
PART TWO

THE NATURE OF RELIGIOUS LIFE

We face these ambiguities as Christians and as members of religious communities. The experience of religious life is rich, inclusive of many charisms, ministries, and concrete ways of living the Gospel. No one can describe its essence in a few sentences or paragraphs. Nevertheless, we continuously try to articulate its meaning both for ourselves and for the Church.

Recent church documents have characterized religious life as "a radiant sign of the kingdom of God for the church and for the world."¹⁹ This description recognizes that religious life does not exist only for itself or for the personal holiness of its members. Rather, it is a gift to the entire church and the world.²⁰ The working document for the 1994 Synod of Bishops on Consecrated Life portrayed the witness of religious life as "a prophetic presence which in a most profound way proclaims hope,

¹⁹ Working document for the 1994 Synod of Bishops, "The Consecrated Life and Its Role in the Church and in the World," par. 8. See *Origins* 24 (June 30, 1994): 101. The document is quoting *Perfectae Caritatis*, par. I.

²⁰ See *Lumen gentium*, par. 44.

voices the message of salvation, proclaims the love of God and denounces evil and infidelity to God's covenant of love.²¹

We proclaim this prophetic, counter-cultural message in the work we do: living lives dedicated to prayer and to the praise of God; working with the poor, the sick, the marginalized; contributing to the advancement of culture and to areas of justice and peace.²² Still, more than any work we do, we proclaim these values in the vows we have taken, the lives we live, the people we are. In this we not only announce the values expressed in the Gospel, we embody the Gospel itself:

Those who are called to the profession of the counsels reveal and realize the most paradoxical dimension of the Christian life—that of Christ crucified and risen. The choice of chastity, poverty, and obedience expresses the resolution to participate in Christ's sacrifice and the glory of his resurrection.²³

This entering into the mystery of the dying and rising of Christ, the very core of the Christian life, is not without pain, particularly in the midst of prolonged sickness, aging, or terminal illness. Can these situations become graced moments in which we religious are able to witness the Gospel to the larger church and to the world?

²¹ "The Consecrated Life and Its Role in the Church and in the World," par. 15.

²² *Ibid.*, par. 10.

²³ *Ibid.*, par. 55.

Questions:

- ▶ How can my identity as a religious bring something special to bear on the issues of illness, suffering, and death?
- ▶ What prophetic message might I bring?
- ▶ What are the graced moments I experience in ministering to those members of my congregation who are facing illness and death?
- ▶ Which moments are painful? Which life-giving?

PART THREE

THE WITNESS OF THE RELIGIOUS FACING SICKNESS, DISABILITY, AND DYING

As we try to witness the Gospel to the larger church and world, we often experience the fact that we have bought into the values of U.S. culture. In their recent study on religious life, David Nygren, CM, and Miriam Ukeritis, CSJ, commented that "members of religious orders are often unaware of the degree of their assimilation into the mainstream culture and how invisible they have become to those who most would call out to them."²⁴ As we try to respond to the choices that contemporary health care occasions, perhaps we can find in these choices an opportunity to reflect upon our identity and our values as religious women and men.

²⁴ Nygren and Ukeritis, *The Future of Religious Orders in the United States*, p. 250.

In a World that Often Denies Death, a Witness to Faith

In his 1994 best seller, Dr. Sherwin Nuland decried the fact that physicians often give false assurances to terminally ill patients:

Too often, physicians misunderstand the ingredients of hope, thinking it refers only to cure or remission. They feel it necessary to transmit to a cancer-ridden patient, by inference if not by actual statement, the erroneous message that it is still possible to attain months or years of symptom-free life. When an otherwise totally honest and beneficent physician is asked why he does this, his answer is likely to be some variation of, "Because I didn't want to take away his only hope." This is done with the best of intentions, but the hell whose access road is paved with those good intentions becomes too often the hell of suffering through which a misled person must pass before he succumbs to inevitable death.²⁵

This may be merely one of a series of denials that plague our society as it tries to deal with sickness and death. In a culture that idolizes youth and the body beautiful, individuals often deny that they are sick at all, or at least deny the severity of their illness. Society often presents old age as a time of life "constantly pressing toward its

²⁵ Sherwin B. Nuland, *How We Die: Reflections on Life's Final Chapter* (New York: Alfred A. Knopf, 1994), p. 223.

betterment.¹¹²⁶ We are even tempted to deny mortality itself, as the title of the 1974 Pulitzer Prize winner indicates.²⁷ The church has not been immune to such denial. One of the standard moral debates earlier in this century was whether anyone should tell a patient whether he or she was dying.²⁸

In the midst of this culture of denial, what witness is a member of a religious community able to give? Perhaps the most prophetic witness is simply that of being truthful in acknowledging illness and death. Communicating pain is often quite difficult. Contemporary experience shows that "suffering renders one mute."²⁹ Yet the biblical tradition has put us in touch with the profound power one obtains by *naming* reality. At the very least, we religious should allow the language of illness and death to be part of our vocabulary. Baptism and religious profession are signs of the paschal mystery. We need to name and honor this mystery in our own lives or religious life itself becomes meaningless.

Yet, such naming demands a certain courage on the part of the one who speaks it and on the part of the one who is willing to listen. Speaking the truth means that we do not allow a simplistic sentimentalizing of illness and death. Neither does it

²⁶ Gerald Gruman, "Cultural Origins of Present-Day 'Age-ism': The Modernization of the Life Cycle," in *Aging and the Elderly: Humanistic Perspectives in Gerontology*, ed. Stuart Specker et al. (Atlantic Highlands, NJ: Humanities Press, 1978), p. 380.

²⁷ Ernest Becker, *The Denial of Death* (New York: The Free Press, 1973).

²⁸ For example, Gerald Kelly's classic text in medical ethics devotes two chapters to this question. See Gerald Kelly, *Medico-Moral Problems* (St. Louis: The Catholic Hospital Association, 1958), pp. 42-50.

²⁹ Casey, "Suffering and Dying with Dignity," p. 153.

demand that we simply give up. Illness, suffering, and death are *evils*. They threaten the well-being and the dignity of the person. It is part of the human condition to fear such evils. It is proper to resist them to the extent that we are able.

Illness, suffering, and death are part of life. Try as we might to resist them, there comes a point when we must accept their hold on us and our own inevitable decline. As Christians and religious, we believe that the paschal mystery proclaims victory over death, but we also believe that it is precisely in vulnerability that we encounter Christ. Grave illness *can* be a time of grace.³⁰ A true theology of the cross acknowledges the ambiguous nature of suffering and gives us the power to name illness and death in our lives. It enables us to resist them when that is appropriate and to accept them when that is appropriate. Faith lets us glimpse meaning when it seems hidden. It tells us that God is present in the midst of illness, suffering, and death. A true theology of the cross reminds us that there is no place where God will not go to be with us.

Questions:

- ▶ How do I deal with my own mortality, especially when family or community members die?
- ▶ How much denial exists in my community? How is it acted out? What factors contribute to such denial?
- ▶ How do we speak the truth regarding illness, suffering and death?

³⁰ McCormick, *Health and Medicine in the Catholic Tradition*, p. 118.

In a World that Often Exaggerates Autonomy, a Witness to Trust

Our society places a great deal of emphasis on the concept of autonomy. Contemporary understandings of individual choice and freedom have developed in relation to this principle.³¹ For example, the U.S. Supreme Court recently reaffirmed that "no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his or her own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."³² In placing such a high value on autonomy, our society has also placed extreme limits on so-called "substituted judgment"—the claim that others, including one's family or religious community, have a right to be involved in these decisions.

At first glance, the language of autonomy seems appropriate so those who are ill may preserve their rights of self-possession and self-determination. The very questioning of the notion of autonomy seems decidedly un-American. However, the experience of those who suffer chronic sickness or are terminally ill is usually one of increasing reliance upon another. As persons encounter increasing physical disability and are unable to do things once easily accomplished, they need others more than at any other time in their adult lives. Those who suffer from the progressive dementia of Alzheimer's disease, for example, must depend upon others to determine what is in their

³¹ Ruth R. Faden and Tom L. Beauchamp, *A History of Informed Consent* (Oxford: Oxford University Press, 1986), pp. 7-9.

³² "Cruzan vs. Director, Missouri Department of Health," *Origins* 20 (July 5, 1990): 128.

best interests. Their independence is compromised not because another person has constrained them but because disease has ravaged them. Ethicist Marshall Kapp has suggested that too much confidence in the language of self-reliance and autonomy can lead to the condoning of neglect of the sick and elderly and to "health care nihilism."³³

In this context, the witness of religious life is a witness to *trust*—trust in God and in others in the community. Each vow moves us from believing that we are self-sufficient and invites us into a life of interdependence. Religious men or women who are chronically sick or dying, by their very existence, witness to the fact that human dignity demands more than autonomy's non-interference. By the very fact that they cannot exercise autonomy or that they choose not to exercise it, they can demonstrate that one's dignity may still be preserved in relinquishing one's autonomy to a trusted sister or brother. Such "letting go" witnesses to interdependence and mutuality and to genuine moral relations among persons, especially among brothers or sisters of the same religious family. The use of the durable power of attorney, including the naming of another as one's agent when one can no longer speak for oneself and the discussing with that person one's values and desires regarding end-of-life decisions, also attests to trust. All these actions express mutual expectations of reliability and trust. They speak to the larger church and to society about our limitations but also about our true dignity and freedom. They are powerful witnesses to faithfulness and responsibility.

³³ Marshal B. Kapp, "Medical Empowerment of the Elderly," *Hastings Center Report* 19, no. 4 (July-August 1989): 6.

Questions:

- ▶ How does autonomy relate to the interdependence characteristic of religious life?
- ▶ How can I exercise my autonomy in ways that open to trust?
- ▶ Can I name those whom I trust?
- ▶ In what circumstances would I be willing to relinquish my autonomy? How does the durable power of attorney as used in our community relate to the issue of trust?

In a World that Often Needs to Control, A Witness to Acceptance

Technology has transformed not only the way we deal with disease but also the way we understand life and death themselves. Daniel Callahan has addressed this contemporary phenomenon:

The use of technology is ordinarily the way, in modern medicine, that action is carried out: to give a pill, to cut out a cancerous tumor, or to use a machine to support respiration. . . . All meaningful actions . . . are technological, whether technological acts or technological omissions. What nature does, its underlying natural causes and pathologies, becomes irrelevant. No death is "natural" any longer—the word becomes meaningless—no

natural cause necessarily determinative, no pathology fatal unless failure to deploy a technology makes it so.³⁴

This belief that all meaningful actions are technological in turn leads to another tendency of contemporary medicine, described by Callahan as "pushing aggressive treatment as far as it can go in the hope that it can be stopped at just the right moment if it turns out to be futile."³⁵

Unfortunately, this strategy often does not work. Medicine simply lacks the precision to control technology so that such procedures can succeed. Lines become more and more blurred; physicians continue to pursue aggressive treatment for their patients because they "must do something." Patients themselves begin fearing not only death, but especially an impersonal death surrounded by tubes, wires, and machines. There are even some patients who have begun to view all such technologies as oppressive, robbing them of the last shred of their dignity. At the same time, they fear refusing such treatments, understanding this refusal to be an acceptance of the fact that they are now "hopeless" cases. They fear that others will no longer respond to their real medical and emotional needs. They fear abandonment.

With increased reliance on technology, many tend to confuse the task of *caring for* a patient with that of *curing* the patient. Not to cure is seen as doing nothing. In contrast to this notion is that of the Catholic moral tradition, recently repeated in the 1994 Ethical and Religious Directives:

³⁴ Daniel Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death* (New York: Simon and Schuster, 1993), p. 68.

³⁵ *Ibid.*, p. 192.

The task of medicine is to care even when it cannot cure. Physicians and their patients must evaluate the use of the technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment about the use of technology to maintain life. The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering, and death. Only in this way are two extremes avoided: on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death.³⁶

One is allowed to discontinue useless or burdensome measures precisely because the task of caring for the patient reaches beyond them. As the hospice movement has shown us, we can continue to care for the patient by means of pain relief and other palliative care, by maintaining the patient's cleanliness and that of his or her surroundings, and by continuing human interaction as far as possible. Especially as the patient faces death itself, members of a religious community do not abandon their brothers or sisters but rather remain with them. We continue to love and honor and pray for them.

As physicians and patients find it increasingly difficult to say "no" to *any* artificial prolongation of life, perhaps the most important witness of a dying member of a religious community is that of maintaining this distinction between caring and

³⁶ *Ethical and Religious Directives for Catholic Health Care Services*, p. 21.

curing. The example of a member of a religious community who allows herself or himself simply to let go, without clinging to life at all costs, can be a powerful witness both to the sacredness of life and to the naturalness of death. This witness is not reserved only for those who are dying. As we religious understand better our society's tendency to do more and have more rather than less, perhaps we need to evaluate all medical interventions, especially those involving high technology, in terms of simplicity of life and our preferential option for the poor.

Questions:

- ▶ What quality of medical treatment do I expect? At what cost to my community?
- ▶ How does the treatment we receive as religious compare to that available to the poor?
- ▶ What are my feelings regarding medical technology? Am I willing to consider alternatives such as respite care or hospice care?
- ▶ When might it be fitting for me as a religious to say "no" to technology?
- ▶ Recall those in my congregation who were able simply to let go. What freed them to do so?
- ▶ What are my expectations and/or attitudes regarding end of life care?
- ▶ Think about a situation when a proposed course of action might in fact be extraordinary means. What information might be helpful to make the decision whether or not to continue treatment?