework that excludes the transcendent, this life appears to be the only life we have, and so it must be preserved at all costs. Anything which threatens life ought to be fought and overcome, and so the eradication of suffering becomes *the* pressing goal of our culture. Of course, at one level this is an honorable objective, since to relieve suffering is and ought to be a pursuit of any truly humane society. Yet, there is a world of difference between *alleviating* suffering and *eliminating* suffering. The modern ideal of progress means that we are striving for a world without suffering – and that we expect to be able to achieve this.

As Granados writes, "Technological man can pursue his triumphant march towards lordship over the future only if he is able to exorcize suffering."[20] Medicine finds itself at the heart of this struggle because it has as its object the human body, in virtue of which we suffer in the first place. Professor Leon Kass argues that the "prolongation of healthy and vigorous life – and ultimately, a victory over mortality – is perhaps the central goal and meaning of the modern scientific project…"[21] Our attempt to overcome suffering becomes a practical project which we approach with all the techniques of the applied science of medicine, and which we expect to be successful. As Granados observes, "science is supposed to be stronger than evil."[22]

What is more, undertaking such a pursuit within a secular anthropology that excludes any idea of God means that the responsibility for overcoming suffering lies squarely on the shoulders of man. Man is to blame for the fact that suffering still exists. As Granados observes, "The burden has passed, then, from the shoulders of God (who is viewed as inoperative in this world) to the shoulders of man (who, with the imperative of progress, has made himself responsible for healing all disease and repairing all disorder)."[23]

The logical conclusion of this technological and progressivist approach to suffering is that we should be able to overcome death. Death stands in front of us as a failure of modern medicine, a reminder of its limits. There is certainly no denying that it is often experienced as a failure, particularly by the physicians and healthcare professionals involved. We see this reflected very simply in the language we use when we are confronted with a terminal diagnosis. The most common phrase patients hear in such a situation is, "There is nothing more we can do…"

or, “There is no more we can offer you…” or again, “We aren’t going to win this one…” As Wendell Berry puts it, “The world of efficiency is defeated by death; at death, all its instruments and procedures stop.”[24] What is being said about the goal and purpose of medicine in such phrases? Kass suggests, “If medicine regards every death as premature, as a failure of today’s medicine, but avoidable by tomorrow’s, then it is tacitly asserting that its true goal is bodily immortality.”[25]

This means that all those we cannot hope to cure – the chronically ill, the disabled, the dying – become, to varying degrees, “hopeless cases.” We cannot hope to fix the situation in which these people find themselves; our technological methods fall short of the reality placed before us. What is more, the suffering experienced in such situations is precisely what a secular anthropology does not *want* to face. The “hopeless cases,” more than any other, remind us of the transcendent aspect of suffering and of the human person, for it is these situations which cause us to ask “why?” and so to seek beyond ourselves for an answer. Within a secular anthropology this question “why?” is unbearable, because we have no one to whom to address it. We have made God absent.

We cannot ignore the alarming tendency in our society to marginalize, and even silence, its most vulnerable and dependent members, the unborn, the mentally disabled, the elderly, the dying. If we cannot live with the question “why?” then we must find a way of silencing those who remind us of it. “If you want to forget that your existence is gift, then you need to silence the language of the body and drown out its testimony to love.” [26]

In so doing, we miss the fact that the so-called “hopeless cases” are in fact “hope-filled.” For, if we were able to hear this language of the suffering body, we would discover in the weakness and vulnerability of the very ill and the dying the authentic revelation of life reduced to its essentials: the relationship of love, given and received. [27] Therein lies an invitation to hope, because if life is about love, death cannot have the final word; love is not defeated by death, it brings with it a promise of fulfillment. As Wendell Berry perceives, “The world is a place where we may learn of our involvement in *immortal love*… such learning is only possible because love involves us inescapably in the limits, suffering and sorrows of mortality.”[28]

Hospices and the hospice movement exist within our healthcare system as places where we can glimpse again the hope present in the “hopeless cases.” The decision to remain with patients as they face their final journey on earth allows hospices to become places of true healing; paradoxically, a wholeness is recovered precisely at the moment of disintegration or brokenness. The principles of palliative care, which were born within a Christian anthropology, give rise to an atmosphere and an attitude to the suffering person that resonates with people at the level of their experience. Patients frequently say they feel “safe” in the hospice, even though they might know that they are dying. If it is not possible for them to be cared for in their own homes, they are always reluctant to be sent to any other kind of care institution. Families regularly comment on the peace and the joy present in the hospice, and how the care their loved one receives helps ease the pain of losing them. As one son said to the nursing staff, after his father was admitted to a hospice and made comfortable enough to spend the last three days of his life singing and laughing with his loved ones: “You gave him back to us.” There is a recognition here (conscious or otherwise) of a model of care that corresponds to the reality of the experience which is being undergone.

However, these principles are not unthreatened in our culture, and palliative care is not immune from the secular anthropology at work in modern medicine. We know that there is a strong movement in our culture to control death in a technological way, to silence this final witness of the body to an adequate anthropology. The euthanasia lobby is extremely strong,

and in many ways this is because euthanasia is the logical way to deal with death within the framework of a thoroughly secular anthropology. Radical individualism, which understands freedom as a purely self-determining autonomy, means that I should have the right, not only to choose *where* I die (one of the much-spoken-of principles of palliative care), but also to choose *when* I die. Dependence and vulnerability can only ever be understood negatively, and the infirm or dying person has no value because they no longer play an active part of our society, contributing to its production; they have no *use* in society, and so are ultimately a social and economic burden. We need to ask, is there anything in the logic of our culture that prevents it accepting euthanasia?

It seems, then, that the needs of the suffering, and particularly those of the "hopeless cases," are being met in our society in pockets where a true anthropology is being held on to and lived; they are not being met according to the principles or logic of our culture, and they cannot be. True compassion and a respect for the person occur within modern healthcare *despite* the system, and it is a struggle to allow them to occur. It is one of the great privileges of working in this discipline that we witness every day, in the words and gestures of our patients and colleagues, beautiful examples of true humanity shining through the experience of suffering, almost in defiance of the impersonal structures which our systems have imposed upon us.

Conclusion

Suffering and death are *the* stumbling blocks for secular anthropology, and so it is that medicine finds itself in a precarious position of privilege at the front line of a conflict. Each time we meet someone who is suffering, we are present in an encounter where two world-views are colliding. On the one hand, we have the reality of the experience of suffering and the truths about the human person which this experience reveals to us (truths which open us to, and are only adequately responded to from within a Christian anthropology). On the other we have the principles of our culture, which has rejected these truths.

This collision is happening *within* the person in front of us, and it will vary depending on their own life experience, decisions, and beliefs. However, *we* are involved in this collision too, and if we remain alive to the language of the body and the call of suffering, this will mean that the experience of suffering is transformed for the sufferer and we too are transformed. The "why?" of suffering is only bearable within an encounter marked by compassion, and it is such an encounter which recovers for us the horizon of meaning, which is love – the only horizon against which our own life is worth living.

In this way, we learn that the real work is not ours at all, for, as Saunders puts it, "the Christian answer to the mystery of suffering and death is not an explanation but a Presence."[29] We love because we are first loved, and our call, or vocation, is to become mediators of that Presence to those whose lives we touch. Medicine, then, if it is going to meet suffering at all, will do so person-to-person. There *is* no other way.

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[1] John Paul II, *Salvifici Doloris, On the Christian Meaning of Human Suffering* (London: Catholic Truth Society, 1984), 2.

[2] Ibid., 3.

[3] Ibid., 7.

[4] Ibid., 9.

[5] Ibid., 2.

[6] Granados, "Towards a Theology of the Suffering Body," *Communio* 33 (Winter 2006), 552-53.

[7] This approach, examining man's experience in order to find meaning, presupposes a synthesis between the corporeal and the spiritual in which the human body, united to the soul, stands as the bearer of a primordial meaning that it communicates within man's experience of life. See Anderson and Granados, *Called to Love, Approaching John Paul II's Theology of the Body* (New York: Doubleday, 2009), 37-38, and Granados, "The Unity of the Human Person under the Light of Love," Melina and Anderson (eds), *The Way of Love: Reflection on Pope Benedict XVI's Encyclical* Deus Caritas Est (San Francisco: Ignatius Press, 2006), 91-106.

[8] Granados, "Towards a Theology of the Suffering Body," *Communio* 33 (Winter 2006), 540-63.

[9] Saunders, "Watch with Me," *Watch with Me: Inspiration for a Life in Hospice Care,* 2nd edn (Lancaster: Observatory Publications, 2005), 3-8.

[10] Ibid.

[11] Ibid.

[12] Saunders, "A death in the family: a professional view," *British Medical Journal,* 1(844) (1973), 30-31.

[13] Granados, "Towards a Theology of the Suffering Body," *Communio* 33 (Winter 2006), 556.

[14] Granados, "Towards a Theology of the Suffering Body," *Communio* 33 (Winter 2006), 540-63.

[15] Saunders, "The Care of the Dying Patient and His Family," *Contact* (Supplement 38, Summer 1972), 12-18. (Emphasis original)

[16] We might ask whether we really *want* medicine to deal with suffering. When I go to the physician with severe abdominal pains because I have appendicitis, I don't want a discussion about my vulnerability and dependence and my need for God; I want a correct diagnosis, a quick transfer to a clean and comfortable hospital, an excellent surgeon, caring nurses and a speedy discharge home. However, I also need to know that the professionals, to whom I am entrusting my *life*, have my "best interests" at heart. Precisely what these "best interests" are imply the whole anthropology at work in modern medicine, which may or may not be true, and which will come forcefully into play should anything go awry during my hospital stay, requiring major ethical decisions.

[17] Berry, "Health is Membership," *The Art of the Commonplace* (Washington, DC: Shoemaker and Hoards, 2002), 145.

[18] Ibid., 150.

[19] Ibid., 146.

[20] Granados, “The Body, Hope, and the Disclosure of the Future,” *Communio* 36 (Winter 2009), 653.

[21] Kass, *Toward a More Natural Science: Biology and Human Affairs* (New York: Free Press, 1985), 300.

[22] Granados, “The Body, Hope, and the Disclosure of the Future,” *Communio* 36 (Winter 2009), 657.

[23] Ibid.

[24] Berry, Wendell “Health is Membership,” *The Art of the Commonplace,* 155.

[25] Kass, *Toward a More Natural Science*, 205.

[26] Anderson and Granados, *Called to Love: Approaching John Paul II’s Theology of the Body* (New York: Doubleday, 2009), 108.

[27] Frederico Lombardi SJ, Vatican Press Office, 11/02/10.

[28] Berry, “Health is Membership,” *The Art of the Commonplace,* 144-58.

[29] Saunders, “Facing Death” *Watch with Me*, 19-30.

Humanum
Issues in Family, Culture & Science

FEATURE ARTICLE

Accompanying Suffering

MARIA SUAREZ HAMM

As a mother of twelve I can honestly say that balancing work and family is a constant struggle that I do only with the help of God, my guardian angel, and the many people who are always making allowances and reaching out to help my husband and I with this tremendous blessing of twelve children.

But I would be amiss if I didn't mention my other six children, children that are smiling down on us from above – yes, I had eighteen pregnancies. The six miscarriages (five in a row) have done as much for my understanding of pregnancy loss and early childhood abuse and neglect as having twelve healthy children has done for my understanding of love and life.

Let me explain. When I was asked to give the talk on the topic of "Meeting Suffering" I was somewhat surprised. But reading over the conference agenda and the topics that have preceded this last panel I realized how providential it was that I was asked to do this talk. Providential because it has been through "meeting suffering" in my six miscarriages and in my mother's two miscarriages that God has brought me to a much deeper understanding of pregnancy losses and their "inner connections" to "human ecology and what we are doing to humanity" – to use the words of Dr Philip Ney (a specialist in the study of maternal losses and their connection to child abuse and neglect).

Having worked at a pro-life Catholic pregnancy center for eighteen years in various positions – board member, Development Officer, Executive Director – I have spent the greater part of my adult life pondering the questions of love and life as it played out among my four constituencies: 1) first and foremost the clients that came to our door in crisis pregnancies; 2) the counseling staff that attended to them; 3) the donors and supporters of the pro-life pregnancy work, each with their own unique story of love and life that led them to participate in this controversial work; 4) the collaborating or antagonistic agencies and NGOs also dealing with what the secular world lightly calls "options counseling."

Add to this the first and foremost work of my adult life – sustaining a thirty-six-year marriage, and raising twelve children – eleven of whom are now adults, and functioning well in this increasingly deteriorating culture. Naturally it is this latter work, this "harvest of love," that gives me the ultimate credibility in sharing what I have learned and hope to pass on to you in this very brief and very personal talk.

Let me refer once again to Dr Philip Ney, a child psychiatrist in Canada who has done most of the pioneering work on the effects of unhealed maternal losses on children and society. This quote is from his book *Deeply Damaged: An Explanation for the Profound Problems Arising from Aborting Babies and Abusing Children* (Pioneer Publishing Co., 1997, p. 75): "Aborting babies is the most self- and species-destructive activity known to humanity. An innocent, unique person is killed. Many human qualities in the Perpetrators and Observers also die." (Here let me stop for a minute and explain that in abortion you have what is called the tragic triangle. This triangle is found in almost all cases of abuse and neglect where there is a Perpetrator, a Victim and an Observer. In the large majority of cases the Perpetrator is the male, the Victim is the child and the pregnant mother, and the Observer can be any of a number of people who allow the abortion to take place.)

Dr Ney continues (p.77):

"Abortion also undermines many species-preserving mechanisms and sets into motion a whole series of tragic cycles. Abortion is the centre of seven interlocking tragic cycles…. Abortion initiates and perpetuates these cycles. They continue from moment to moment and from generation to generation because a number of self- and species-preserving instinctual and social mechanisms become distorted by abortion.

"It appears that almost everyone is capable of killing. We all hope that we are never in circumstances where we would be 'forced to kill.' The circumstances of early childhood abuse and neglect, dehumanization, starvation or chemical dis-inhibition make people more likely to kill. Humans are restrained from killing by three important barriers: the law, morality, and instinct….

"Unhappily, in almost every country, *laws* no longer restrain, but encourage the killing of the unborn young. *Established morality* is so confused and is so confusing that it no longer keeps many people from their aggression towards helpless babies. *Instinct* is badly weakened by these seven vicious cycles that are set in motion by abortion. Thus, abortion is cause and effect in a series of events that are increasingly uncontrolled."

I could continue explaining the seven vicious cycles that are set in motion by abortion, but in the interest of time and of getting one critical point across I will instead focus on one of these cycles, the PASS cycle or Post-Abortion Survivor Syndrome – what happens to the siblings of the aborted child. I will focus on this in order to give hope to post-abortive women that the cycle of abuse can be broken, and love and life can be restored to its proper place in the next generation.

Yes, we must "meet" their suffering, "accompany" their suffering. But in the process we must be clear about what *causes* their suffering. We must do the hard work of separating the causes from the effects, the truth from the lies, in what is becoming a tangled web of confusion and misinformation leading many to believe that yes is no, bad is good, and lies are truth.

I want to share with you the very painful case of one of my miscarriages, so you can see the moral confusion that is dominating the American health system as it deals with "procured abortion" patients and "spontaneous abortion" patients in a hospital setting. I was undergoing a "spontaneous abortion" commonly called a "miscarriage." I was taken to the same-day surgery floor for my D&C procedure (Dilation and Cutterage, where the cervix is dilated to gain entry to the uterus, and the uterus is scraped clean of any remaining tissue from the pregnancy). The same room is used pre-op and post-op for prepping and recovery. I was waiting to be taken in for the surgery when a young woman was wheeled into the bed next to me. She was crying softly. The curtain between us was quickly drawn. Her mother, who was

elegantly dressed, was with her, and after a few minutes the young woman said: “Thanks mom, for being here for me.”

The mother answered in a somewhat brisk voice: “Where did you think I would be?” It struck me as odd, since I would have expected a gentler tone. The daughter mumbled something I didn’t quite catch. But then she asked her mother if she could call “him.” The mother said: “I don’t think you want to do that or the whole school will find out.” The young woman answered: “Mom, the whole school already knows.” It was then that I realized that this poor woman had gone in for a D&C abortion. The same procedure I would be having shortly – only she went in with a live baby while mine was already dead.

I found myself in a surreal frame of mind as I pondered how the very same nurses who had comforted me on my loss had to also comfort this young woman – yet what could they say since she was “choosing” to abort her child? What a schizophrenic country we are! One child is denied life and even acknowledgement, while another is mourned and the mother consoled.

When it came time for this young woman to be sent home the nurse came in to give the “discharge instructions,” and said that the young woman should not do any horseback riding for at least four weeks. The mother defiantly asked: “Why not, she loves horseback riding!” The nurse replied: “Because when you ride a horse you go thump, thump (and she clapped her flattened hands one on the other) on the surgical wound.” The mother responded sharply: “If you know how to ride a horse properly you won’t go ‘thump, thump.’” The nurse got up and said in disgust: “Then you do whatever you want, I am just telling you what it says on the chart.” Once again, in overhearing this conversation I was struck by the mother’s unwillingness to acknowledge that anything of importance had just happened. She wanted her daughter to return to life as normal as soon as possible and put this whole thing behind her.

Then came my turn to go in for surgery. The orderly – a young black male – came in and said that he could not find a wheelchair and could I walk down the hall to the operating room. I was shocked at his request since I was bleeding heavily and had several pads placed between my legs to keep the blood flow under control. In theory I could walk, but in reality it would have been quite difficult with the blood flow. I started to cry, not knowing how to explain my dilemma, and he went and got the nurse. If you think about it, his job was also schizophrenic – in that the previous patient, the young woman, going for the same procedure, was perfectly able to walk since she had a live, intact pregnancy.

How was he to know that my D&C was needed because my baby had died and I was “bleeding out.” As they wheeled me into the surgery I saw one last reminder of this surreal situation. On the chalkboard listing the procedures that where scheduled (above my emergency D&C) were the letters “VIP.” Lest you should think that someone important was ahead of me in the operating room, let me tell you that VIP is a euphemism for Voluntary Interruption of Pregnancy – the procedure that the young woman had undergone.

So you see the ironic situations into which obstetrics and gynecological care has gotten itself. Life and death come and go. Some babies are chosen, some are not. What this is doing to our society is largely unknown, but now we are beginning to connect the dots. How so? Psychiatrists are beginning to see a whole cadre of patients suffering from Post Traumatic Stress Disorder connected to their mother’s abortions. This is one of the eight cycles of disorders associated with abortion that Dr Philip Ney has identified:

CAN = Child Abuse & Neglect

CEF = Convenient Eugenic Feticide

PAS = Post-Abortion Syndrome

LAR = Lessened Aggression Restraint

PASS = Post-Abortion Survivor Syndrome

FOA = Fear of Ageing

CFF = Contraception's False Freedom

LOPS = Lack of Partner Support

One of the biggest components of PAS is the "unmourned death" that has occurred. It is the secrecy around the death. Remember the young woman in the bed next to me was not allowed to call her boyfriend because the mother wanted to pretend that nothing had happened. Society also wants to pretend that nothing has happened. And so we have 50 million women walking around with unmourned deaths in their hearts and minds.

And what this does to their other children is now becoming more evident. Why? Because when a woman has a child after an abortion – if she has not healed; that is, if she has not forgiven herself and her partner and asked for God's forgiveness – she is likely to *detach* or *over-attach* to her other children.

Why is this? Detachment occurs when she cannot bond with the child because of her "fear of losing this one as well." Part of that fear is her own self-hatred: she cannot trust her motherly instincts, as once already they have betrayed her into death. In the case of the "over-attached" mother, she over-attaches for the same reason – fear of losing this child. Also she needs to prove to herself and the world that she is a good mother, and that her meticulous care for this child is proof that the other child had merely arrived at an inconvenient time.

But then it is these children that become entrapped in the emotional nightmare of being wanted but not loved; at least not loved in the proper way, with proper boundaries. Turning once again to Dr Ney, here is what he has to say about PASS and how it is manifested. When children are raised in families where there has been (or could have been) an abortion, they are "survivors." We call their resulting conflicts and symptoms the Post-Abortion Survivor Syndrome (PASS). Abortion survivors might have died because:

Other babies in their country are frequently aborted;
Their parents deliberated on whether or not they would abort them;
Their siblings were aborted;
Abortion was considered because they were the wrong sex;
Abortion was considered because they had a handicap.

Then Dr Ney further explains the conflicts these children are left with. There are many types of abortion survivor but they suffer from similar conflicts:

These children grow up with *survivor guilt*, which makes them doubt the validity of their existence and their future.
They do not trust their parents and have difficulty *attaching to* or trusting them and other authorities.
Their anxious attachment to parents tends to make them clinging, demanding, hard-to-raise children who are *less likely to explore their environment and develop their own intelligence*.
Because PASS children are insecure and demanding, their parents find little fulfillment

in parenting. They tend to reject their role as a parent, will then abort a subsequent child.
Thus we see a cycle of abortion and neglect being passed on from generation to generation. Dr Ney also makes the claim that unexplained violence of the type we saw at Columbine (and I would add Newtowne) is most likely a result of unhealed post-abortion pain in the parents of these children. Remember that the Columbine killings were done by middle-class teens, in seemingly intact families living in relative comfort and ease. This was not the result of inner-city abuse and neglect we usually see in combination with drugs and alcohol abuse. The question then remains: "Why were these parents, and in particular the mothers, so detached from their children that they did not realize what their teenage sons had gotten into?" Perhaps they had "put their eggs in other baskets" – becoming overly attached to work, or success, or some other set of goals independently of raising their kids.

In Newtowne I would suspect serious psychological problems with a mother who was over-attached to her son. The questions we should be asking are:

Why would a woman use recreational shooting to bond with her son? To help him become a man? Supposedly she has said as much. And yet how can a mother substitute a father in this role?
I would guess this was a case of over-attachment due to abortion and divorce. She must have had deep gender-identity conflicts herself, leading to her son's "love/hate ambivalence" and subsequent murders first of her, then the innocent children.
Dr Ney further clarifies what the symptoms are of the Post Abortion Survivor Syndrome:

A child with PASS, when he grows up, is *less optimistic* about the future in general, and the future his children might have in particular.
For those and other reasons, he or she is less likely to welcome children into the world.
If a woman does become pregnant, she is more likely to abort the infant.
Because PASS people are more likely to have been neglected as children, they will tend to re-enact that mistreatment by picking a less mature, less supportive mate, thus a connection is formed with the cycles of CAN and LOPS.
In sheer numbers, according to fertility rates, there are over 100 million potential PASS sufferers in this country.
I would like to focus further on the *male* children of post-abortion women. These children have a good chance of developing a Gender Identity problem along with their PASS. Why? Because the mother's unhealed grief will keep her from allowing the male child to bond to males. In order to understand this we need to look at how the gender identity is formed in males. These views are controversial, but I believe well supported by experience.

It is during the second year of life that all children, male and female, form their gender identity. It comes about during and after the child's first separation from the mother. In the case of the girl child, her sexuality is more clearly stamped on her body. She is "like mother," and she more easily accepts her female body. The boy child has a second, bio-sexual development task of separating from the mother and attaching to the father.

If you look at adult male homosexuals you will always find an absent, abusive, or distant father. The relationship is wounded. This does not automatically mean that he will end up with a same-sex attraction deficit. The mother holds the key. To the extent that she loves herself and her husband she will not feel threatened by releasing her child to the male. Males in her eyes are not those horrible people that pushed her into having an abortion. A well-balanced and happy mother is key for this release of the child to the father to take place.

After all, mothers are known to be the emotional centers of the family. Precisely because the child has bonded first to the mother he is more likely to trust her than the father who only is introduced to the child after the birth. (Although we know that children hear and can identify their father's voice from within the womb). At any rate, the process of identifying with males is an important one for the proper psychosexual development of the male. If this process is interrupted or hindered then, when puberty hits, the male child will eroticize his need for male approval and identity. He cannot be attracted to females until this maturation process is complete – until he feels affirmed in his masculinity.

I want you all now to suspend what I have discussed so far – about the pain and suffering brought on by abortion and its effects on the sexual identity of the male child – and hear for a minute what Pope Emeritus Benedict XVI had to say to his staff at Christmas, about a topic that is very related to PASS but of which very few health professionals are aware.

"The Chief Rabbi of France, Gilles Bernheim, has shown in a very detailed and profoundly moving study that the attack we are currently experiencing on the true structure of the family, made up of father, mother, and child, goes much deeper. While up to now we regarded a false understanding of the nature of human freedom as one cause of the crisis of the family, it is now becoming clear that the very notion of being – of what being human really means – is being called into question.

"He quotes the famous saying of Simone de Beauvoir: 'one is not born a woman, one becomes so' (*on ne naît pas femme, on le devient*). These words lay the foundation for what is put forward today under the term 'gender' as a new philosophy of sexuality.

"According to this philosophy, sex is no longer a given element of nature, that man has to accept and personally make sense of: it is a social role that we choose for ourselves, while in the past it was chosen for us by society. The profound falsehood of this theory and of the anthropological revolution contained within it is obvious. People dispute the idea that they have a nature, given by their bodily identity, that serves as a defining element of the human being. They deny their nature and decide that it is not something previously given to them, but that they make it for themselves. According to the biblical creation account, being created by God as male and female pertains to the essence of the human creature. This duality is an essential aspect of what being human is all about, as ordained by God. This very duality as something previously given is what is now disputed. The words of the creation account: "male and female he created them" (Gen 1:27) no longer apply. No, what applies now is this: it was not God who created them male and female – hitherto society did this, now we decide for ourselves. Man and woman as created realities, as the nature of the human being, no longer exist. Man calls his nature into question. From now on he is merely spirit and will. The manipulation of nature, which we deplore today where our environment is concerned, now becomes man's fundamental choice where he himself is concerned. From now on there is only the abstract human being, who chooses for himself what his nature is to be. Man and woman in their created state as complementary versions of what it means to be human are disputed.

"But if there is no pre-ordained duality of man and woman in creation, then neither is the family any longer a reality established by creation. Likewise, the child has lost the place he had occupied hitherto and the dignity pertaining to him. Bernheim shows that now, perforce, from being a subject of rights, the child has become an object to which people have a right and which they have a right to obtain. When the freedom to be creative becomes the freedom to create oneself, then necessarily the Maker himself is denied and ultimately man too is stripped of his dignity as a creature of God, as the image of God at the core of his being. The defense of the family is about man himself. And it becomes clear that when God is denied, human dignity

also disappears. Whoever defends God is defending man."

An entire conference would not be enough to dissect and discuss this excerpt. It concerns what man is, how people experience themselves, and how a family is formed. It is because of this that the traditional understanding of how gender identity is formed in the second year of life is now being denied by developmental psychologists.

Conclusion

In order to come alongside the suffering man, woman, or child we have to dig deep and discover if there is a sexual identity problem related to an unhealed abortion, or in some cases a traumatic miscarriage. By mere statistical analysis there are approximately 100 million sibling abortion survivors in this country right now, all of them possibly suffering from some gender identity confusion as a result of over-attached or detached mothers. We can only truly accompany this suffering if we learn to recognize it for what it is. In order to heal one has to begin by identifying the source of the wound. Once that is known and acknowledged, real healing can begin. And as our Lord said, "The truth will make us free."

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FEATURE ARTICLE

Going Off the Grid: Opportunities in Catholic Medicine

DR. JOHN I. LANE

Secular medicine in the modern age is driven by the "technological imperative" (*if it can be done, then it must be done*), and operates within a culture that has replaced the ancient Judeo-Christian anthropology (implicit in the biblical reference to the *Imago Dei)* with the post-modern concept of radical personal autonomy devoid of any obligations to a Creator.

In many ways secular medicine has enabled post-modern man to exist as if he were his own God. Post-modern man, with the assistance of medical technology, has uncoupled the connection between sex and procreation through contraception, abortion, and in vitro reproductive techniques, including IVF, pre-implantation genetic screening, "savior siblings," and surrogate mothers, launching our culture into a new era of eugenics in the process. Many medical and pharmaceutical therapies developed to treat disease are now being utilized to enhance or augment the normal human state.

This has been most evident in the abuse of anabolic steroids among professional and amateur athletes. In the future, the potential benefits of neurotropic drugs will tempt many healthy individuals to use pharmacologic enhancement to improve all forms of cognitive activity. In the area of biomedical engineering, the fusion of man and machine is well underway. Cochlear implant technology, a therapy that has been marvelously successful for providing otherwise deaf individuals with the ability to hear, has been the prototypic model for this class of medical interventions. There has been rapid proliferation in the use of similar devices such as deep-brain stimulators to treat certain neurodegenerative movement disorders, and use of these devices to treat certain psychological disorders is currently under investigation. Similar technology is also being used in the development of eye implants to provide sight in certain forms of blindness.

Is it likely that our society will be able to resist the temptation to use these technologies to augment or enhance normal human sensoria and cognition? What part will professional medicine play in the proliferation of these biomechanical enhancements? If science fiction becomes reality, to what extent do the obligations of the physician to attend to the suffering of his/her fellow man extend to the *cyborg*? How does the Christian health care professional give witness to the *Imago Dei* within a society based on such an impoverished secular anthropology?

The pontificates of John Paul II and Benedict XVI have given the post-modern world in general and the Church in particular a new language with which to proclaim the ancient truths of the faith. This new language, now commonly referred to as the *Theology of the Body*, has much to teach us about the human person in light of a proper Christian anthropology and, given time, can transform first the Church and subsequently the larger culture. Its potential to impact our understanding of health and medicine is limitless and just the right prescription to address much that ails the post-modern world, especially as it applies to our understanding of marriage and family.

In the United States, our ability to proclaim this gospel message will depend in part on the degree to which those in positions of power observe and respect our God-given freedom to practice our faith without governmental interference as it is enshrined in our constitution's First Amendment. Unfortunately, many of our founders' assumptions regarding the common good based on Natural Law principles have not fared well in the arena of modern jurisprudence. Legal positivism (which assumes that the existence and content of law depends on social facts and not on its merits) is now the rule of the land. Likewise conflicts between modern society's understanding of radical personal autonomy as represented by a patient's request for a legal medical service, and a medical professional's personal obligation to follow the dictates of his or her conscience regarding what is in the best interest of the patient, are not likely to be resolved to the satisfaction of the conscientious objector.

The prognosis for sustaining a right of conscience in a society that has rejected the principle of absolute truth (to which our inalienable rights are ordered) is not good. The rescission of the 2008 Leavitt Health and Human Services (HHS) Rules granting extensive conscience rights to all health care professionals and institutions by current HHS Secretary Sibelius in 2010 is a case in point, and holds little hope for any meaningful statutory protection for conscientious objection for the foreseeable future (Allott & Bowman, 2009). Given this prognosis, the Christian health care professional must consider the possibility of voluntarily (or perhaps involuntarily) practicing his or her art outside the confines of the current government-controlled system (whether this control is exercised through entitlement financing or legislative/executive mandate).

Going Off the Grid

This brief essay will explore some of the models that have been or are being developed that may allow the practitioner to provide morally licit care to his/her patients without the frustrations imposed by our current private insurance-based system, or the threat of coercion through government-reimbursed entitlement programs.

The "Boutique" Catholic Clinic

With the full implementation of the Affordable Care Act by 2014, it is likely that many medical practitioners will seek to operate outside the system to avoid onerous government oversight and progressive decreases in state and federal entitlement program reimbursement. These "boutique" outpatient practices do not bill private insurance or government subsidized programs, and operate exclusively on monthly premiums paid by the patients in exchange for immediate access to a physician's services. This assumes that these patients have the financial wherewithal to take advantage of the benefits of Health Savings Accounts (or other similar vehicles) to offset medical expenses and carry catastrophic insurance to cover major hospitalizations. Unfortunately, most of these models are not designed to maximize care to the poor, and are often criticized for exclusively targeting the well-to-do.

Recent success in sustainable boutique practices incorporating charity care as an integral part

of the practice is worthy of note. St Luke's Family Practice Clinic in Modesto, CA, has been open since 2006 (Forrester & Heck, 2009). Drs Forester and Heck reserve 50% of their daily appointment slots to treat the uninsured population of the surrounding county. Every effort is made to refer those who qualify for existing state or federal assistance programs to the proper agencies, but for those who fall between the cracks, St Luke's will treat and follow them. All the uninsured are seen either the same or next day.

The uninsured side of the practice is underwritten by a group of "benefactors" who pay monthly fees for the unrestricted services provided by the two staff physicians. Benefactors have confidential on-line access to the office calendar, and can schedule appointments on their own, often being seen the same day if they desire. They have immediate access to physicians by way of e-mail or cell phone. These patients sign on for these services knowing in advance that their monthly fees support the charity work that is provided by this non-profit Family Practice.

Office overhead is kept to a minimum since there is no insurance or entitlement billing. The physicians do all their own charting, in one of their two-office/ examination rooms. Both Catholic physicians practice in accordance with the *Ethical and Religious Directives*, and credit the success of this unique venture to the power of faith and the importance of daily prayer in sustaining their vocations. Since St Luke's Family Practice opened in 2006, five similar practices have been established elsewhere in the US. This model has proven to be a viable alternative to a more traditional for-profit practice for the faithful Catholic physician, and deserves a more widespread consideration by those Catholics entering the field of medicine. To that end, Dr Forester has presented this model of practice at the Annual Meeting of the Catholic Medical Association, and has begun to receive invitations to speak to medical student groups throughout the country.

The Consecrated Health Care Professional

The Church and the nation will be forever indebted to the selfless service rendered by so many women religious, who built an entire network of Catholic hospitals across the North American continent during the 19th and early 20th centuries. The demise of these religious orders and the fate of the hospital systems they founded have been well documented. But a new day is dawning. Not long ago, it was commonly believed that the vocational traditions of the Church were a relic of the past. The workings of the Holy Spirit through the long pontificate of John Paul II are beginning to change the landscape. The effects of this "New Evangelization" have begun to staunch the loss of vocations and new clerical and lay orders are being established both here and abroad. It is inevitable that some of these groups will have as their mission the care of the sick.

One of these orders worthy of mention is the Religious Sisters of Mercy founded in Alma, Michigan, in 1973 at the nadir of the post-conciliar decline in vocations. They currently operate three Mercy Health Care Clinics (Alma, MI; Jackson, MN; and Breuberg, Germany) and have 41 women trained in the health care professions. This includes 11 physicians and 4 current medical students.

Another order dedicated to protecting the sacredness of all human life is the Sisters of Life, founded by Cardinal O'Connor in 1990. The Sisters of Life offer assistance to women dealing with crisis pregnancies, and hope and healing to those who suffer following the tragedy of abortion. The Sisters also provide Catholic medical students an opportunity to deepen their commitment to a culture of life by volunteering at their Visitation Mission Center in New York City (Spaminato, 2013).

The Missionaries of Mercy (MoM) are a canonically approved ecclesial family founded by Fr Scott Francis Binet, OC. The purpose of this organization is “to witness to the Divine Mercy in word, deed, and sacrament for the salvation of souls through serving the neediest of the needy in man-made and natural disasters.” Fr Binet’s vision is to grow the Missionaries into a Catholic *Doctors without Borders*. The first MoM clinic opened in Haiti in 2012.

The Catholic Rest Home Revisited

In the next two decades the pressures of an aging population on a health care system already strained to the breaking point will likely resulted in mandated rationing of care to the elderly. These demographic realities will be further exacerbated by the ever-increasing breakdown of family structure in the West, leaving the state rather than the extended family as the caretaker for many abandoned elderly. The risk that passive as well as active euthanasia in this context will be seen as a solution to this elder crisis is all too real. The Right to Die Movement has made significant inroads in State legislatures across the country, largely fueled by a sense of radical personal autonomy and personal fears of becoming a “burden.”

The Church is obligated to respond to this crisis in ways that go far beyond political and cultural advocacy. Several of the lay faithful have begun to step forward to serve the needs of the abandoned and underserved elderly, providing environments in which their lives are appreciated and in which the Holy Spirit can work through them until the very moment they are called to meet their Creator.

Nan and Don Weber perceived this need in their Texas Panhandle community and opened Loreto of the Plains home in 2009. Their mission is to “provide Catholic Healthcare at the end of life by creating an environment where Medical and Spiritual Care are united to bring God's hope and peace through ministering to the sick and terminally ill and their family in the light of the Gospel message.” Their not-for-profit home can accommodate three residents and one guest, and operates on a combination of monthly fees paid by the residents and their families, and donations. They accept no government subsidies. Both husband and wife have nursing backgrounds, with supplemental services being provided by a team of trained volunteers. Similar facilities are currently being planned in the Diocese of Dallas and Oklahoma City.

Care of the demented patient requires specialized services that are often beyond the means of many standard nursing home facilities. One faithful Catholic that has responded to this demand in a manner that integrates clinical care with the spiritual needs of the patient is Ann Marie Hanson in Minneapolis, MN (Wiering, 2009). She has opened her non-profit Gianna Home, a private facility in a residential neighborhood that is dedicated to skilled memory care of the demented patient. The home is named after St Gianna and designed to “honor God, nurture family, and foster friendship.” She currently is working with a local developer to open a small community of Memory Care Homes that would also include Memory Day Care services for elderly whose primary caregivers are working and Child Care services for the skilled employees serving the elderly.

The utilitarian ethic in the setting of Hospice Care is an area of increasing concern to the Church. The waning stages of existence of the terminally ill can be viewed as senseless outside the Church’s understanding of the sanctity of life until the moment of natural death. In a utilitarian context, ending the life of one suffering from terminal disease may be considered a humanitarian act. Passive forms of euthanasia to include voluntarily withholding nutrition and hydration in concert with “terminal sedation” techniques to hasten death are probably more common then generally admitted.

Karen Bussey of Lansing, MI perceived the need for a more holistic approach to the care of the

terminally ill based on the understanding of the inherent dignity of the dying person (Horning, 2011). She is a consecrated virgin who was called by God to provide "a place where people who had no family or hospital care could go to be cherished and treasured." With the assistance of the local diocese she opened Mother Teresa House in 1997 shortly after the passing of the patroness for whom the home was named. Hospice nurses visit the residents as needed, but volunteers provide round-the-clock care working 3-6 hour shifts to complete a 24-hour cycle of care. Volunteers are required to exhibit a "willingness to be with a sick person, to learn to sit with the suffering face-to-face, knowing that the person being cared for is dying… challenging them to set their daily cares aside so that they can focus on the guest they have come to serve." Ms Bussey operates the facility in full compliance with the ethical and religious directives of the USCCB.

Casa USA: Continuing the "Work" of Padre Pio

The divisions between certain segments of the Catholic community and the hierarchy over the Sanctity of Life were nowhere more apparent than during the battle to pass the Affordable Care Act. If one did not perceive the depth of this divide before this crisis, the apparent collusion between certain Catholic health care trade associations and the current administration to pass the bill was enough for most orthodox Catholics to conclude that these Catholic organizations had lost their way. The complex fiscal web in which Catholic institutions now find themselves, particularly in light of the HHS mandate, underscore the need to build anew institutions that are grounded on the fullness of the truth embodied in the Church's teaching regarding human dignity and the sanctity of life.

Jere Palazollo is an accomplished hospital administrator who perceived this need long before the crisis surrounding the Affordable Care Act arose. His life's work is now focused on building a network of clinics, a teaching hospital, and a medical school modeled on Padre Pio's Casa Sollieva della Sofferenza (Home for the Relief of Suffering) in San Giovanni Rotondo, Italy (Pallazollo, 2012). St Pio, a well-known stigmatist and mystic, is buried in San Giovanni on the site of the hospital which he considered his life's "work." Mr Palazollo's organization, Catholic Healthcare International (CHI), has signed a collaborative agreement with the original Casa to work together to establish a Casa USA here in North America. It was St Pio's vision that these facilities would be founded all over the world to continue the healing mission of our Savior here on earth. CHI is committed to operating all its facilities in a manner that is completely faithful to the teachings of the magisterium. Its first clinic has opened in the diocese of Lexington, KY, and plans for additional nearby clinics, the hospital and the medical school will be implemented over the next five to ten years.

Conclusions

These opportunities understood within the context of the New Evangelization have the potential over the long term to revolutionize the delivery of authentic Catholic health care for future generations of the faithful, and ultimately for all God's children. We should not entertain the delusion that this larger transformation will occur anytime soon. In the meantime, as we await this re-enculturation, the Church must prepare to subsist and flourish outside the cultural mainstream. In the words of *First Things* editor R.R. Reno, we may be awaiting the imposition of a New Dhimmitude; a softer version of the second-class status of citizenship that Islam imposed on conquered Christian societies during the period of Muslim expansion (Reno, 2013).

But any attempt to force orthodox Christian physicians and other Christian health care professionals out of our government-controlled medical system will ultimately fail in its

purpose to suppress our ability to proclaim the Church's vision of human dignity. It will merely displace those who are committed to remaining faithful to the Church beyond the control of the Secular Ascendancy. This will likely mean significant sacrifices in the way of remuneration and professional status for those called to the healing ministries. But these are small concessions indeed for those called to follow the Divine Physician in his work to heal the sick and attend the suffering of His people.

References

Allott, D. & M. Bowman, "The Right of Conscience in the Age of Obama," *American Spectator*, November 2009, pp. 22-27.

Forrester, R.A. & R.J. Heck, "What You Can Do to Help Your Uninsured Patients," *Family Practice Management*, October 2009, pp. 21-24.

Spaminato, C. & E. O'Donnell, "Living Faith and Medicine," *Linacre Quarterly*, February 2013, p. 3.

Horning, B., "A House of Peace and Love," *Columbia Magazine*, January 2011, pp. 19-20.

Wiering, M., "Gianna Homes Founder Strives to See Person, not Disease," *The Catholic Spirit*, September 2009, pp. 3b-5b.

Reno, R.R., "The New Dhimmitude," *First Things*, April 2013, pp. 10-15.

Pallazollo, J., "Padre Pio's Hospital in Kentucky," *Catholic Health Care International Newsletter*, Summer/Fall 2012.

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FEATURE ARTICLE

Who Is the Patient?

SARA DEOLA

I take care of patients who suffer from hematologic cancers: leukemias in particular, and patients who undergo bone marrow transplantation. In answer to the question in the title, I would say that the patient is a person, whom is asked an unexpected and mysterious sacrifice. Life is turned upside-down. No matter if you are rich or if you are poor, if you are a famous or an unknown person. A new self-perception identifies something evil in one's own body, and strangely, something good surrounding you: people (caregivers/medical staff), who may unexpectedly respond to your strong need of health. There is a limit in your body, a disorder, which tries to dissect, to divide the unity of it (disease is always an interruption of a functional part in the organism), and there is a surrounding reality, trying to recompose the unit.

A sick person usually feels very naked. The usual structure of life with its habits cannot protect anymore the dramatic experience of the "I." Looking at my patients, one of the questions I often ask to myself while in front of them is: what is being asked of you? What does this mysterious event ask you? A Christian gaze tries not to interrupt the deep dialogue between the Mystery and the person.

I would like to exemplify this in the simple description of some encounters with my patients in the Hematology Division where I work.

There was an old farmer, who came into the Hospital. All he had experienced in life was taking care of his family, his animals, and his fields in a small town in the mountains. When I told him the diagnosis of leukemia, he burst into tears, telling me that I had no idea how homesick he was (after one day), and for him it was better to die, than to remain in a closed room for receiving therapies. So I tried to console him, and instead of explaining the ten pages of informed consent, I only promised him that everything would be OK (I told that to my chief the next day and…fortunately… he said, "Of course, what else could you tell him…!"). With patience I convinced him that it was good to try to get a cure, and hopefully this sacrifice would allow him to go back to his family and his cows. At the same time, while spending all my energy to facilitate his permanence, I daily faced in front of him a mysterious gap: there was nothing I could do to stop him crying like a child. And he was crying, and accepting to stay, at the same time. What God was asking him was incommensurable, and neither of us possessed the answer.

There was a young man coming from eastern Europe. He did not speak a word of Italian, his parents put him on a flight to Italy, where he had a sister, because nobody in his hometown understood what he had, and in that place he was doomed to die. Without a penny to pay for medical care, he was looking at us from his bed, suffering and grateful, while he was receiving his therapy (we didn't know how we were going to pay for it either, but we started anyway…), and had a chance to heal. What is God asking you? I often thought: in a foreign land, abruptly detached from your life, but with a chance to heal.

There was a 16-year-old boy, who came breathless, because of a neck lymphoma which was almost suffocating him. He was barely looking at me, when I was trying to explain him the diagnosis and the program. It was evident he was feeling entrapped in a situation which was bigger than him. The boy – his mother later told me – suffered a lot in his life. The father abandoned the family very early, and they suffered in every sense: emotionally, and physically, because they did not even have the money to pay the heating in winter. At the age of four the boy started assuming the role of "father of the family," trying to help and console his mother, who was very depressed. Before learning to write, he drew a picture of the family, symbolizing himself as an angel. While talking to me, this woman was crying, not only for her painful story, but also because she was feeling guilty. She was convinced that the origin of the disease was the distress in the family.

While listening I was astonished. Such great things were asked of this young fellow. "It seems to me" – I told the mother – "he is called to become a saint, and the whole family will learn from him."

I went back to the boy, and asked him if he did want to undergo therapy, a big and long sacrifice, with the goal to be cured and go back to normal life. He looked at me very seriously in the eyes and answered a courageous "yes." And I thought: you'll see, if God wants, you will go back to a lot more than your ordinary life. You'll enjoy the meaning of things, of study, of family, a hundredfold more than your friends of the same age.

The patient is called in front of the Mystery, and the one who is in front of him has the enormous privilege to be involved as well in this call: the privilege to accompany the person in this journey, and to remain with the person in front of the Mystery.

There was a patient who was really dear to me, and we walked together a human path at the end of her life. She was a 45-year-old mother of three teenagers. The first time she was hospitalized, it was for a high-risk leukemia, with blood values putting her in danger of death. On the first day I faced her she asked me: "Will you heal me for my three kids?"

One of the most common feelings a physician has is the disproportion. You are given responsibility for the life of a patient. It is completely disproportionate. "The first duty of the physician is to ask for forgiveness from the patient."[1] The very simple cry for health of the patient is *per se*something disproportionate. Its truth is a cry to God: heal me! This cry totally surpasses the human possibilities of the physician. The truth of the physician's work – in my experience – is the participation in this mysterious cry for salvation.

The chemotherapy worked well for her, and the leukemia was soon in complete remission. Fortunately she had a brother whose compatibility genes were fully matched with her, so she underwent bone marrow transplant and everything went fine. Not even three months after the transplant, she came in the outpatient clinic, telling me that she was feeling very sick. Leukemia was back, and I had to inform her. When I spoke to her, she replied very seriously: "You guys all do your best to heal us, but when God calls, we have to go. Will I die?" I replied that I did not know, but I promised her to do my best to offer her another chance with an

experimental therapy. And I really did my best, I also argued with almost all my colleagues, who did not want to proceed with the cures, judging them wasteful. At the end I came up with a cell therapy program, and the chief agreed.

It is very interesting actually to follow this dynamic: in these extreme situations, there is often one person (one is enough), who proposes the "last ditch attempt," and the human heart is made for hope so much, that all of a sudden the attempt is welcomed, or at least not discarded.

As she was hospitalized again to receive the salvage-therapy, she told me: "Come here, I have to tell you something." What she told me was this: "I have a husband. I always considered him a fool. He lost all the money of the family gambling, leaving us with lots of debts. I had breast cancer, some years ago, and the way I approached my husband at that time, was like a threat: 'You'll see, I will be cured with chemotherapy, and then you'll hear me!' I was so aggressive with him. This morning before coming in to the hospital, I woke up, and he was not in the house: since he had the flu, he went to his mother, in order to avoid infecting me before chemotherapy. I had breakfast alone, and suddenly I realized: I love him. You see: it took me to undergo leukemia, and its relapse, in order to realize that I love my husband."

The salvage cell therapy she underwent did not succeed, and I could not avoid telling her the truth, since she specifically asked me the results of the bone-marrow evaluation after the therapy. But one day before the result was available, she called me in her room: once again, she wanted to talk to me. She said that she had a visit from a lady who was in contact with the angels. In my mind I was very skeptical, and sorry for her. But strangely enough, she was joyful, even if the signs of leukemia were undoubtedly back. So I sat on her bed and listened. "This lady," she told me, "came and told me that my mother loves me and God loves me. My mother died years ago, and for my whole life, because of something that happened between us, I was not sure of her love for me. This lady carefully described my mother, and told me that she was assuring me that God was forgiving all my sins, and not to be afraid, and when I would see the light, to let myself go without fear."

She was sincerely moved. It was probably the first time in life she experienced anything like that. She had never entered a church in her life. I was very moved as well, seeing her like that. It is impossible to be joyful in this situation. You cannot in any way force yourself alone to be joyful when you fear to die. Only a presence, an event has the power to move you.

The day after, I entered the room to tell her that the bone marrow showed another leukemia relapse. She was at peace, and for the first time ever in my life, while communicating such a result to a patient I was at peace as well.

What I think to be the most precious experience for the patient (and for the physician as well) is this experience of an unexpected company, shedding light over the sense of the illness. It is the experience of consolation, of the presence of the "fourth one in the fire," as the Bible recounts in the book of Daniel, where the three young Hebrew where thrown into the furnace: "*Did we not cast three men bound into the fire?" "Assuredly, O king," they answered. "But," he replied, "I see four men unfettered and unhurt, walking in the fire, and the fourth looks like a Son of God."* [2]

To deepen the definition of "patient," then, I would say that this person, of whom is asked a mysterious sacrifice, identifies both in the something evil in the body proper, and the something good surrounding him, contingent signs of the presence of the Mystery, who is calling him.

What Place Does Technology Have in the Fate of the Patient?

Medicine-related technology is the fruit of human research, trying to serve the human path, when man is confronted with sickness. *"The more one has a passion for the other human being, the more he throws himself into research in order to gain a knowledge that could help men and women. But then, research, that is 'work,' becomes charity: to serve the human path so that man could walk in an easier and less painful way toward his own destiny."* [3]

And what is the real meaning of research? "*Research is an entreaty (from* quaestio, quaerere*). Man who does research is a man who seeks, who asks reality to reveal its secret. There are people who perceive a way to penetrate reality that makes them to proceed for three feet instead of the usual three inches. And everybody marvels – "three feet?" – while reality is infinite.... The truth of research – and here is its greatness, its nobility, its risk – is the comparison, the relationship with the Infinite. Man is a 'need' of comparison with the Infinite, with the ultimate meaning.*

"One who seeks does not even possess the necessary instruments to go one step forward: it is pure fortuity if one steps forward: is the bursting of factors, circumstances into his path, which one did not even dream about, did not even discover by himself.

"We treat hair as if it was hair. We must treat hair for what it is: hair with an infinite depth. That the Infinite counts the hairs on your head means that hair has an infinite value. Work is the use of reality in as much as it is knowledgeable, tangible, and useful for the ideal. The Ideal in all its features and all its factors is called charity, love of being." 3

I quoted these pieces of Fr Luigi Giussani because they have been giving a direction to my whole perception of work for many years. The truth of my research, and of my work with patients, does not really differ from the truth of looking at myself, at my friends. If I am forgetful of Christ in my gaze, I will be forgetful in my looking at myself, and at my patients, and at my experiments. The same degradation I will use in trying to possess a friendship, instead of respecting the freedom of the other, will also spoil my looking at the results of my experiments, and the use of technology in my work.

When does technology loose its balanced place in health care, to gain a violent dominant position? When the health care relationship ceases to be a dialogue exchanged between two subjects, because the physician abandons this totalizing relationship with the patient, or because the patient hides him/herself from the dramatic perception of the "I," and the mysterious Unknown bound with it. Without a human subject to confront, technology occupies the leading position. When they lose the perspective of the whole human being, both doctor and patient entrust the care relationship to a mechanistic approach.

Two different reasons, in my view, lead the physician to this distortion: first is the overloading burden of the human relationship, where the doctor clearly feels unable to answer the need of the patient. So he steps back. It is very comprehensible, and it often happens to me as well. It is a sort of discouragement – if you want, a "burn-out" feeling. The second reason counteracts this disproportion in the opposite way: it is the presumptuous (and blind) attempt to demonstrate that with the power of technology we will measure all things, and eventually put everything under control. It is the human attempt to be lord of reality, and I recognize this temptation in me as well. "Do not worry, I will take care of your fever with the right antibiotic." It sounds encouraging, of course, if it is pronounced with charity towards the patient, but there is another way to intend the concept: *I have the power to heal you*.

It takes a strong love of reality to be faithful to it, to take all its factors into account, without forgetting to count anyone or anything. If you see a tree branch with a hundred and one little leaves, it takes a loyal effort to count them all, to be sincere. If you arrive to count a hundred of

them, and you affirm, “This branch has a hundred leaves,” you are being presumptuous. The same attitude leads you to believe that you possess reality. You have to forget some piece of it, if you are to pretend that you control it.

To transform your work into a possession of reality is a real temptation, if you do not humbly value the truth of things more than your attachment to your idea of them. The patient ceases in this case to be a subject, a person, with whom you walk a stretch of road, and becomes the object of your possession, and technology is your means of control.

The piece of reality you have to forget in order to proclaim yourself the lord of reality is actually what makes reality so beautiful. It is the unexpected sign, emerging from the experience. It is that *something greater*, that something you cannot measure, to whom you belong. It is is the loving order of everything; and above all, it is talking to you unceasingly.

“Yet you have made him little less than a god
With glory and honor you crowned him
Gave him power over the work of your hands
Put all things under his feet” (Psalm 8).

But why does God value the small action, the instant that passes, when man tries to express himself? Because man is constituted by a relationship with him. The whole cosmos reaches a certain point of evolution or of qualification in which it becomes self-aware: that point is called “I.” The “I” is the world’s self-awareness, the self-awareness of the cosmos, of itself. And so the cosmos as it is in reality is the context in which the relationship with God lives, the relationship with the Mystery lives.[4]

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[1] Ingmar Bergman, in the movie *“Wild Strawberries.”*

[2] Dn 3:14-20, 91-92, 95.

[3] Translation from L. Giussani, *Vivendo nella carne: Quasi Tischreden* (Biblioteca Universale Rizzoli, 1998), pp. 155-58.

[4] Translated from L. Giussani, “Natale: motivo della vita come lavoro” (*Litterae Communionis-Tracce*: 11, December 1998), p. vi.

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FEATURE ARTICLE

The Catholic Roots and Changing Anthropology of Western Medicine

GLENN W. OLSEN

The Bible and the liturgy have a good bit to say about sickness and health. For the first couple weeks after I had been asked to give this talk, I took note of the references in the daily liturgy to things medical, and formed a sizeable list.

The liturgy also points us in the direction of understanding our physical limitations. Thus the Hymn of Prayer for the Morning for this past July 10 (2012) sings: “O my soul, bless God the Father…Thy diseases all who heals….”[1]

By the late Roman period, illness had been linked with Christian sanctity in many ways. In pre-Christian times sin and disease were often seen as connected, and so it remained in Christianity. Disease could be seen as test, judgment, or sign to others; and medicine could be viewed as a remedy given by God or a diabolical temptation. A contrast between the medicinal penance of the Christian East and a claimed Western bureaucratized, legalistic penance can be easily overdrawn.

After the rise of monasticism, the sick monk was viewed as particularly ambiguous, but one of the common ideas, found in the life of the chronically ill Gregory the Great (590-604) and very common in the close association between sanctity and illness in many of the lives of the saints to the present, was the idea that God shows special favor to those who bear the Pauline “thorns in the flesh.”[2]

Slowly study is filling in the many *lacunae* in our knowledge of the history of western medicine. Thus Brooke Holmes has published a fine study of the body in ancient Greece, and Achim Thomas Hack has given us a history of early medieval medicine, showing, not surprisingly, that the medicine practiced at Carolingian courts was linked to the world of late Roman medicine, but much less to the monasteries than had previously been thought.[3]

Bioarchaeology has been revealing much about such things as the social structures and religious practices of non-elite people. We now know, for instance, that the once common belief that medieval people could not diagnose leprosy (Hansen’s disease) properly is incorrect: 80% to 90% of the skeletons of people buried in European leprosaria cemeteries had

leprosy.[4] The journal *Micrologus* has a monographic series with much on medieval and early modern medicine.[5] Publication of the documents produced by high medieval medical faculties proceeds apace.[6] And vernacular medical writings also have drawn scholars' attention.[7] In sum, though there remains much to be learned, what has thus far been established much exceeds even mention here.[8]

Over the centuries most people have had to practice a kind of folk medicine. When I mentioned at dinner with friends that in the continuing search to find something that reduced my back pain I had now been put on an opiate, another historian remarked that one of his Iranian students, who preferred to be called Persian, had referred to opium as "the old people's medicine." That is, in a traditional culture that lacked many of the remedies for old people's illnesses, the poppy was always at hand. In most of the middle ages, healing centered in the monasteries, and one of the medieval scholarly associations is called "Medica: The Society for the Study of Healing in the Middle Ages." At Kalamazoo this year (2013), this Society will join forces with the Society for the Study of Disability in the Middle Ages.

One of the delights of being a medievalist is that one is able to associate with some very unusual people. Thus a woman, Victoria Sweet, who has gained some fame for her book, *God's Hotel: A Doctor, a Hospital, and a Pilgrimage to the Heart of Medicine,* is a member of a professional society to which I belong, the Medieval Association of the Pacific. Dr Sweet is an Associate Professor of Medicine at the University of California, San Francisco. She worked for twenty years at San Francisco's Laguna Honda Hospital, the last almshouse in the United States and a descendant of the medieval Hôtel-Dieu, the God's Hotel that took care of the sick in the middle ages.[9]

Among other things, Dr Sweet has studied perhaps the greatest of the medieval writers about medicine, the twelfth-century nun Hildegard of Bingen, canonized on October 21, 2012, who features in Sweet's book on *God's Hotel*. This book contrasts pre-modern and contemporary medicine.[10] I presume that all physicians have experienced moments of mystery, but what seems infrequent today was common in earlier centuries. Sweet uses a classical vocabulary of *spiritus* and *anima,* the latter with the sense of "life force," that which animates the body. I am told that a current form of Dante's descent into the *Inferno* is the trajectory by which interns begin with an idealistic and humanistic vision of medicine, but by the end of their first year have become "bitter, cynical, depressed, and mercenary."[11]

God's Hotel is a counterpoint to this story of alienation. In her years at Laguna Honda Hospital, Sweet draws nearer and nearer to her unpromising patients – commonly street people, filthy, delusional, and addled in various ways, not unlike the denizens of one of Mother Teresa's homes. Over time she realizes that the principal difference between the world of modern medicine, in which she has one foot, and the world of Laguna Honda is a different experience of time. The modern hospital is oriented toward efficiency, and has an imperative to push its patients out the door as soon as possible. But Laguna Honda has time and practices "slow medicine." There is "no imperative to diagnose and treat a patient quickly, no administrator trolling through the wards checking 'length of stay,' a merciless metric that pushes patients out the door so that the institution is paid well."

I say Laguna Honda is perhaps the last Hotel of God surviving in America, but elsewhere, in what is usually called the "third world," there are others. When I was a graduate student in Italy in the 1960s, a group of us were in an accident, and took the most seriously hurt to the closest hospital in Florence. This young lady was put in bed with a stranger, and given what was called "the cure," an indefinite period in bed to see what would happen. Even then, this was far from the treatment she would have received in the sleekly efficient hospital in Rome,

run by very well trained German nuns, to which John Paul II would go from time to time.

Anyway, it seemed to us that this young woman was in shock, and sure enough, after a time of rest, she was released from the hospital without, apparently, much of anything having happened. I as the medievalist in the group thought "just like the middle ages." Sweet's argument is that what the people who come to her hospital need above all is "sanctuary, a safe place."[12] She realizes that even to her hopeless patients she has a gift to give, friendship.

In Hildegard, Sweet found concepts quite foreign to modern medicine, especially the idea of *viriditas*. Hildegard did not think of the body as a machine, or disease as mechanical breakdown. Rather, she saw the body as having a power analogous to that seen in the greening or vigor or "power of plants to put forth leaves," etc.[13] What Laguna Honda could give was the basics, "good nutrition – tasty food, vitamins, liquids – deep sleep, fresh air, and sunlight," and as much time as was needed.[14] Sweet's goal came to be to ask of her patients, "Is anything interfering with *viriditas*? What can I do to remove it?" From having made the again thriving pilgrimage to Santiago, the subject of a decent movie starring Martin Sheen, *The Way* (2010), she incorporates the idea of hospitality. But foremost is the idea of love, for it "opens up an avenue for understanding the patient as a person rather than as a body with disease."[15]

Although running reservations about the monks engaging in medicine were expressed throughout the history of monasticism, many medieval monasteries had within them a herbarium, and prescribed various herbs for the illnesses they encountered. There still survive herbals from the early Middle Ages, and one summer when I taught at Eichstadt I wandered through the herbarium there. At Eichstadt one can also see early-modern printed herbals on display. And there has been study of "Discussions on the nature of medicine at the University of Paris, ca. 1300."[16]

Observers such as Wendell Berry and John Lukacs have argued that in the future the growing division will not be between liberals and conservatives, but between those who view themselves as creatures, and those who view themselves as machines.[17] In an essay on "The Return of Purpose," arguing for the necessity for science of an idea of final causality, I quoted the classic description by E.A. Burtt of the turn from the medieval and creaturely to the modern and mechanical:[18]

For the dominant trend in medieval thought, man occupied a more significant and determinative place in the universe than the realm of physical nature, while for the main current of modern thought, nature holds a more independent, more determinative, and more permanent place than man…[in the Middle Ages] on the teleological side: an explanation in terms of the relation of things to human purpose was accounted just as real as and often more important than an explanation in terms of efficient causality…. Analogies drawn from purposive activity were freely used.[19]

Burtt goes on to contrast the purpose-filled world of the Middle Ages with the purposeless world which modern science seems to present us.[20]

The difference between thinking of humans as creatures and as machines has been worked out by such writers as David S. Crawford and Michael Hanby. Crawford follows Benedict XVI in noting that "modern thought tends to reduce the physical world, and in particular the human body, to its merely material properties and laws, those that can be measured and… which can be exploited by technical means."[21] Hence, the "ethical message contained in being" becomes unintelligible.[22]

There is not space here to describe Crawford's complicated analysis of what follows from this,

but his broad comparison of the pre-modern and modern situations is very much to the point. We live in an age of individualism in which little heed is paid to the impact of our choices on whatever broader community is left, whether social community or the community of the created order.[23]

Crawford is part of a multi-front movement under the patronage of the American *Communio* group seeking to replace the Cartesian/Baconian understanding of man and nature with something more plausible philosophically and with theological depth. This group of thinkers finds many of the common criticisms of modern science, its scientism and reductionism, for instance, good so far as they go, but wishes more.[24]

Thus David C. Schindler and Adrian J. Walker are discontent simply to note the difference between non-living and living being, or between nature in general and animate nature. The criticisms of early modern science do not go far enough for them. Yes, anti-reductionism is right to say that "animate nature cannot be reduced downwards to inanimate nature, and inanimate nature cannot be reduced upwards to animate nature."[25] But a more grievous error is to think that we can give an adequate "explanation of *inanimate* substance without referring thematically to its original wholeness." If we do this we likely miss "the originality of *animate* substance."

Walker rejects "both a general faith in progress and the specifically scientific form of that faith, whose ideal is an (asymptotic) elimination of suffering and death through technology."[26] Science, born of a desire to better humanity's lot through control of natural forces, has reduced the mystery of evil. The Baconian-Cartesian world is a machine, and this, as C.S. Lewis noted, at least reduces an earlier sense that evil is demonic refusal of God. The great temptation facing science and technology is the elimination of suffering without taking into account the mystery of evil.

It is not at all that suffering should not be reduced, but that we are tempted to accept a false distinction between a supposedly neutral technique and the use of this technique, the goodness or badness of which depends on human intention, thus making humans, rather than humans with the cosmos, the source of value, effectively dethroning God as the Lord of all.

Of the *Communio* thinkers, especially Michael Hanby has pursued the post-Cartesian and post-Newtonian situation in which formal and final activity must be extrinsic to nature, and the mind-body problem eventually erases human nature.[27] Hanby uses David J. Depew's and Bruce H. Weber's demonstration of how in the nineteenth century biology became a Newtonian science, that is became as narrow ontologically as had the other sciences.[28] Into an empty nature demons entered in the form of an almost unbridled development of medicine, and there appeared such figures as the "heroic physician," or the medical researcher who believes that nature places no limits on what may be manipulated.[29]

For centuries the sexes have been spoken of not just as differentiated in biology, but in some spiritual or psychological way, such as expressed by the idea of "the eternal feminine." Some of what has been said is quite useful, but today it is common to speak politically of "what women want," as in the manner of abortion or reproductive "rights." It should be obvious that "women" are not a class who all want the same thing, but nevertheless many speak as if that were so.[30] In fact, studies have shown that to predict a woman's (or a man's) politics, it is much more important to know her marital status and level of religious practice than her sex. Again, the concept of "health care" has become very slippery. For instance, the packaging of contraceptives often involves portraying the reproductive system as dysfunctional.[31]

This likely is part of a larger campaign, as in high school textbooks, to present adolescent

sexual activity as virtually inevitable. It is said that continence is unrealistic. No longer is sex education a responsibility of the parent, but of the government and public educational system. The state has come to see itself as responsible for controlling female fertility, and personal continence as for the most part an unrealistic ideal. Thus a utilitarian view in which at the end sexual license is a health right. It may be difficult to present behavioral therapy as a more proper alternative, but my daughter pediatrician and son psychiatrist say this can be done.

It took millennia to develop a "best practice" of sexual intercourse as between a man and a woman, with intercourse restricted to marriage, to the end of preparing the best environment in which children could grow, but no one ever said that life is easy. From an anthropological point of view, much of human history is an experiment with the question of how fertility is best dealt with. Hence such behavioral codes as post-partum abstinence and extended breast-feeding. In our day the natural family planning movement has tried to build on such ancient experimentation, to the goal of being more respectful of what we and our families are. Now some of this has gained the approval of such journals as the *British Medical Journal* (20 Nov., 1993), and I myself am privileged to live in a Diocese which encourages and teaches natural family planning.[32]

In an article in *First Things*, a somewhat naïve and underinformed rabbinical student compared medical education at Georgetown and Yeshiva Universities, not to the clear benefit of either. The ideal at Georgetown was *cura personalis*, "the healing of the entire person, mind, body, and soul."[33]While making it clear that in some matters this was an ideal honored in the breach, this student thought this ideal guided the school in some important ways, teaching students how to take patients' spiritual histories and encouraging extended bedside visits, while making sure that they knew that, though the hospital itself cooperated in activities prohibited by Catholicism, the students could be excused from any activity they objected to on religious grounds.

At Yeshiva the school largely complies with the teachings of Rabbi Joseph B. Soloveitchik so far as conformity to Jewish law, diet, and daily observance is concerned. Soloveitchik, deeply suspicious of the irreligion and cult of scientism he had commonly found among physicians, thought only practicing Jews made fit Jewish physicians.

A Christian form of this observation would be to say that though, even today, the greatest gift that Christendom has given us, the idea that man is made in the image of God, has not been entirely effaced from our culture, we can not really speak of reconceiving fields such as medicine without returning them to this original observation that humans are made in the image of God. A proper healing is only possible in faithfulness to that observation.[34]

I would not expect that in fact the medicine of the future would significantly slow down its technologization and pursuit of efficiency and profit, but the figure of the Christian physician can still provide a counterpoint, returned somewhat, say, to a nineteenth-century model in which the village doctor plays in the local orchestra and is well-read outside his own field, that is, is less a specialist and more a full human being. Christianity in America is very forgetful of one of its central tasks, to teach humans how to die well. The Christian physician must finally place what he does under this heading of relativizing his own importance and presenting medicine not simply as an heroic effort to keep the demons of suffering and death at bay, but as a relative good ordered to life eternal.

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[1] Translation *Magnificat*, vol. 14, No. 5 (July 2012), p. 130, followed (p. 131) by the Intercession "O God, we fear the mortality we cannot cure: – grant insight and faith to all those who do the work of medical research." The Gospel reading for this day is Matthew 9:32-38, on

Jesus' driving out of a demoniac and "curing every disease and illness." A note, p. 138, explains: "Sickness is a harbinger of death. Jesus cured the sick as a counter-sign: in the reign of God, there will be neither illness nor dying. By taking death upon himself on the cross, Jesus cured the one incurable reality that haunts the human race: mortality." An Intercession for Evening Prayer, p. 139, asks that those with chronic illness be granted patient endurance, and another Intercession asks that those with a terminal illness be granted peace of mind.

[2] Andrew Crislip, *Thorns in the Flesh: Illness and Sanctity in Late Ancient Christianity* (Philadelphia: University of Pennsylvania Press, 2012).

[3] Brooke Holmes, *The Symptom and the Subject: The Emergence of the Physical Body in Ancient Greece* (Princeton University Press, 2010); the entry "Medicine," in *The Classical Tradition,* ed. Anthony Grafton, Glenn W. Most, and Salvatore Settis (Cambridge, MA: Harvard University Press, 2010); and Achim Thomas Hack, *Alter, Krankheit, Tod und Herrschaft im frühen Mittelalter: Das Beispiel der Karolinger* (Stuttgart: Anton Hiersemann, 2009). The last part of *Love, Sex and Marriage in the Middle Ages: A Sourcebook*, ed. Conor McCarthy (London: Routledge, 2004), contains "Medical Writings," and see *Medieval Medicine: A Reader*, ed. Faith Wallis (University or Toronto Press, 2010). Bettina Bildhauer, *Medieval Blood* (Cardiff: University of Wales Press, 2009), criticizes the contrast between an alleged medieval Christian reluctance to pursue science, and a modern scientific curiosity.

[4] See the review of Chryssi Bourbou, *Health and Disease in Byzantine Crete (7th-12th centuries, AD)* (Burlington, VT: Ashgate, 2010) by Timothy S. Miller, *Speculum* 87 (2012), p. 530-31.

[5] Chiara Crisciani and Gabriella Zuccolin, *Michele Savonarola: Medicina e Cultura di Corte* (Micrologus' Library, 37; Florence: SISMEL, Edizioni del Galluzzo, 2011), and *Between Text and Patient: The Medical Enterprise in Medieval and Early Modern Europe*, ed. Florence Eliza Glaze and Brian K. Nance (Micrologus' Library 39; Florence: SISMEL, Edizioni del Galluzzo, 2011). The Edizione Nazionzale "La Scuola Medica Salernitana," vol. 6 also has appeared: *Terapie e guarigioni,* ed. Agostino Paravicini Bagliani (Florence: SISMEL, Edizioni del Galluzzo, 2010).

[6] Bernard C. Bazàn, *Les questions disputes et les questions quolibétiques dans les facultés de théologie, de droit, et de medicine*, Typologie des Sources du Moyen Âge Occidental 44-45 (Turnhout: Brepols, 1985).

[7] Michael Solomon, *Fictions of Well-Being: Sickly Readers and Vernacular Medical Writing in Late Medieval and Early Modern Spain* (Philadelphia: University of Pennsylvania Press, 2010). The 48th International Congress on Medieval Studies, Kalamazoo, May 9-12, 2013, had a session devoted to "Medicine in Medieval Iberia," and sessions on "The Theory and Practice of Medieval Medicine," "Mental Health in Non-medial Terms," and "Fourteenth-Century Health Care."

[8] See for instance Enrique Montero Cartelle, *Tipologia de la Literatura Médica Latina: Antigüedad, Edad Media, Renacimiento* (Turnhout: Brepols, 2010).

[9] There is an appreciative review of this book by Jerome Groopman, "In a Medical Sanctuary," *The New York Review of Books*, 59, 14 (September 27, 2012), pp. 24-8.

[10] For context see Michael Bliss, *The Making of Modern Medicine: Turning Points in the Treatment of Disease* (University of Chicago Press, 2011), and Keir Waddington, *An Introduction to the Social History of Medicine* (New York: Palgrave Macmillan, 2011). See also Nicanor Pier Giorgio Austriaco,*Biomedicine and Beatitude: An Introduction to Catholic Bioethics*

(Washington, DC: The Catholic University of America, 2011).

[11] Groopman, “Medical Sanctuary,” p. 26.

[12] Groopman, “Medical Sanctuary,” p. 26. Obviously what Sweet is doing is related to the hospice movement, on which see Ruth Ashfield, “The Gift of the Dying Person,” *Communio* 39 (2012), pp. 381-97.

[13] Sweet quoted in Groopman, “Medical Sanctuary,” p. 28.

[14] Sweet quoted in Groopman, “Medical Sanctuary,” p. 28.

[15] Groopman, “Medical Sanctuary,” p. 28.

[16] See Cornelius O’Boyle, *Learning Institutionalized: Teaching in the Medieval University*, ed. John Van Engen (Notre Dame, Ind.: University of Notre Dame, 2000).

[17] See section three of Lukacs’ *The Future of History* (New Haven: Yale University Press, 2011).

[18] The following is quoted from Burtt, *The Metaphysical Foundations of Modern Physical Science* (Garden City, N.Y.: Doubleday & Company, Inc., 1954), in my “The Return of Purpose,” *Communio* 33 (2006), pp. 666-81 at 666-67.

[19] Burtt’s goal in *Metaphysical Foundations*, originally published in 1924, was a critique of positivism, showing that there is “no escape from metaphysics” (p. 227). For more recent comment on the “grey ontology” that results from the Cartesian and Newtonian elimination of teleology, in which wholes are viewed as no more than aggregates of their parts, see Jean-Luc Marion, “Descartes and Onto-Theology,” in *Post-Secular Philosophy: Between Philosophy and Theology*, ed. Phillip Blond (London: Routledge, 1998), and Michael Hanby, *Augustine and Modernity* (London: Routledge, 2003), pp. 134-177. Peter J. Bowler and Iwan Rhys Morus, *Making Modern Science: A Historical Survey* (Chicago: University of Chicago Press, 2005), pp. 175-176, 180-181, also have useful things to say.

[20] Over a longer sweep of time, things would be more complicated than Burtt indicates. For instance, neither ancient Chinese thought nor Aristotelian thought was anthropocentric in the sense of making man either the most important thing in the cosmos or the consciousness through which all understanding flows. These ancient forms of thought simply assumed a *fit* between nature and consciousness, as if the former existed to enable the latter. This of course continued in the Middle Ages. On the Chinese side, where Daoism is the best example, especially the first seven chapters 0f the *Zhuangzi*, see*The Complete Works of Chuang Tzu* (New York: Columbia University Press, 1968), pp. 83-85, or the section on Daoism in Benjamin Schwartz, *The World of Thought in Ancient China* (Cambridge, MA: Harvard University Press, 1985). Of the extensive bibliography on Aristotle, see Joseph Owens, “Teleology and Nature in Aristotle,” *Monist* 52 (1968), pp. 159-173, and John Cooper, “Aristotle on Natural Teleology,” in *Language and Logos*, ed. Malcolm Shofeld and Martha Nussbaum (Cambridge University Press, 1982).

[21] “Benedict XVI and the Structure of the Moral Act: On the Condom Controversy,” *Communio* 38 (2011), pp. 548-82 at 559. See also in the same journal 39 (2012), pp. 269-93, Larry Chapp, “*Gaudium et Spes* and the Intelligibility of Modern Science.” See also *The Body Divided: Human Beings and Human ‘Material’ in Modern Medical History*, ed. Sarah Ferber and Sally Wilde (Burlington, VT: Ashgate Publishing Company, 2011).

[22] Nicholas J. Healy, "Introduction: *Toward a Human Ecology Person, Life, Nature," Communio*, p. 38 (2011), pp. 519-22 at 520, describing Crawford's analysis.

[23] See Patrick J. Deneen, "Unsustainable Liberalism," *First Things*, Number 225 (August/September 2012), pp. 25-31.

[24] See for instance the articles by Chapp and Hanby in *Communio* 39 (2012), pp. 269-313. Hanby ("*Aggiornamento* and the Sciences: What Does It Mean?" pp. 294-313 at 307) explains why the modern sciences are inherently reductive.

[25] Adrian J. Walker, "Original Wholeness": (Living) Nature Between God and *Technê," Communio* 38 (2011), pp. 643-56 at 645 n.9, for this and the next two quoted phrases, with reference to D. C. Schindler, "*Analogia Naturae*: What does Inanimate Matter Contribute to the Meaning of life?" pp. 657-81, in the same issue, of which esp. pp. 657-62 are on "the challenge of mechanism," and see pp. 666-67, for Schindler's brilliant solution of the problem of the problem of the "relationship between living things and their material parts."

[26] "'Rejoice Always.' How Everyday Joy Responds to the Problem of Evil," *Communio* 31 (2004), pp. 200-35 at 204 n. 3, on this and the following.

[27] Michael Hanby, "Beyond Mechanism: The Cosmological Significance of David L. Schindler's *Communio* Ontology," in *Being Holy in the World: Theology and Culture in the Thought of David L. Schindler,* ed. Nicholas J. Healy and D. C. Schindler (Grand Rapids, MI: Eerdmans, 2011), pp. 162-189 at 174.

[28] Depew and Weber, *Darwinism Evolving: Systems Dynamics and the Genealogy of Natural Selection* (Cambridge, MA: MIT Press, 1997).

[29] Hanby, "Beyond Mechanism," pp. 179-80.

[30] See Colleen Carroll Campbell, "What Women Want," *Voices* 27, 2 (2012), pp. 9-12.

[31] Rita Joseph, "Serving an Epidemic of Sexual Excess," *Voices* 27, 2 (2012), pp. 15-17 at 15.

[32] See the citation of John Paul II's January 2004 message on "Natural Regulation of Fertility and the Culture of Life" in Joseph, "Serving an Epidemic of Sexual Excess," p. 17.

[33] Peter Kahn, "Grand Rounds with Jews and Jesuits," *First Things* 224 (June/July, 2012), pp. 22-23 at 22.

[34] See Deneen, "Unsustainable Liberalism," p. 30.

Humanum
Issues in Family, Culture & Science

FEATURE ARTICLE

Medicine after the Death of God

MICHAEL HANBY

There seems to be a broad consensus in our culture that medicine stands at some kind of perilous crossroads. Medical technology of all kinds, including some that were heretofore imaginable only in science fiction, is evolving at an astonishing rate, holding out great promise for earlier and more exact diagnosis and for new cures, therapies, and microsurgeries. In this sense, you might say that the state of medicine has never been healthier. And yet in spite of this astounding technical proficiency, or perhaps also because of it, people are justly worried. The technological evolution of biology and medicine has made it possible to do things to ourselves and our posterity that we do not know how to think about, and that many of our contemporaries apparently do not want to think about. Every few weeks, we are presented with what seems like a new bioethical quandary made possible by our technological expertise.

There are other issues as well, not unrelated. Medical costs are out of control, especially where the quality of medical care is poorest. Nobody seems to know how to tame them, and some experts even suggest that the problems are so intractable, and the center-less system so vast and complicated, that it cannot be fixed. Medical professionals find themselves under constant pressure from forces external to medicine itself: pressure to maximize efficiency, pressure to minimize liability, pressure to see more patients, pressure to see fewer patients, and layer upon layer of administrative oversight. Many of the medical professionals I've talked to express a sense of frustration and helplessness about all this. This sense can be even more acute for patients, as the experience of submitting oneself to the vast labyrinthine workings of industrialized medicine and its administrative apparatus can often compound the already dehumanizing experience of being ill.

And yet even in the face of all these misgivings, many in our society seem to hold an almost blind faith in the progressive power of medicine, expecting it to cure every personal and social malady, cater to every desire, and enhance our very humanity. And of course such hopes and expectations only fuel the engine of unrestrained biotechnical development, which proceeds on its course, in Hans Jonas' image, like a ship navigating with its landmark tied to its own bow.[1]

All of this has given rise to a great deal of confusion and to radically competing visions of what medicine ultimately is and is for, creating for medicine – at least medicine as we have known it

– something of an "epistemological" and perhaps indeed even an *existential* crisis.[2] There are real grounds for concern that the *art* of medicine may be overtaken entirely by the *science* of medicine, that the *science* of medicine may be overtaken, in turn, by the*business* of medicine, and that the business of medicine may collapse under the weight of social, economic, and demographic pressures and its own internal contradictions.

Catholics in medicine have their own special reasons for anxiety. In the 2010 special election to fill the Senate seat left vacant by the death of Ted Kennedy, candidate Martha Coakley, the Massachusetts attorney general, opined on a radio show that maybe people with Catholic convictions shouldn't work in emergency rooms. It turned out that Coakley had a special talent for ill-advised remarks, and this one was quickly shot down along with her election chances; yet the incident left many Catholics with the sense that Coakley had inadvertently revealed the thinly veiled sentiments of much of secular America and perhaps even the current government. Needless to say, subsequent actions by the government have not been reassuring.

Yet, what I think is most striking about such sentiments is not their hostility, which should really come as no surprise, but rather their historical ignorance and superficiality, as if all these hospitals with saint's names affixed to them just dropped out of the sky. And if Coakley does in fact speak for our emerging post-Christian culture, it betokens a grave crisis indeed. The Orthodox theologian David Bentley Hart makes gets at a similar point when he notes the sheer intellectual un-seriousness of the so-called New Atheists, who, cheerfully reveling in their ignorance of both philosophy and history, seem to think it possible to erase the memory of Christianity from the culture without losing much else that is important besides.

Friedrich Nietzsche, surely the gold-standard among atheists, certainly entertained no such illusion. He understood, as most of our contemporaries do not, that the Death of God would be the death of everything which had heretofore guided the West, that our killing of God would be a great deed tantamount to drinking up the sea, wiping away the horizon, and unchaining the earth from its sun – though such deeds take time to become fully manifest – and that new gods and new values, whose character was yet unclear, would have to be invented.[3] Nietzsche stands as a warning against the superficiality of today's secularism and our anachronistic tendency to confine "religion" to some little private compartment of life. And Hart issues a caution in this Nietzschean spirit: "It is pointless to debate what it would mean for Western culture to *renounce* Christianity," he writes, "unless one first learns what it meant for Western culture to *adopt* Christianity."[4]

Sensing a cultural sea-change, and feeling themselves the object of scorn and incomprehension in an age which is not simply secular, but historically and philosophically post-Christian, American Catholics seem palpably anxious to carve out a "me-too" place for themselves within medicine, a place where they are free to practice medicine according to the peculiar shape of a Catholic conscience, however unintelligible that may now be within the larger culture. In contrast to this, I raise this Nietzschean observation first to suggest that while this reaction is understandable, and perhaps all we can reasonably hope for given our cultural situation, it is not adequate either to secure the viability of Catholics in medicine over the long-term or to address what is really at stake in this crisis. I raise it, second, to introduce the animating assumption of this essay, which I will come to in due time. Suffice for now to say that we need to re-frame the question in light of a deeper and more comprehensive understanding of what is at stake.

There are of course many ways in which the history of Western medicine could be and has been written, each of which contains fundamental assumptions about the nature and purpose of medicine itself. There is what has been called the "great men in white coats" school of

medical historiography, which was dominant until just recently. One could read the history of medicine as the history of medical technology, and indeed important work has been done showing how revolutionary inventions from the stethoscope to the x-ray machine, artificial kidneys, and respirators have transformed not only clinical practice, but what Foucault called "the medical gaze," the frame through which medicine views, categorizes, and problematizes the human body, health, and disease.[5]

Taken to its logical conclusion, this gaze culminates in the new "genetic" and "clinical" understanding of the human person and society according to which, in the words of Richard Lewontin, "the model of cystic fibrosis is the model of the world."[6] Or, relatedly, one could tell the history of medicine as Guenter Risse has done, as a history of the hospital and the central images through which we understand it: from its origins as a place of mercy and a refuge for the dying in late Christian antiquity, through its role as a house of rehabilitation during the Renaissance and a place of cure in the eighteenth century, to a center of teaching and research in the nineteenth century, surgery after 1850, advanced science in the early twentieth century, and high technology in the late twentieth. And one could consider how each of these focal images reflects profound changes in the underlying assumptions of the surrounding culture.[7]

Each of these perspectives on medicine is a legitimate aspect of the overall picture, and each would show us in historical terms what we already know to be true on philosophical grounds: that the history of medicine is not simply a history of institutional development and technical, scientific progress, but that institutional development and technical and scientific progress are always mediated by deep, often unarticulated metaphysical assumptions about the ultimate natures of persons and things. But no history would be adequate to the truth, much less to what is presently at stake, if it fails to consider the ways, both subtle and specific, that Western medicine was nurtured within the bosom of the Church and the Christian imagination.

To grasp the more subtle and diffuse sense of this claim, let us return to the point by David Bentley Hart. In addressing the blithe superficiality of the New Atheists, Hart asks us to imagine a world in which Christianity had never happened, sort of the intellectual equivalent of a Narnia under the White Witch, where it is always winter, never Christmas. "A world from which the gospel had been banished," he writes, "would surely be one in which millions more of our fellows would go unfed, unnursed, unsheltered, and uneducated." But more deeply still, though we have forgotten it, citizens of the West are inheritors of a social conscience whose ethical grammar would have been very different had it not be shaped by Christian theological, ontological, and moral premises."[8] "It is simply the case," he continues, " that we distant children of the pagans would not be able to believe in things such as human rights, economic and social justice, providence for the indigent, legal equality, and basic human dignity – all palliated echoes and haunting fragments of Christian moral theology – such things would never have occurred to us – "had our ancestors not once believed that God is love, that charity is the foundation of all virtues, that all of us are equal before the eyes of God, that to fail to feed the hungry or care for the suffering is to sin against Christ, and that Christ laid down his life for the least of his brethren."[9]

Of course, the Greeks and the Romans, epitomized by Hippocrates and Galen, had a "naturalistic" conception of medicine as well as pagan healing cults such as the cult of Asclepius and, and, indeed, Christian medicine, whose development was encouraged by Sts Basil of Ceaesarea, Gregory of Nyssa, Gregory Nazianzen, and John Chrysostom among others, was by and large an appropriation of Galenic holism, environmentalism, and humoralism. Christian refuges, such as what is now the Basilica of Sts Cosmas and Damian on the Forum of Vespasian in Rome, took up residence in what were formerly pagan temples and shrines.[10]

These developments had their roots in the call to charity and in the image of the *Christus Medicus*, popularized by St Augustine. Yet the fact that Christianity appropriated Greco-Roman secular medicine does not diminish but underscores our culture's debt to Christianity; for here, as in philosophy, art, and literature, we have Christian charity and universality, the openness to goodness and truth to thank for the preservation of the remnants of classical culture.

This is why our anachronistic understanding of "religion," as a private (and ultimately irrational) compartment of life is such a distorting lens through which to perceive the profundity of Christianity's contribution to our culture. But even with a relatively developed medical art, "Pagans," writes Guenter Risse, "lacked a comprehensive religious doctrine that could energize and compel them to consider collective charitable actions."[11] And so as soon as Christianity emerged fully into the open and assumed social responsibility, new factors were introduced into medicine and its self-understanding. Asclepius, for instance, only served individuals who sought him out, worshiped him, and made offerings, and he offered no eternal salvation. Many pagans avoided contact with the sick, refusing to nurse them, and they would flee their homes and cities in times of famine and epidemic, sometimes even leaving their dead unburied. By contrast, Christians in Edessa, Caesarea, and other places mobilized during such events to create hostels and refuges for the sick and the destitute.

Galen himself attests to the willingness of Christian women to nurse unbelievers as well as fellow Christians during epidemics.[12] Gregory Nazianzen reports that during one such event in Cappadocia and Caesarea, "Basil assembled in one place those afflicted by the famine, including some who had recovered a little from it, men and women, children, old men, the distressed of every age. He collected through contributions all kinds of food helpful for relieving famine. He set before them cauldrons of pea soup and our salted, meats, the sustenance of the poor. And he goes on to describe this refuge as "a new city, the storehouse of piety… there sickness is endured with equanimity, calamity is a blessing, and sympathy is put to the test."

By 370 this institution was patronized by the Emperor Valens.[13] By this point, the Church already had become the most important patron of charitable works in the Roman Empire with religious foundations maintaining infirmaries to care for the poor and the sick, and in at least one case in Antioch in the 340s, dedicated to giving specifically medical attention. Thus was inaugurated the long tradition of religious almshouses and hospices that would eventually evolve into the hospital during the Renaissance.

Historians often refer to the medico-religious character of the late hospitals that emerged, especially after the Black Death, as supplying medicine for the body and medicine for the soul. There is of course true in a certain sense. There is, after all, a proper distinction between body and soul which the ancients and medievals would have readily acknowledged, and modern medicine has surely shown us that it is possible to successfully treat the health of the body in abstraction from any considerations about the soul, indeed without acknowledging the existence of soul, which seems to modern thought like a curious relic of a superstitious pre-scientific past.

But we must take care not to interpret this through our own inveterate Cartesianism, lest we miss its real significance. In their appropriation of Galenic holism, environmentalism, and humoralism, and their therapeutic use of Galenic "non-naturals" such as music and art, in their architecture, which is scarcely distinguishable from that of the monastery and which sometimes made a provision for the sick in their beds to adore the sacrament, in their role as recipients of artistic patronage, and their prominent place within the liturgical life of their cities, in the structure they provided for the outworking of the religious vocation, and not least,

in the impetus that this vocation provided to assist in the *ars moriendi* and to care in hope for those who stood no chance of physical recovery – in all of this – the very existence of these institutions testifies to an understanding of the of the person that is more than a machine or an "autocatalytic dissipative system," an understanding of his wholeness or unity that is more than a unity of aggregation or organization; more than a psychological or affective ghost tacked onto a machine. The very existence of such institutions is testimony to an understanding of health that is more than mere physical or even psychological homeostasis, an understanding of care that is more than cure, and an understanding of the medical vocation that is more than a career.[14]

These deeply engrained understandings, the sometimes half articulated assumptions of our Christian inheritance, would persist – especially in America – well beyond the advent in the nineteenth century of what *we* would consider properly scientific medicine, an understanding we must admit, that is partly an attempt to free biology, and by implication medicine, from precisely those metaphysical and religious presuppositions that were operative in the birth of Western medicine and to account for and modify life solely in physico-chemical terms.[15] Nevertheless, Milton J. Lewis notes that "between 1849 and 1900 no fewer than six Catholic sisterhoods established hospitals in New York and Brooklyn. The Sisters of Charity, Sisters of St Joseph, Dominican Sisters, Franciscans, Misericordia Sisters, and the Missionary sisters of the Sacred Heart founded at least one hospital each; as a result, after New York and Brooklyn merged in 1898, altogether they were running about half of the city's charitable hospitals and associated institutions. Their hospitals were the site of their spiritual life, as well as their communal world, and patients were seen to be like them – sufferers in the mystical body of Christ."[16]

Between 1829 and 1900, Catholic sisterhoods established 299 hospitals nationwide and really helped give birth to the modern profession of nursing, until the role of the sisterhoods in nursing came under scrutiny during the Progressive era and nursing was "professionalized" in the modern sense of the term. The Mayo Clinic is one of these, along with its sister institution, St Mary's Hospital, founded by the Mayo Brothers in the wake of a devastating tornado at the behest of the Franciscan sisters who raised the funds for it, staffed it with nurses and administered it for many years. Sadly, just as I was writing this essay it was announced that the Catholic designation is being removed from St Mary's Hospital and that it will now be merged with its Methodist neighbor to become Mayo Clinic Hospital, Rochester.

Now I am no historian, and I do not wish to suggest that this history is all glory and light, or that the advent of scientific medicine hasn't brought about a giant advance in the efficacy of medicine. That would be foolish to the point of unmeaning. Though neither do I wish in acknowledging this point to indulge the triumphalist attitude of modern historiography toward premodern medicine and the early hospital, which is sometimes denigrated as the place where people went to die. In fact *we* are more likely to die in a hospital than our medieval and renaissance ancestors, so we can say with some justification that it is the *modern* hospital where people go to die, and we can ask with equal justification whether in comparison those who undergo the experience are likely to be more or less contemplative, more or less at peace, more or less alone.

What I do hope is that I have offered enough evidence to justify the assertion that Western medicine owes a great deal to the Christian imagination, more perhaps, than we can ever fully say or appreciate, because Christianity's contribution to the shaping of Western culture cannot be easily segregated into a religious compartment and dismissed. This is a consoling thought, on the one hand, for perhaps it means that this inheritance, which is truly human as well as Christian, is so deep in the bones of medicine and the culture that it can never be squandered

entirely. And yet, on the other hand, it requires us to acknowledge that we this inheritance cannot be renounced or forgotten without losing a great deal of what has heretofore constituted our humanity, and the humanity of Western medicine. Certainly Nietzsche didn't think so.

And recognizing this we see what is really at the bottom of this contest between conflicting visions of the health and medicine: "What is man, that though art mindful of him, and the son of man, that though visitest him?"[17] Underlying these competing understandings of the nature of medicine and health, in other words, are competing fundamental anthropologies, competing visions of who and what the human being is, or indeed whether he is finally anything at all but the coordinated interaction of his physical parts and the and the sum of the antecedent causes that produced him. Pope Benedict understood that this is precisely what is at stake in the survival of an intelligible sense of creation in our technological society. The question, he said, is not simply whether God exists, but whether human beings do.[18] Contemporary medicine is on the frontlines of this question, where, one way or the other, it will be answered in practice.

I said previously that we need to re-frame the question, and here we confront this point again, along with the assumption that animates this reflection. The most urgent question in the current situation is not what place is there for Catholicism within modern secular medicine – after all, the Church does not exist for itself but for the world – but rather, what will become *of medicine* when its Christian origins and spirit have been forgotten? We can of course hope in the basic goodness of humanity and the good will that continues to motivate the many good people who give their lives to medicine. But is there any guarantee that a culture at war with the foundations of its good will can sustain the humanism necessary for sacrificial and humane care? Can a culture lacking a transcendent horizon or a redemptive understanding of suffering long endure the presence of the suffering among us? Is there any principled theoretical limit to a reductive biology? Is there any principled moral limit capable of resisting the technological imperative, the new eugenics, or the pressure to maximize efficiency? Can "professionalism" substitute for "vocation"? Can "professional standards" and physician "self-care" replace spiritual discipline?

These are extremely difficult questions, and we face enormous obstacles in thinking about them clearly, much less in providing efficacious answers to the problem they denote. The culture that sustained and was sustained by this religious endeavor no longer exists, and the theological and anthropological assumptions which animated this work, though they are still operative in some sense in the fragments we now possess, are no longer part of our cultural common stock. We are all aware of the depressing demographics, and we know that, barring a miracle, many of the orders that founded these institutions will cease to exist within our lifetimes, necessitating that Catholic medical institutions be sold to secular management or that its Catholic identity be entrusted to lay "review boards." And even where that is not the case, the "Catholic identity" of many Catholic institutions is often a shell of its former self, having gone the way of the religious identity of most of our once Christian universities: incrementally sacrificed on the altar of cultural assimilation and social respectability, professionalism, and guild accreditation and licensing standards. All of these trends appear to be irreversible, at least in the near term.

But the obstacles within are perhaps even more daunting than the obstacles without. As children of the modern West and heirs to the whole, complex history of Western medicine, we are the recipients both to the classical and Catholic conception of the person as an indivisible unity of body and soul, a*corpore et anima unum* and its corresponding understanding of medicine as an art *and* to the mechanistic ontology of modernity, which imagines the human

organism as a machine or an “autocatalytic dissipative system,” and its corresponding understanding of medicine principally as a technological science.[19]

There is truth in both of course, but ours is a fragmented inheritance, and so we really do not know how to relate the two dimensions in an intellectually cogent way. We imagine that reintegrating religion and medicine is a matter of integrating or joining together two things that are essentially separate and external to each other: *spirituality*, which in a reduced understanding now has to do with some special affective or religious region of experience outside of reason, and *medicine*, the business of hard science whose subject is the mechanical or systematic body. The theoretical result is that notions such as the person and the soul, even life and health themselves, tend to be relegated by analytic science to an epiphenomenal realm of “folk biology.”

The practical result is that care of the *person*, as a *per se unum* of body and soul, tends to be delegated to the priest, to the counselor, to family members, or other agents fundamentally external to medicine as such, and often somewhat marginal within the institutional organization of medicine. It may even be delegated to the physician *qua* concerned Christian or compassionate human being. But it is not a concern of the physician *qua* scientist, because we cannot see what difference such notions might make to a *scientific* understanding of health and disease, even though a full accounting of the unity and integration of the human person permanently eludes the grasp of reductive science. In a particularly acute way, this problem exemplifies what Nietzsche meant when his madman declared that God is dead and we have killed him, and when the people in the market place responded with incredulity, derision, and laughter. It is not that we have somehow disproved God. It is rather that we have come to understand the world in such a way that we can no longer see what difference God’s existence or non-existence might make to it.

If this is an accurate diagnosis of the factors underlying our cultural anxiety about medicine, then we will have to take a hard headed look at “the signs of the times,” and we will have to think more rigorously about what it means to integrate spirituality and medicine and why it is important. If this is diagnosis is accurate, then whatever contribution that religion can still make to medicine in this post-Christian culture will consist not simply in deeper compassion or greater interpersonal communication – doctors being willing to talk to patients about God, for example. All of this is good and salutary, but it is not enough to prevent the further fragmentation of medical practice or to delay the arrival of the brave new world already on the horizon.

If this diagnosis is correct, then the physician’s task in bringing faith to bear on medical practice will consist, in the first instance, in *being a better physician*, and this in turn, will require an even more comprehensive and humanistic approach to medical education, as if med students didn’t already have enough to do. It will entail acquiring a more critical appreciation of the *philosophical* presuppositions of medical science, and a deeper and a more comprehensive vision of the medical art and of the patient.

No doubt there is a first-person dimension to making medicine more human. Western medicine, as we have seen, was nurtured within the bosom of religious life, and it is doubtful that professional competence can substitute for the interior life which that discipline sought to cultivate. Nor do I suspect that physicians can long bear the awesome burden of the secular priesthood that our culture has thrust upon them in its quest for medical salvation without cultivating such a life. This burden, I recognize, demands a discipline no less heroic than that faced by earlier generations and maybe more so, given the temptations of our culture and the enormous power that comes with this responsibility.

But the crisis of confusion currently besetting modern medicine is not just a crisis of morality or spirituality, even in this more rigorous, ancient sense, but a crisis of *truth*: the truth of who and what the human being is. And if he is indeed a person, a *per se unum* of body and soul, then that truth must permeate the whole of his being, in all its dimensions, including his physiology and biology, and it must be visible, in principle, even to the scientific gaze.

This means that the task which physicians and other medical professionals face in integrating spirituality and medicine is a task they must confront not just*qua* compassionate human being, but *qua* nurse, *qua* physician, *qua* scientist. This task is not just spiritually demanding but intellectually and scientifically demanding, and consists in nothing less than making the human person, in his physiological and biological dimensions, visible once more to the eyes of medicine. And yet the threat of a technico-medical juggernaut turned *in*human presents not only an enormous obstacle, but also an enormous opportunity for Catholics working in medicine to do just that. Should they succeed even in witnessing to the truth of the person in all its fullness, it would demonstrate – not for the first time – that the Death of God is not the final word.

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[1] Hans Jonas, *Philosophical Essays: From Ancient Creed to Technological Man* (New York: Atropos Press, 2010), p. 81.

[2] For more on this crisis and confusion, see Leon Kass, *Toward a More Natural Science: Biology and Human Affairs* (New York: The Free Press, 1985), pp. 157-86.

[3] Nietzsche, *The Gay Science*, trans. by Walter Kaufmann (New York: Vintage Books, 1974), p. 125.

[4] David Bentley Hart, *Atheist Delusions*: *The Christian Revolution and Its Fashionable Enemies* (New Haven: Yale University Press, 2009), p. 16.

[5] See Stanley Joel Reiser, *Technological Medicine* (Cambridge University Press, 2009); Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A.M. Sheridan Smith (New York: Vintage Books, 1994); Keller, "Nature, Nurture, and the Human Genome Project," Richard Lewontin,*Biology as Ideology: The Doctrine of DNA* (New York: HarperCollins, 1991).

[6] See Richard Lewontin, *Biology as Ideology: The Doctrine of DNA* (New York: HarperCollins, 1991), p. 75.

[7] Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (Oxford University Press, 1999).

[8] Hart, *Atheist Delusions*, p. 16.

[9]*Ibid*., p. 33.

[10] See Risse, *Healing Bodies, Saving Souls*, pp. 69-165; Owsei Temkin, *Hippocrates in a World of Pagans and Christians* (Baltimore: The Johns Hopkins University Press, 1991), pp. 109-248; Gary B. Ferngren, *Medicine and Healthcare in Early Christianity* (Baltimore, The Johns Hopkins University Press, 2009); Vivian Nutton "Medicine in Late Antiquity and the Early Middle Ages," in L. Conrad, M. Neve, V. Nutton, R. Porter, and A. Wear, *The Western Medical Tradition: 800 BC to AD 1800* (Cambridge University Press, 1995), pp. 71-88.

[11] Risse, *Healing Bodies, Saving Souls*, p. 83.

[12] Risse, *Healing Bodies*, Saving Souls, p. 80.

[13] Risse, *Mending Bodies, Saving Souls*, p. 84. St Gregory Nazianzen, "On St Basil," in *Funeral Orations by St Gregory Nazianzen and St Ambrose*, trans. L.P. McCauley, *et al*. (New York: Fathers of the Church, 1953), p. 58

[14] See John Henderson, *The Renaissance Hospital: Healing the Body and Healing the Sou*l (New Haven: Yale University Press, 2006).

[15] See, e.g., Claude Bernard, *An Introduction to the Study of Experimental Medicine*, trans. by H.C. Greene (New York: Dover, 1957); Jacques Loeb, *The Mechanistic Conception of Life* (The University of Chicago Press, 1912).

[16] Milton J. Lewis, *Medicine and Care for the Dying: A Modern History* (Oxford University Press, 2006), p. 17.

[17] Ps. 8:4.

[18] Joseph Ratzinger, *'In the Beginning…' A Catholic Understanding of the Story of Creation and the Fall* (Grand Rapids: Eerdmans, 1990), p. 86. He continues, "The fact of human beings is an obstacle and irritation for 'science,' beause they are not something science can exactly 'objectify'."

[19] On the unity of organisms and persons and the metaphysical problems in conceiving of it adequately, see Michael Hanby, *No God, No Science? Theology, Cosmology, Biology* (Oxford: Wiley-Blackwell, 2013), pp. 250-96, 334-74.

Humanum
Issues in Family, Culture & Science

EDITORIAL

Editorial

STRATFORD CALDECOTT

In this issue we take a break from the sequence we have set for ourselves in order to focus on an issue of intense interest to all of us, with the help of a symposium recently held at the John Paul II Institute's Center for Cultural and Pastoral Research on the future of medicine, with a focus on the fate of Catholic medicine specifically.

Delays to this issue are partly due, ironically enough, to the Editor's own experience of hospice care at Sobell House in Oxford, which has made the present issue of more than usual interest to him. Though Sobell is not a Catholic institution, his experience there brought home to him the importance of the spirit or ethos that pervades any community of carers.

This conference issue tries to cover a number of important issues. They include rising health-care costs, the emergence of giant for-profit health-care systems, the decline in religious vocations, controversy over reproductive medicine, end-of-life care and other bioethical issues, not to mention new government regulations limiting religious liberty. Such changes are conspiring to reduce or perhaps even eliminate the institutionalized presence of Catholicism in American health-care over the course of the next generation. This naturally raises the question of what place there may be for Catholicism in health-care in the coming years.

This is not the only question; however, nor even, perhaps, the most important. Western medicine is a highly advanced science, but it is also an art nurtured from its very beginning within the bosom of the Church. The Church's understanding of the human person, her distinctive notions of health and of care, and the discipline of religious life, all helped give birth to hospital and to medical care in the West and have profoundly shaped the self-understanding and institutions of modern medicine, its view of the patient, and the meaning of the medical calling up till now. Perhaps a still more urgent question, then, is not, what is the fate of Catholicism in modern medicine, but *what is the fate of modern medicine* and the ethos it inspires once its religious roots are forgotten?

Glenn Olsen and Michael Hanby address the historical dimension of these issues. Historically speaking, Catholicism profoundly shaped the soul of Western medicine in several ways. In many instances, Western medicine was the direct outworking of a religious vocation. Monastic foundations created institutions devoted to charity that would become the modern hospital, and generations of women religious saw nursing as an integral dimension of their vocation.

Such factors deeply informed medicine's self-understanding in terms analogous to a religious vocation and its spiritual disciplines, as seen, e.g., in the adoption of the Hippocratic oath. Implicit within this self-understanding is a corresponding understanding of the patient as a person, a person, a *per se unum* of body and soul, whose health is not merely physical. The radical changes brought by scientific and bureaucratic medicine portend changes both to medicine's self-understanding and to its underlying medical anthropology. What are these changes in medicine's underlying anthropology, and how will they affect medicine's self-understanding and the formation of its practitioners? Are professional and quality control standards an adequate replacement for a vocational sense of medicine and its corresponding disciplines?

Turning to the present and the future, Sara Deola discusses how the patient and his health will be viewed in medicine increasingly (and exclusively?) understood as a technical science. What, in other words, is the anthropology of technological medicine and how will this be brought to bear on medical care? John I. Lane asks whether there are any opportunities for "creative minorities" to practice medicine *in a Catholic way* within the emerging cultural, legal, economic and technological context? Apart from the usual bioethical considerations, how might Catholic medicine look different from and improve upon medicine as it is currently developing?

Finally, Mary Hamm and Ruth Ashfield ask whether medicine's fascination with its scientific prowess and own power to cure, rising costs, scarce resources, and the need for greater efficiency all call into question our ability to abide patiently with those who cannot be cured. How is suffering understood within the anthropology of contemporary medicine? Is it intelligible? What are the expectations for how a thoroughly secular medicine will cope with "hopeless cases"?

In an Appendix, Allen Aksamit looks at the history of the Mayo Clinic itself, and shows how cultural, governmental, and economic forces are combining to erase the last vestiges of the Catholic character of once-Catholic medical institutions. What might the future hold for these and other medical institutions*without* the witness that Catholic health-care once provided?

We hope that these rich and thoughtful papers on so many aspects of health-care will help to orient Catholics and a wider public in a debate that (either now or in the future) affects all of us in one way or another.

Stratford Caldecott and

The Center for Culture and Pastoral Research

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