ABSTRACT

The Great Physician: Jesus' Healing Ministry as Model for Encountering Suffering in Modern Medicine

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The goals of modern medicine are often described as the elimination of suffering and cure of disease, rather than the healing of the individual. As such, technology, scientific research, and cultural norms have been directed towards eliminating physical suffering. However, this shift in the goals of medicine has come at the cost of the ability and resources to attend to non-physical suffering. In an attempt to recover some of these resources, I will analyze Jesus Christ's healing ministry in the Gospel of Luke through selected narratives, recognizing distinct ways in which Jesus encounters and heals the suffering individual. I will then discuss the role of these traits in the healing ministry of the Early Church, as well as the modern healthcare system. Finally, I will attempt to describe ways in which modern healers can recover some of these traits to faithfully encounter and heal suffering individuals.

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THE GREAT PHYSICIAN: JESUS' HEALING MINISTRY AS MODEL FOR ENCOUNTERING SUFFERING IN MODERN MEDICINE

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CHAPTER ONE

Introduction

> The field of human suffering is much wider, more varied, and multi-dimensional. Man suffers in different ways, ways not always considered by medicine, not even in *its* most advanced specializations. Suffering is something which is *still wider* than sickness, more complex and at the same time still more deeply rooted in humanity itself.
>
> —Pope St. John Paul II, *Salvifici Doloris*

Modern medical professionals undoubtedly encounter suffering in mass quantity during clinical practice. Oftentimes, such suffering stems from physical pain or ailments that can be cured through a prescription, surgery, or therapy. Medicine is equipped with more resources than ever to cure or mitigate the physical effects of disease. However, medicine's ability to heal suffering seems much more limited. In this chapter, I will begin by setting a framework of understanding suffering that will be foundational in discussing encounters with suffering in the following chapters, as well as outline the subsequent analysis of the ways in which Christians have and should faithfully encounter suffering.

Suffering is Transcendent and Varied

As Pope St. John Paul II concludes in the above quote, suffering seems to extend beyond the physical manifestations of disease. In this same quote, he points out two of the key aspects of suffering, especially as they relate to this discussion. First, suffering is varied in manifestation and cause. Second, suffering extends beyond bodily pain and illness.

Eric Cassel argues that there are many potential "causes" of suffering, each of which stems from a different domain or aspect of a person. Cassel states, "All the aspects of personhood – the lived past, the family's lived past, culture and society, roles, the instrumental dimension, associations and relationships… and the transcendent dimension – are susceptible to damage and loss."[1] This damage and loss described by Cassel is later translated into suffering. Each of the listed domains, and the many more that form the complex human being, are opportunities for suffering. Therefore, the breadth of suffering is great, making it more difficult to untangle the many entwined threads of suffering and its causes that exist within each person.

In cultural definitions, suffering and pain seem to be inherently distinguishable. In discussions of litigation or even health, the phrase "pain and suffering" is used. The listing of both suggests that there is a difference, and that such a distinction is important. This means that suffering is more than physical pain or bodily illness, or at least something other than pain. If suffering is much wider than the physical body, medicine is bound to encounter suffering which cannot be countered with scientific interventions, making it necessary to determine practices for physicians that are able to provide healing to the non-physical suffering of patients.

[1] Eric J. Cassel, "The Nature of Suffering and the Goals of Medicine," *The New England Journal of Medicine; Boston* 306, no. 11 (March 18, 1982): 639–45.

The Role of the Physician in Non-Physical Suffering

In his book, *The Healer's Calling*, Daniel Sulmasy outlines the necessary response of the physician, or healer, to suffering. Identifying compassion as the central expectation of the physician, Sulmasy writes:

> True compassion is the most complete response that a clinician can have toward a patient. The compassionate health care professional engages the suffering of he patient at three levels. First, the compassionate clinician is the one who objectively recognizes the suffering of the patient, giving it a name and understanding its natural history. Second, the compassionate clinician is the one who subjectively responds to this suffering with feelings of genuine empathy for the patient, striving to understand the situation of the patient as experienced by the patient. Third, the compassionate clinician is the one who is moved to concrete healing actions – words and deeds. Compassion is always active, even if these actions are no more than kind words and a gentle touch.[2]

Physicians are called upon to be compassionate, and Sulmasy argues that this compassion cannot be without action. Therefore, it is not enough for the physician to only approach physical suffering and ignore the full reality of the patient's suffering. The physician is called to do what she can to bring healing into each domain of suffering, through various aspects of healing. Without this action, from Sulmasy's perspective, the physician is not truly compassionate. There can be no excuse for ignoring non-physical suffering as the job of another. The truly compassionate physician will attend to, empathize with, and act upon all areas of suffering, not only those which deal with physical manifestations of disease.

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[2] Daniel P. Sulmasy, *The Healer's Calling: A Spirituality for Physicians and Other Health Care Professionals* (New York: Paulist Press, 1997), 103.

Suffering in the Present

Modern medicine seems particularly overwhelmed by suffering that it cannot treat with pharmaceuticals or other traditional medical interventions. In the U.S., chronic pain and the coinciding opioid crisis have brought millions to the steps of physicians' offices with physical pain and subsequent suffering that cannot be treated with any modern medical resources. One study found that one-third of respondents reported "frequent or persistent pain for at least three months of the last year."[3] If one-third of the population reports chronic pain, millions of individuals suffer each day. Jean-Claude Larchet, in his *Theology of Illness*, states, "Every form of illness causes suffering. Most cause us to suffer both physically and psychologically. All of them create a spiritual suffering, since they reveal, sometimes with a certain cruelty, the fragile nature of our condition."[4] If every form of illness causes suffering, and there is a high prevalence of untreatable, chronic pain, it follows that there is much suffering in the healthcare system that cannot be mitigated by medicine. Therefore, there must be other ways, outside of prescriptive or invasive treatments, to achieve healing of a non-physical sort.

However, with regard to the existential suffering caused by illness, Jean-Claude Larchet, in his *Theology of Illness*, states, "And there is no question that people today

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[3] Russell K. Portenoy et al., "Population-Based Survey of Pain in the United States: Differences among White, African American, and Hispanic Subjects," *The Journal of Pain* 5, no. 6 (August 1, 2004): 317–28, https://doi.org/10.1016/j.jpain.2004.05.005.

[4] Jean-Claude Larchet, *The Theology of Illness*, Book, Whole (Crestwood, N.Y: St. Vladimir's Seminary Press, 2002), 9.

have far fewer resources than their ancestors did to deal with the entire problem."[5] If Larchet is correct, an abundance of suffering caused by untreatable pain is met with a lack of resources in the modern healthcare system to deal with it. In this case, where are suffering individuals to turn for healing? I propose that the suffering individual need not turn elsewhere, but the physician must find ways in which to intentionally and faithfully encounter the suffering individual and bring healing to the non-physical suffering in the life of the patient.

Healing versus Curing

Of particular concern to define for this thesis, healing remains a distinct entity from a cure. Cure aims to end suffering, to end the disease that may be causing physical pain or suffering at its very root. Cure results in the absence of disease and suffering. On the contrary, healing does not necessitate the end of suffering or disease. Healing can involve social, spiritual, psychological, or biological suffering. Essentially, healing is the mitigation of suffering in any one of these areas. Therefore, finding healing amidst suffering may be different from ending this suffering. This is particularly important to clarify with regards to medicine and its goals. If the goal of medicine is to end suffering, such goals entail severe consequences for individuals whose suffering cannot be cured, such as individuals with disabilities or chronic pain. In these cases, the goal of eliminating suffering must be qualified. As Stanley Hauerwas writes, "This is not so only because we know that therapy can require us to endure suffering, but also and more

[5] Larchet, 10.

importantly because it seems odd that in the name of eliminating suffering, we eliminate the sufferer."[6] If cure is the goal, there is no place for individuals with disabilities or incurable pain in the world of medicine.

The Christian physician, in valuing the gift of life in each person, must see gift in the life of the sufferer, and therefore, must be called to a goal other than the cure of suffering, when cure is not possible. However, if the goals of medicine are to profoundly encounter suffering in a way that promotes healing, even unmitigated suffering provides an opportunity to fulfill medicine's goals. In this thesis, I will focus on care that revolves around healing, rather than curing. Individuals with intractable pain and suffering are often the ones lost in the gaps of the medical system. Therefore, it remains vitally important to focus on ways in which healing can positively enter the lives of these patients through faithful and fruitful encounters with physicians which mitigates suffering that scientific or medical interventions cannot help. However, this does not mean that physical cure or healing is unimportant; all three of the healing narratives in the Gospel of Luke that will be analyzed involve full cure of the illness or disability. However, at the core, these encounters are concerned entirely with healing. In the absence of healers with the abilities of Jesus Christ and in a culture that often seeks cure at the cost of healing or care, a focus on healing remains vital to a conversation on encountering suffering.

[6] Stanley Hauerwas, *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church*, 1 edition (Notre Dame, Ind: University of Notre Dame Press, 1986), 2.

Outline

In this thesis, I will describe the ways in which Jesus models a way of encountering suffering individuals that allows for healing and can be imitated by modern day physicians. First, I will analyze particular dimensions of suffering through three healing narratives in the Gospel of Luke: the hemorrhaging woman, the bent woman, and the blind beggar. Then, I will focus around five aspects of healing in which Jesus brings healing to the suffering individual: attention, reintegration into community, affirmation of value and wholeness, physical touch, and provision of comfort and hope. I will articulate the ways in which these may be particularly useful for understanding and healing both physical and non-physical suffering. In Chapter Three, I will describe the ways in which the Early Church understood and utilized these aspects in encountering the suffering of individuals, especially the ways in which monastic life and the Church Fathers encountered suffering individuals. In Chapter Four, I will explore the ways in which the modern medical system either rejects or utilizes these aspects of healing. Finally, in Chapter Five, I will describe practices and dispositions that may allow the modern physician faithfully encounter suffering in clinical practice in a way that follows the model of Jesus Christ and brings healing to the suffering individual.

CHAPTER TWO

Christ's Healing Ministry in the Gospel of Luke

For Christians, Christ remains the ultimate hermeneutic, the standard by which the actions of human beings are to be measured. Christ demonstrates the ultimate meaning of what it means to be human, to act in the manner which glorifies and defines humanity at its fullest. Christ has commonly been referred to as the Great Physician. Therefore, Christ's actions as healer should serve as the ultimate example for modern day healers. Christ's actions may serve as the ultimate example of what it means to truly encounter and heal individuals who are suffering. In this chapter, I will examine a selection of healing narratives from the Gospel of Luke, describing the various domains of suffering that exist in the story and analyzing the characteristics of Christ as healer during each of these encounters. I will describe the ways in which Christ reconstructs community, provides comfort and hope, views the patient as a whole and deserving of care, initiates physical touch, and practices the virtue of attention.

Luke the Physician

Luke, the assumed author of the third Gospel, has traditionally been known as a physician. Colossians 4:14 even refers to "Luke, the beloved physician" (NRSV).[1] Evidence supporting this includes the use of many physician-related metaphors that are

[1] All quotes from the Holy Bible will be taken from the New Revised Standard Version (NRSV), unless otherwise noted.

absent from the other Gospels, including "physician, heal thyself" (Luke 4:23) and "those who are well have no need for a physician" (Luke 5:31), as well as a potential extension of professional courtesy in the story of the hemorrhaging woman. Luke speaks of the woman spending all of her money on physicians (Luke 8:43). Mark, on the other hand, writes that she has used all of her money, suffered much under the care of physicians, and had only grown worse (Mark 5:25-26). This difference may indicate a subtle defense of or courtesy to physicians at the time. All of this, combined with the technical medical language that Luke uses, seems to indicate that the author of the third Gospel very well may have been a physician himself.

For this reason, I chose to analyze healing stories from the Gospel of Luke, drawing upon his attention to detail and perspective as a physician which emphasizes the stories that are particularly relevant for other physicians. While other aspects of Luke's being are important to his account, such as his status as a Gentile, for the purpose of this reading, it remains most important to understand his role as a physician, how this differentiates him from the other Gospel writers, and the authority it grants to healing narratives in Luke's Gospel.

Hemorrhaging Woman

> As he went, the crowds pressed in on him. Now there was a woman who had been suffering from hemorrhages for twelve years; and though she had spent all she had on physicians, no one could cure her. She came up behind him and touched the fringe of his clothes, and immediately her hemorrhage stopped. Then Jesus asked, "Who touched me?" When all denied it, Peter said, "Master, the crowds surround you and press in on you." But Jesus said, "Someone touched me; for I noticed that power had gone out from me." When the woman saw that she could not remain hidden, she came trembling; and falling down before him, she declared in the presence of all the people why she had touched him, and how she had been

immediately healed. He said to her, "Daughter, your faith has made you well; go in peace" (Luke 8:42-48).

Diagnosis and Prognosis

The woman of Luke 8:42-48, named here as the hemorrhaging woman, had been long-suffering when she encountered Jesus amidst the crowd. She had been bleeding for twelve years, hemorrhaging day after day. Bock speculates that her condition, as described, may have been a uterine hemorrhage, a both painful and inconvenient condition.[1] According to traditional Hippocratic medicine, menstruation was seen as a means of evacuating excess fluid.[2] Galen describes "menstrual flux," a condition which he describes as a "chronic rheum of the uterus where the secreted fluid is perceptibly increased."[3] He notes that the patient may be "pale, wastes away, lacks appetite, often becomes breathless when walking, and has swollen feet."[4] Luke, as a physician, would have been familiar with how untreatable this condition was. While none of these are

[1] Darrell L. Bock, *Luke 1:1-9:50*, 1St Edition edition (Grand Rapids, Mich: Baker Academic, 1994).

[2] Louise A. Gosbell, *"The Poor, the Crippled, the Blind, and the Lame" : Physical and Sensory Disability in the Gospels of the New Testament* (Mohr Siebeck, 2018).

[3]Galen, *Galen: On Diseases and Symptoms*, trans. Ian Johnston (Cambridge: Cambridge University Press, 2009).

[4] Galen.

directly described in the account, if it is "menstrual flux" or uterine hemorrhage, this may help modern readers better understand the experience of the hemorrhaging woman.

Isolation

The woman's perpetual bleeding would have left her unclean and unable to worship in the Temple with the rest of the faith community. "If a woman has a discharge of blood for many days, not at the time of her impurity, or if she has a discharge beyond the time of her impurity, all the days of the discharge she shall continue in uncleanness" (Lev. 15:25). Levitical law mandates that individuals who are unclean are not allowed to worship in the Temple. While scholars are divided as to whether menstrual purity laws were normative in first-century Palestine, there is some evidence that may indicate great social ramifications of purity. The Qumran Jewish community, an Essene settlement, is most widely known as the site of the Dead Sea Scrolls and remains an important community for understanding Jewish social life and customs in the centuries before and after Christ. The *Temple Scroll* exists as the longest of the Dead Sea Scrolls and contains extensive details of the plans for a Temple, ritual sacrifices, and purity laws. According to the *Temple Scroll*, special quarantine areas were necessary for the ritually impure for those within the Qumran Jewish community, of which the hemorrhaging woman would

be included.[5] As noted by Gosbell, the Dead Sea Scrolls are often used as indicative of practices common to most Jewish communities of the first century C.E.[6] If the *Temple Scroll* is indeed indicative of the practices of Jewish communities, the social isolation of the hemorrhaging woman could be assumed.

Even if the hemorrhaging woman was not ritually impure and forced into quarantine, there would have been socially-isolating inconveniences associated with constantly bleeding. The practicality of controlling or cleaning up after a constant stream of blood in the absence of feminine products or other medical solutions would mean constant changing and washing of clothing. It would also make it very difficult to travel far from one's home for extended periods of time. If it were not the inconvenience of the flow of blood, it may have even more so been pain from her condition that prevented interaction with the community and travel beyond her home for the hemorrhaging woman.

As Gosbell points out, it was the "duty of the *paterfamilias*, the head of the household, to seek healing on behalf of anyone in the *domus* who required medical intervention."[7] Therefore, the woman may not have had any head of household other than

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[5] Gosbell, *The Poor, the Crippled, the Blind, and the Lame*, 247.

[6] Gosbell, 247.

[7] Gosbell, *The Poor, the Crippled, the Blind, and the Lame*.

herself, as she is shown seeking out healing for herself. This aspect of her life is emphasized, as her story is placed within the narrative of Jairus and his daughter. Jairus, as head of the household, or the *paterfamilias*, seeks out healing for his daughter. The hemorrhaging woman must seek out Christ and healing for herself. The lack of a *paterfamilias* indicates that she was not married or was widowed and lacked any sons, as any male would have been the *paterfamilias* before her. A specifically male presence may have been important for advocacy and respect in the community. A lack of social support, as potentially indicated by the lack of the *paterfamilias*, is a further reflection of her social isolation and potential absence of friendships.

In addition to not having a family, the hemorrhaging woman would have been limited in her ability to create or find one, as she would be unable to fulfill her expected community role of being a mother and wife. In *Special Laws*, Philo, a prominent Hellenistic Jewish philosopher of the first-century B.C.E., states in book three of the *Special Laws*, "Whenever the menstrual issue occurs, a man must not touch a woman, but must during the period refrain from intercourse and respect the laws of nature."[8] If, as it was for first-century Jewish communities, the primary goal of marriage was procreation,

[8] Philo of Alexandria, F. H. Colson, and G. H. Whitaker, *Philo: With an English Translation*, vol. 226–27, 247, 261, 275, 289, 320, 341, 363, 379., (London;New York; Heinemann, 1929).

then the hemorrhaging woman would have been unable to fulfill her role as a wife, as she would not have been participating in intercourse, and therefore, procreation. In addition, healers of this time period understood a disordered menstrual cycle as resulting in infertility.[9] Philo also addresses infertility, stating that men who married infertile women were "destroy(ing) the procreative germs with deliberate purpose."[10] Philo seems to argue that men who knowingly marry women directly subvert the purposes of marriage and their ends in procreation. Whether or not the hemorrhaging woman was actually infertile cannot be known. However, the individuals around her, especially as she had sought medical care, would have assumed so. Therefore, her chances of being married and fulfilling her role as a wife were minimal, resulting in greater isolation and a lack of an established and meaningful role in the community.

Healing or Purification?

Two opposing scholarly views dominate the ultimate meaning behind this passage. One focuses on the freedom of the woman from a constricting purity system and Jesus' willingness to see past her impurity to heal her. The other view contends that this

[9] Multiple commentators have noted the issue of infertility with the hemorrhaging woman, including: Frances Taylor Gench, *Back to the Well: Women's Encounters with Jesus in the Gospels*, 1st ed., (Louisville, Ky: Westminster John Knox Press, 2004). and Cecilia Wassen, "Jesus and the Hemorrhaging Woman in Mark 5:24-34," *Scripture in Transition*, January 1, 2008. discuss this at greater depth.

[10] Philo, Colson, and Whitaker, *Philo: With an English Translation*.

purity system has no influence or role in the events of the passage and the focus is on physical healing. If cleanliness were her greatest need, this event would be classified as a cleansing or purification. However, if the cleansing were not the main need, this would be considered a healing, as in the case of the lepers. D'Angelo contends that this is very little language dealing with purity within the passage, unlike other cases throughout the Gospels.[11] The encounter happened in Galilee, a lengthy distance from the Temple. Cleansing would be relevant if the woman wished to enter the Temple. However, the large distance between the woman and the Temple means that ritual cleansing may not have been the primary purpose of this encounter. This is an important distinction to make, as it forms the imagination for what type of occurrence this is, that it is not focused on ritual law, but on healing and restoration. In addition, it may be revealing of Christ's intentions, to either refute ritual purity laws or to provide total healing for the hemorrhaging woman.

However, I argue that these two aspects of the story are closely linked. Her physical illness, as most illnesses do, reaches far beyond her physical body and touches each aspect of her life, some of which were tied up within her religious community and the purity system. While Christ may have been making a statement regarding the purity

[11] Mary-Rose D'Angelo, "Gender and Power in the Gospel of Mark: The Daughter of Jairus and the Woman with Flow of Blood. 83-109 in John C. Cavadini, ed., *Miracles Jewish Christian Antiquity: Imagining Truth*, Revised ed. edition (Notre Dame: Univ of Notre Dame Pr, 2000).

system, her healing goes beyond ritual laws and speaks to greater truths about the healing of an entire suffering person, socially, emotionally, psychologically, and physically.

Bent Woman

> Now he was teaching in one of the synagogues on the sabbath. And just then there appeared a woman with a spirit that had crippled her for eighteen years. She was bent over and was quite unable to stand up straight. When Jesus saw her, he called her over and said, "Woman, you are set free from your ailment." When he laid his hands on her, immediately she stood up straight and began praising God. But the leader of the synagogue, indignant because Jesus had cured on the Sabbath, kept saying to the crowd, "There are six days on which work ought to be done; come on those days and be cured, and not on the sabbath day." But the Lord answered him and said, "You hypocrites! Does not each of you on the Sabbath untie his ox or his donkey from the manger, and lead it away to give it water? And ought not this woman, a daughter of Abraham whom Satan bound for eighteen long years, be set free from this bondage on the sabbath day?" When he said this, all his opponents were put to shame; and the entire crowd was rejoicing at all the wonderful things that he was doing (Luke 13:10-17).

Diagnosis and Prognosis

Jesus was attending a worship service in a local synagogue as anger from Jewish leadership was building against him. In the case of the bent woman, this is an important note. As is seen in the narrative, his actions on the Sabbath only add to this anger. The healing that does take place must be important enough, which Jesus affirms, to warrant both "working" on the Sabbath and further angering Jewish leadership.

While He is teaching in the synagogue, Jesus encounters the bent woman. The woman had been "bound by Satan" for eighteen years. While the exact diagnosis of the bent woman is not possible to definitively identify, consideration of the type of illness may lend to a better understanding of the woman's suffering. Wilkinson notes that the

aorist indicative tense is used, meaning "the action denoted by the verb took place at a specific point in the past."[12] For Wilkinson this indicates two possibilities: this spinal deformation could either be a progressive spinal disease or the result of a traumatic incident, with either event occurring eighteen years prior. The former seems the more likely cause of the deformity, as a traumatic injury would have been recognized as the cause of the deformity rather being "bound by Satan." However, degenerative diseases would have much less obvious causes, and therefore, would be more likely attributed to Satan. Wilkinson proposes a diagnosis of ankylosing spondylitis, a disease in which spinal joints begin to fuse.[13] Whether this is an accurate diagnosis or not, any spinal deformation that caused her bent posture is most likely to carry similar consequences on the rest of the woman's life and induce considerable suffering, including suffering from the unknown causes of the disease.

Effects on Role as Mother or Wife

While few details are given about the woman, regardless of social, marital, or employment status, a severe spinal deformity would significantly affect her life and role in both her home and the community. As discussed above, the primary goal of marriage, a centerpiece of Jewish community life, was to procreate. If already married, the woman

[12] John Wilkinson, *The Bible and Healing: A Medical and Theological Commentary* (Edinburgh : Grand Rapids, Mich: Handsel Press ; Wm. B. Eerdmans, 1998), 132.

[13] Wilkinson, *The Bible and Healing*.

would most likely be unable to engage in sexual intercourse, and if she had children, she would be limited in her activity in caring for them.

As is the case with the previously discussed hemorrhaging woman, her roles as a wife and mother would be constrained by her disability, perhaps creating great amounts of anxiety and distress about role fulfillment. Undoubtedly, the bent woman would have not been able to fulfill her culturally expected role, a fact that may have isolated or marginalized her within her community. If not an external source of isolation or marginalization, it may have created stress or anxiety within the bent woman, stemming from a discordance between her ideal self and the reality of her condition. Therefore, it is reasonable that the bent woman would have suffered greatly in the compromise of her role fulfillment.

With regards to social attitudes towards disfigurement or disability in the time period, Caspary writes that "a human being was considered to be of value in view of his or her potential to contribute both materially and through acquired virtue to the good of the family and of society."[14] In being able to contribute materially, the bent woman most likely would not have been valued. Her disability may not have allowed for productive work either outside of or in the home. As such, the bent woman may have suffered greatly from feelings of being burdensome or unproductive, and in society's eyes, of lesser value.

[14] Almut Caspary, "The Patristic Era: Early Christian Attitudes toward the Disfigured Outcast," in Brian Brock and John Swinton, *Disability in the Christian Tradition : A Reader* (William B. Eerdmans Publishing Company, 2012), 25.

Blind Beggar

> As he drew near to Jericho, a blind man was sitting by the roadside begging, and hearing a crowd going by, he inquired what this meant. They told him, "Jesus of Nazareth is passing by." Then he shouted, "Jesus, Son of David, have mercy on me!" Those who were in front sternly ordered him to be quiet, but he shouted even more loudly, "Son of David, have mercy on me!" Jesus stood still and ordered the man to be brought to him; and when he came near, he asked him, "What do you want me to do for you?" He said, "Lord, let me see again." And Jesus said to him, "Receive your sight; your faith has saved you." Immediately he regained his sight and followed him, glorifying God; and all the people, when they saw it, praised God (Luke 18:35-43).

Blindness

In the case of the blind man, called Bartimaeus in the Gospel of Mark (10:46-52), the diagnosis is evident. While the etiology of the blindness is unknown, whether it was degenerative or congenital, there is no question as to the nature of the symptoms and the effects of the illness. At the time of his encounter with Jesus, Bartimaeus could not see and had been begging on the streets. His eyesight had most likely been the cause of his reduction to begging on the streets, as he would have been unable to work in most professions at the time. In this manner, he would have failed to fulfill his role as a working member of society. It may have prevented him from having a family of his own, as he would have been unable to support them through a steady income. If he did have a family, his begging would remain a most likely inconsistent and insufficient means of financial support. The suffering caused by poverty was most likely significant on its own, induced by marginalization and distress. One can imagine the distress caused by not knowing if the money from begging would be enough to finance an individual's needs, or the marginalization caused by false and negative views of an individual.

Physiognomy and the Etiology of Disability

The crowd's silencing of Bartimaeus may have been a sign of disregard or hostility towards Bartimaeus, or at the very least, of his exclusion from the community gathered there. This may have been due to a utilitarian view of his ability to work, but may also have been due to the physiognomic views of the culture. Physiognomy, the belief that the interior character is reflected by exterior characteristics, played a prominent role in the beliefs of communities at the time of the Gospel.[15] For example, blindness, for those understanding disease through physiognomy, would be reflective of an inner spiritual blindness, an inability to see truth.

In the case of another blind man in John 9:1-5, the disciples ask, "Rabbi, who sinned, this man or his parents, that he was born blind?" Christ responds that it was not anyone who had sinned, but a case for God's works to be revealed to the world (John 9:3). Disability, including blindness, was seen as punishment from God for sins, and therefore, a reflection of the interior state of an individual. This is why the disciples ask who has sinned; their explanatory framework for disease and disability offers no other explanation.

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[15] Lincicum, David. "Philo and the Physiognomic Tradition." *Journal for the Study of Judaism*44, no. 1 (2013): 57-86. Physiognomy warrants more attention than can be given for the sake of this analysis. For a more in-depth analysis of physiognomy: Mikeal C. Parsons, *Body and Character in Luke and Acts: The Subversion of Physiognomy in Early Christianity* (Waco, Tex: Baylor University Press, 2011). Parsons analyzes the ways in which Luke counters physiognomy throughout his entire gospel and this text serves as an excellent analysis of this subject.

If the community surrounding Bartimaeus understood physiognomy as the explanatory framework for disease and disability, it is understandable that he would be isolated or shunned, as his blindness would reflect a spiritual blindness, deficiency, or sin. None of these would be desirable for an acquaintance. In this manner, Bartimaeus' blindness could limit his friendships and community, an isolation that would only further suffering, leaving Bartimaeus' innate need for human relationship unfulfilled.

The Impact of Christ's Encounters

Thus far, I have articulated particular areas of potential suffering in the lives of the individuals of the selected stories in Luke. In the following section, I will describe the ways in which Christ's encounters with suffering entered into this suffering and provided healing. I will describe Christ's attention, the reintegration of individuals into community, the provision of comfort and hope, and the affirmation of wholeness and value, and use of physical touch.

Attention

Simone Weil, a 20th century philosopher, describes the virtue of attention throughout many of her writings, including *Waiting for God.* For Weil, attention involves an active passivity, one which waits for the reception of truth, beauty, and goodness from outside of one's self. The perfection of attention allows for the perception of reality as it is, as "the soul empties itself of all its contents in order to receive into itself the being it is

looking at, just as he is, in all his truth."[16] Weil believes it is cultivated through academic studies, in the solving of a geometric proof or in the reading of poetry, and it is ultimately perfected in prayer.[17] Attention is a necessary virtue to exercise when in the company of the suffering. Weil says "it *is* a miracle" to give ones attention to a sufferer, that attention is the way of looking at the suffering.[18] This depth and sharpness of attention goes beyond a compassionate glance at the individual. As Weil points out, "warmth of heart cannot make up for it [attention]."[19] Attention is valuable, because it allows for the reception of truth from the other; it is through attention that one can understand another, an especially important understanding in the midst of suffering. This understanding cannot be replicated by sympathy or emotional attachment to another; no matter the best intention, only attention reveals the reality of suffering. Suffering is unique to every individual, and therefore, remains difficult to understand in its fullness by someone other than the sufferer. Therefore, if there is a mode to understand suffering more fully, it is essential to faithfully encountering suffering. If there is a path to healing for the sufferer, attention allows one to find it.

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[16] Simone Weil et al., *Waiting for God*, 1st Perennial Classics ed (New York: Perennial, 2001).

[17] Simone Weil et al., *Gravity and Grace*, (Lincoln: University of Nebraska Press, 1997).

[18] Weil et al., *Waiting for God*, 64–5.

[19] Weil et al., 57.

Attention in the Gospel of Luke

Daniel Sulmasy writes that attention allows "Jesus, who recognized the one who touched him as a real person, not just as one among a faceless crowd of sick, weak, fallible, complaining, needy people toward whom he was personally indifferent and unconcerned."[20] Christ's ability to focus on a single individual, fully and deeply, is indicative of his attention. This occurs in all three of the narratives described previously. He sees the reality of the man or woman as a real and suffering human, and is able to identify his or her needs, as He receives the full reality of his or her existence. Being perfectly divine, Christ knew all of these things, and yet, He still exercised perfect attention.

Christ's attention manages to fix upon Bartimaeus as he is crying out from amidst a crowd. It is noted that Jesus is amidst a "multitude going by," making it even more unlikely that, from a crowd surrounding and pressing upon him, He attends to Bartimaeus (Luke 18:35). It is this attention to the suffering individual, even when a crowd is trying to silence that individual, that allows the healing encounter to occur, as well as allows Christ to recognize the many aspects of healing that must occur for Bartimaeus. These aspects of healing were not incidental, but reflected a deeper attentiveness to Bartimaeus and his needs. Christ's attention both recognizes the need for healing, by attending to the individual in the crowd and the aspects of healing necessary for the individual encounter.

[20] Sulmasy, *The Healer's Calling: A Spirituality for Physicians and Other Health Care Professionals*.

Not only does attention allow Christ to identify the needs of Bartimaeus, but allows Bartimaeus to be heard and received by another. In the midst of a crowd quieting him, Bartimeaus is heard by the One who is above all. Christ waits to hear from Bartimaeus, asking him, "What do you want me to do for you?" (Luke 18:41). Christ already knew the deepest desires of Bartimaeus' heart, but remains attentive in carefully listening to and receiving these words from Bartimaeus. Christ empties himself and the foreknowledge He has about Bartimaeus' wishes, and instead, receives this information from Bartimaeus himself.

In the case of the hemorrhaging woman, a great crowd is present. They are described as pressing upon Christ, depicting an almost overwhelming scene (Luke 8:42). In the chaos of this crowd, the woman reaches out and touches Christ's garment. Christ notices this and pauses amongst the crowd to identify who has touched him. Christ is attentive to the touch of another, even though the woman has only touched his garment, an act that would be hardly noticeable in a crowd. Even Peter reacts in amazement when Christ tries to identify the individual who has touched him (Luke 18:45). Clearly, Christ displays great attention to the fact that someone has touched him, but He also is attentive to the hemorrhaging woman herself when she emerges from the crowd.

When the hemorrhaging woman is isolated from the crowd, she falls trembling and explains everything that has transpired (Luke 18:47). Christ has no need to hear an explanation; He already knows why she has touched him and what has transpired. However, part of the healing is occurring in his listening. In listening to the hemorrhaging woman, Christ, as He did with Bartimaeus, receives the hemorrhaging woman in her full

reality, understanding every facet of her suffering. In being attentive, He realizes that this explanation is a necessary aspect of healing for the hemorrhaging woman. Simply bearing witness and hearing this story may have allowed the hemorrhaging woman to create a cohesive narrative of her illness or promote understanding within the community of her experiences, thereby reintegrating her into the community. Christ saw her as more than simply an unfortunate woman, but saw her in her full reality, as a valuable child of God whose life had been upended by illness. It is even in his attentive gaze that a miracle occurred, to see the marginalized woman as she is and, in all of this brokenness, Christ brought healing to every piece of the hemorrhaging woman's life.

The healing of the bent woman remains unique for Christ's initiation of the healing encounter. Christ identifies her as she enters, which would have been in the midst of his teaching as indicated by the phrase "just then." He immediately recognizes her needs, rather than experiencing annoyance over her late entrance. It is this immediate attentiveness to her needs that forms the basis for the subsequent encounter and healing. It is an astute attentiveness that allows Christ to recognize the need for healing, as well as the necessary aspects of healing for the situation. In her healing, Christ restores her ability to fulfill her role in the community and affirms her value and wholeness despite the illness. Christ also touches her, reinstituting her intimacy with others and providing comfort and peace amidst the change in her life. Christ recognizes the need for all of these aspects of healing through his attentiveness to her.

Reintegration into Community

Community plays a large role in many aspects of suffering. It can help determine one's ability to cope with the illness, bring suffering through isolation or shame, or even cause suffering by lacking meaningful roles for the sufferer to fulfill. Hauerwas posits, for early Christians, suffering "did not create a metaphysical problem needing a solution; rather, it was a practical challenge requiring a communal response."[21] For Early Christians, the community was meant to be essential in the response to suffering, highlighting the individual's practical need for community, as well as spiritual.

Oftentimes, illness and suffering are isolating. Larchet describes the consequences of illness as:

> Illness normally plunges into unfamiliar territory, where the conditions of our life are significantly modified and where our relationships with those around us are disturbed and often weakened by imposed isolation. In such cases, we are obliged to deal not only with physical pain, but with anxiety and disengagement, even anguish and despair. This simply increases our sense of solitude, since we feel so very much alone in our efforts to confront the situation.[22]

In this description, the isolating effects of illness are apparent and the suffering that stems from this isolation could be associated with the anxiety, disengagement, anguish, and despair that Larchet describe. Isolation can be seen as a great source of suffering for the human meant to be in relationship with others and the presence of this in the healing narratives of Luke is apparent. It reflects a need that dwells within every human, for

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[21] Hauerwas, Stanley. *Naming the Silences: God, Medicine, and the Problem of Suffering*. Grand Rapids, Mich: W.B. Eerdmans, 1990. p.85.

[22] Larchet, *The Theology of Illness*, 10.

relationship and community. Community, especially in the absence of advanced medical technology, is the main resource for the suffering individual. Whether this is the religious or geographic community, communities are able to provide financial, physical, emotional, and spiritual support. It is within community that individuals have a safe space in which to process, grieve, and rebuild during illness amidst other individuals who bear witness and practice compassion.

Eric Cassel identifies role fulfillment as one of the key aspects of a person and concludes that suffering comes from damage to any one of these key aspects.[23] When roles go unfulfilled or are changed, individuals can suffer from discordance between who they think they should be and who they are able to be. It is in this discordance that anxiety and feelings of worthlessness can occur, resulting in suffering in the individual. However, this also means that restoration or replacement of roles may provide for the healing of suffering.

Reintegration into Community in the Gospel of Luke

As previously discussed, the hemorrhaging woman was most likely isolated from her community due to the illness. In all likelihood, this isolation only added to the

[23] Eric J. Cassel, "The Nature of Suffering and the Goals of Medicine," *The New England Journal of Medicine; Boston* 306, no. 11 (March 18, 1982): 639–45, https://doi.org/http://dx.doi.org/10.1056/NEJM198203183061104. Cassel defines suffering as a threat to an individual's continued existence, which includes threats to key characteristics such as past, family-ties, personalities, cultural expectations, and relationships amidst others. While debate could ensue over the definition of suffering, such arguments extend beyond the scope of this paper.

physical suffering she was experiencing. Gosbell distinguishes two stages of the woman's healing: "the physical cure and the process of being reintegrated into her community and to reconnect with those roles and responsibilities she had been prevented from fulfilling."[24] In her encounter with Jesus, the hemorrhaging woman's isolation has ended through multiple components of reintegration. First, her status as ritually impure has changed, and she will be able to participate in her community to a greater extent. The hemorrhaging woman would be no longer confined to quarantine areas or unable to touch or be touched by others. In this way, her daily life is radically changed, with many more opportunities to connect and interact with other members of the community. In addition, the cessation of blood means that she may be able to venture into public more, as the inconvenience of flowing blood is no longer an obstacle to this.

A major part of this healing involves a reconciliation of the social consequences of her illness, including a restoration of her role in the community. The use of the word "daughter" indicates a placement and reintegration into a societal structure, a sense of belonging to a family, especially as this "daughter" either refers to her status as a child of God or a daughter of Abraham, and therefore, an indisputable member of the Jewish people and community. In addition, she may be able to fulfill the roles of mother and wife after her healing. There would no longer be the assumption of infertility, as was discussed previously, and she would no longer be considered ritually impure, leaving open the possibility for marriage and procreation. The hemorrhaging woman's

[24] Gosbell, *"the Poor, the Crippled, the Blind, and the Lame." p.271*

reintegration into community is one of the key aspects of healing that profoundly encounters and heals suffering in the narrative.

In the bent woman, Jesus encounters a woman who has most likely been unable to fully participate in her community and fulfill her roles in that community for approximately eighteen years. Like the hemorrhaging woman, the bent woman may have been unable to fulfill her roles as a wife and mother. After her healing, both of these roles would be possible for her. In addition, much like the hemorrhaging woman, Jesus distinctly identifies the bent woman as a "daughter of Abraham" (Luke 13:16). Again, Jesus intentionally reminds the Jewish community of the bent woman's identity as a member of it, and therefore, their responsibility to attend to her. The bent woman has experienced reintegration into community and a restoration of community roles in this single encounter.

In the narrative of Bartimaeus, the reintegration into community seems less obvious. However, the restoration of Bartimaeus' sight would open up many opportunities for greater community participation for him. Bartimaeus may be able to work, providing a steady source of income for himself and fulfilling a role in the community as a productive worker. In addition, Bartimaeus would rid himself of the physiognomic assumptions about his character, perhaps diminishing marginalization and opening others up to the possibility of friendship with Bartimaeus. While Jesus does not verbally place Bartimaeus within a societal framework, the restoration of Bartimaeus' sight could potentially heal the suffering which may have stemmed from social causes.

Provision of Comfort and Hope

Peace amidst the often life-changing occurrence of illness seems to be one of the greatest gifts one can bestow upon the ill. The experience of illness can be a confusing and identity-shattering experience. Hans Reinders, in *Disability, Providence, and Ethics*, posits this in-between of the before and after of illness causes many patients suffer.[25] Reinders describes the anxiety that stems from being unable to piece together the narrative before and after illness as especially producing suffering. Serious illness often acts as a prominent marker in the life of the patient, meaning it must also play a large role in the narrative of the patient's life. Many patients find themselves trying to construct this narrative in a cohesive and meaningful way, but endure an increase in anxiety and suffering when such work is not easily accomplished.

It is peace amidst chaos that many patients need, amidst the sense-making and identity formation and deformation that occur with illness. One study found that among cancer patients, hope and peace were ranked as the greatest spiritual needs.[26] As such, the provision of comfort and hope remains an important way in which to encounter and heal suffering.

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[25] Hans S. Reinders, *Disability, Providence, and Ethics: Bridging Gaps, Transforming Lives* (Waco, Texas: Baylor University Press, 2014).

[26] Jinsun Yong et al., "Development and Validation of a Scale Assessing Spiritual Needs for Korean Patients with Cancer," *Journal of Palliative Care* 24, no. 4 (2008): 240–46. While this particular study was conducted with Korean cancer patients, many other such studies have pointed to peace as one of, if not the, most important domains of care, regardless of geographic or cultural context. This domain has often coupled comfort with hope.

Provision of Comfort and Hope in the Gospel of Luke

In his parting words to the hemorrhaging woman, Christ reassures the woman: "Daughter, your faith has healed you. Go in peace" (Luke 9:48, NRSV). In this utterance, Christ recognizes that the woman came trembling to his feet, most likely full of anxieties about her bold and potentially violation of ritual law. Even by her touch, she could have made him unclean. He acknowledges the faith of the hemorrhaging woman and commands her to be filled with peace. He assures her of her faith and that she is well, fully and truly. Christ's reassurance lays the ground for peace in the hemorrhaging woman's heart. In the midst of anxiety, evident in her trembling, she is comforted.

Reaffirmed Wholeness, Value, and Worthiness

Regardless of outcome, the patient must be viewed as whole and valuable, even as he is suffering. Christ demonstrates this in his Resurrection, when He appears with his Blessed Wounds. The Apostle Thomas sees these wounds and by them, recognizes Christ. Christ, in his resurrected and wholeness of self, still bears his wounds. If Christ, perfectly human, bears his wounds and remains whole, then the suffering humans Christ encounters remain whole, even with broken bodies and lives. This theological premise remains important for the practicality of providing care, especially to patients unable to be cured.

Viewing the patient as a whole, even in illness, changes the ways in which one views his or her illness. Illness does not become a barrier to wholeness or dignity, but a piece of a patient's narrative that shapes his or her experiences and forms identity. It informs the way in which physicians treat patients, that the persistence of illness does

nothing to lessen the value or dignity of the patient in the exam room. The person, or his or her illness, does not become a frustration that cannot be fixed, but remains a patient as whole and dignified as the next.

It is also important, for the suffering of the patient, that the patient himself understands that he is still whole and valuable. Especially when he is unable to fulfill roles or do activities that the patient may define himself or his life by, suffering can be great when he feels his value is diminished or perhaps life is not worth living. Therefore, this remains an important domain into which healing must enter.

Reaffirmed Value and Wholeness in the Gospel of Luke

The bent woman does not seek Christ out. She does not advocate for her own healing, or demonstrate any extraordinary faith. Christ seeks her and heals her without any extraordinary act or demonstration of faith. The bent woman did not need to earn her healing. She did not have to prove she was faithful, spiritually-wise, or bold enough to be healed; Christ healed her to free her, regardless of what she had "earned." Although she praises God after her healing, it is not known whether she believed in Christ as Messiah or even if she praised God before the healing. While she was present in the synagogue, it is impossible to know her inner state, as it is not described in the story. Luke includes many details in his telling of Christ's ministry, and even tells of the faith of other people who are healed by Christ, such as the hemorrhaging woman. However, in this account, we do not have any evidence of the woman's faith in God, or more specifically, in Christ as Messiah. She is healed without regard to the strength of her faith or any other attribute, except for the fact that she needed healing.

Indeed, in the others, it is not implied that faith, courage, or spiritual wisdom earn anyone healing. This distinction must be carefully made, as such theology can be hurtful to individuals with chronic illnesses or disabilities. If healing was earned, individuals who suffer from incurable illness may feel as if they are not good or whole enough and that is the reason they continue to suffer. The bent woman demonstrates that it is not faith that guarantees healing. She does not seek out Jesus or even indicate belief that He is the Messiah. Christ heals her out of a desire to free her from her infirmity. This detail provides two key aspects of Christ's healing ministry. First, Christ's healing is not earned or bought with faith, one need not prove him or herself "worthy" to be healed; each person is whole and valued regardless of faith. Secondly, suffering is not the result of a lack of faith, and freedom from that suffering is not the result of proper faith.

When Christ does call to the bent woman, he says that she is "set free from" her "infirmity" (Luke 10:13, NRSV**)**. Wilkinson notes the use of the verb *apoluo*, stating, "This word means literally 'to free a person from some condition or situation… it is applied to release from disease on only occasion." [27] The use of the concept of "freedom" rather than "restoration" or "completion" is important. The illness was not seen as a deficiency of the bent woman, but rather, a constraint upon her. Although the bent woman was unable to fulfill her expected role in society, Christ acknowledges her freedom and wholeness. Her role did not define her value or worth to her community. In fact, in declaring her a daughter of Abraham, He affirms her rightful role and value in her

[27] Wilkinson, *The Bible and Healing*, 83.

community. Even failure to fulfill expected roles does nothing to detract from her wholeness or value.

Bartimaeus' healing challenges the physiognomic framework of his culture. When Jesus heals Bartimeaus, He says, "Receive your sight; your faith has saved you" (Luke 18:42). Christ acknowledges the faith of Bartimaeus, an ability to recognize Christ and trust in his power to heal. As previously discussed, others may have assumed that Bartimaeus was "spiritually blind" or unable to see the truth. However, in his parting words, Christ reveals that Bartimaeus was far from spiritually blind; there was no deficit in him. As such, Christ both challenges the explanatory framework of the community that would say Bartimaeus was lesser or insufficient and reminds Bartimaeus of his own wholeness, including the magnitude of his faith. As such, Christ's affirmation of wholeness and value operate dually, as a reminder to both Bartimaeus and the community.

Physical Touch

Physical touch remains an important part of healing, as it demonstrates a comfort and intimacy that physical distance cannot communicate. Kelly et al. found, according to patients, touch by healthcare professionals communicated care, exercised power, and created a safe space.[28] As evidenced by the perception of these patients, touch communicates much more than physical presence and carries much more power than for

[28] Martina Ann Kelly et al., "Experience of Touch in Health Care: A Meta-Ethnography Across the Health Care Professions," *Qualitative Health Research* 28, no. 2 (January 2018): 200–212.

clinical examination. Abraham Verghese, a physician of internal medicine, recounts his realization of the importance of physical touch:

> When we are sick, we become infantilized; we seek the reassuring touch of the surrogate father or mother, the only ones who can touch us with impunity and bring about laughter and comfort. A careful exam invokes the mythic rites of priest and confessant, of saint and disciple, of healer and sufferer… a thorough exam conveys attentiveness in addition to providing comfort and reassurance. At the end of this ritual, physician and patient are no longer strangers but are bonded through touch.[29]

Verghese mentions the 'mythic rites… of healer and sufferer' as intimately tied with a careful physical examination. Again, touch seems essential to the relationship between healer and sufferer.

Touch is much more than the transfer of healing power, as many have interpreted it in the story of the hemorrhaging woman. Human touch invokes a sense of intimacy and community, connecting the individuals on both ends of the touch. Christ's touch responds to more than the physical pain of patients, and communicates comfort, peace, and attention. Each of these forms connections and safe spaces for patients to heal, to feel a connection to and support from another human being amidst the often difficult throes of illness.

Physical Touch in the Gospel of Luke

Physical touch plays a large role throughout Jesus' healing ministry. Jesus uses physical touch in many of the healings described throughout the Gospels. Other instances of physical touch include the healing at evening of the crowd (Luke4:40), the healings at

[29] Abraham Verghese, "A Touch of Sense," *Health Affairs (Project Hope)* 28, no. 4 (July 1, 2009): 1177.

Nazareth (Mark 6:5), and the healing of Malchus (Luke 22:51). In each of these instances, Jesus' use of touch is intentional and oftentimes, the only aspect of healing that occurs. With this prevalence in the Gospels, physical touch must be seen as an essential part of Jesus' encounters with the suffering individual.

The touch of the hemorrhaging woman is unique amongst the healing narratives. While many descriptions feature Jesus Christ comforting or healing the ill through touch, the hemorrhaging woman reaches out to touch Jesus herself. She believes that through this touch, she could be healed. For her, there was great power in touch, and this touch did prove to be a catalyst for healing. As a ritually impure individual, her touch was risky, as it could have made Jesus unclean. In this touch, Jesus recognizes power has gone out from him, and in this instance, connects with the hemorrhaging woman. He does not reprimand her, but instead, commends her for her faith. While physical touch was the mode of healing, it was also the end of the hemorrhaging woman's isolation and the beginning of her reintegration into community and the normalcy of social life, namely, the intimacy and connectedness that physical touch conveys.

In the story of the bent woman, Jesus "laid his hands on her" (Luke 13:13). Following this physical touch, the woman "immediately stood up straight and began praising God" (Luke 13:13). Physical touch also demonstrates power to heal in this narrative, as it did with the hemorrhaging woman. However, the woman had been thought of as "bound by Satan," a label which may have indicated spiritual or, even ritual impurity, to others. Before this woman is healed of her infirmity, Jesus reaches out and touches her, potentially doing what another has not done in eighteen years. As such, like

the hemorrhaging woman, the bent woman encounters the physical touch of Jesus as the mark of a reintegration into community. Physical touch brings healing beyond the transfer of healing power from Jesus to the body. Rather, physical touch enters into non-physical domains of suffering and brings healing to them.

Conclusion

The narratives of the hemorrhaging woman, the bent woman, and Bartimaeus reveal the breadth of healing that occurs in Jesus' ministry. In this chapter, I have described the various healing aspects of Jesus' healing ministry in the Gospel of Luke, as well as the ways in which these aspects work to heal the suffering of the individuals Jesus encounters. In the next chapter, I will describe the ways in which these aspects of healing are utilized and rejected by the Early Church in its own healing ministry.

CHAPTER THREE

The Tradition of Healing: The Early Church's Response to Suffering Individuals

In this chapter, I will trace some of the ways in which the previously articulated aspects of Jesus' healing ministry in the Gospel of Luke (attentive presence, physical touch, provision of comfort or hope, reaffirmed wholeness and value, and reintegration into community) are utilized or lost by the Church in responding to the suffering of individuals. Many of the examples come from the Early Church, that is, the Church that came in the first few centuries following the New Testament. As such, many of the sources are Early Church Fathers, who were leaders in the Church and served as authority figures in shaping the institutional form of the faith. While not all responses to suffering were positive, the ministry of the Early Church serves as an example of what humans can do to imitate Christ on Earth. While there could be examples to be found in later centuries, I will focus on this early period, as the Early Church may be drawing more heavily on Scripture, and therefore, the healing ministry of Jesus, rather than a rich tradition of ministry.

Background

To begin, it is vitally important to understand the context in which the Early Church encountered the suffering of individuals, as well as the importance to the Church of attending to the sick and suffering. I will outline the resources available to the Church for healing, as well as the centrality of healing to Church ministry, and specifically,

monastic communities. Monasticism served as the ultimate Christian life, a complete devotion of one's life to the Christian faith. Therefore, the actions of individuals thought to be living the Christian faith out to the highest degree remain important for understanding the Early Church's beliefs about healing and encountering suffering.

Limited Treatments and Cures

In addition, I will focus primarily on the Early Church's encounters with suffering as attending to the sick. As was discussed previously, illness can cause suffering through a variety of consequences in nearly every part of an individual's life. Therefore, the ways in which the Church attends to the sick are the ways in which the Church often attends to the suffering. The conception of healing, as it was described in the previous chapters, remains a broader category than that of curing. Healing is primarily concerned with reducing or mediating suffering, while curing is concerned with the end of suffering or disease.

While miracles are attributed to this time, the Early Church was often limited in its ability to address physical suffering and was left to address non-physical suffering. While some effective treatments existed, for the most part, healing, rather than cure, was the goal. Therefore, the previously articulated aspects of healing became important in addressing and profoundly encountering the suffering of individuals. Timothy Miller concludes that early guidebooks for Christian conduct do not mention medicine as part of caring for the sick, indicating early Christians relied upon other methods to provide

healing amidst suffering.[1] This conclusion is understandable, as the tools at medicine's disposal were few and far between. As such, the Early Church emphasizes actions such as being attentively present, ensuring community for the sick, and providing comfort and hope, rather than specific cures or treatments for illness.

Attending to the Sick as a Center of Monastic and Church Life

In the Early Church, healing was a priority. The first act of ministry portrayed in Acts 3:1-10 is the healing of the lame man at the Temple by Peter, in which Peter "directed his gaze at him." Early and Medieval Christianity were marked by an intense devotion to care of the sick. Such devotion stemmed from a perceived call to care from the sick, stemming from the Gospel message and example of Jesus Christ. This calling prompted many to care for the sick during great epidemics, even when others fled the community. Rodney Stark even attributed the immense growth of Christianity in the second and third centuries to this strong devotion to healing during epidemics.[2] Healing was central to evangelization and church activity and responsible for the conversion of many.

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[1] Timothy S. Miller, *The Birth of the Hospital in the Byzantine Empire* (Johns Hopkins University Press, 1997), 51.

[2] Rodney Stark, *The Rise of Christianity: How the Obscure, Marginal Jesus Movement Became the Dominant Religious Force in the Western World in a Few Centuries*, unknown edition (San Francisco, Calif.: HarperSanFrancisco, 1997), 73–94.

Monasticism, in particular, placed the care of the sick at the center of the community. Antony of Egypt, considered the father of the monastic movement, placed care for the sick at the center of his ministry.[3] In the centuries that followed, the monastic movement followed Antony's example. A plan for the St. Gall monastery placed medicine as an essential aspect of monastic life, with a physician's home, hospital, and herb garden for patient treatment included in the plans for the building, which seemed to indicate that this was to be a community hospital compound.[4] This plan, created in the 9th century, reflected the typical Benedictine monastery. Therefore, this was not a unique occurrence, but a central priority of monastic communities. Benedictine monasteries were designed around *The Rule of St. Benedict*, a 6th century document outlining the rules of Benedictine monastic life. This rule specified medical care as a central duty of the monastic and commanded the cellarer to "take the greatest care of the sick, of children, of guests, and of the poor."[5] While these examples are drawn from the centuries following the Early Church, they serve to point out the emphasis on caring for the sick present in

[3] R. J. S. Barrett-Lennard, *Christian Healing After the New Testament: Some Approaches to Illness in the Second, Third and Fourth Centuries* (Lanham: UPA, 1994).

[4] Florence Eliza Glaze, "Medical Writer," in *Voice of the Living Light: Hildegard of Bingen and Her World*, ed. Barbara Newman (Berkeley: University of California Press, 1998) 127.

[5] Darrel W. Amundsen, "The Medieval Catholic Tradition," in *Caring and Curing: Health and Medicine in the Western Religious Traditions,* ed. Ronald L. Numbers and Darrel W. Amundsen (1986; Baltimore: Johns Hopkins University Press, 1998), 83.

the Early Church, and therefore, stress the importance of the aspects of healing individuals that I have described.

Attentive Presence

In his teachings, Jesus never clearly outlines the specific ways in which Christians were to alleviate suffering, except for visiting individuals in their suffering and offering prayers. As the only specific instruction of Jesus in caring for the sick, besides the Great Commission to go out and heal the sick, visiting, and with it, attentive presence, remains one of the most effective and important aspects of Christian healing ministry, especially for the Early Church.

St. Basil

In *The Long Rules*, a monastic handbook for his order, St. Basil writes against living in isolation, explaining that the commandments are easily observed in community, but not in solitude, for "when he is visiting the sick, he cannot show hospitality to the stranger and, in the imparting and sharing of necessities (especially when the ministrations are prolonged), he is prevented from giving zealous attention to [other] tasks."[6] While primarily an argument for living in Christian community, the subtle implications of his description of attending to the sick carry weight. Basil, firstly, speaks of visiting the sick amongst the commandments that a monk is called to obey. In Matthew 25:36, Jesus states that he was "sick and you took care of me" amongst the list of actions

[6] Vasilii Blazhennyi and St Basil, *Ascetical Works*, trans. M. Monica Wagner (Washington, D.C: The Catholic University of America Press, 1999). pp. 249.

now labeled as the corporal works of mercy. In this way, Basil relies upon Scripture to encourage attending to the sick.

Second, the implication is clearly not that visiting the sick is less important than other tasks. It is seen simply as an option amongst many potential and necessary tasks. Basil indicates that it is necessary to give "zealous attention" to the tasks at hand, which, would include visiting with the sick. Basil does not seem to indicate that simple passive presence is enough, but that intentional attention is necessary for properly caring for the suffering. Attending to suffering is not characterized as less than any other task or any less-deserving of intense attention.

Third- and Fourth-Century Laypersons

Barret-Lennard, in an extensive study of letters written on papyri mentioning health and illness in the third and fourth centuries, analyzes the various themes written in the personal letters of Egyptian Christian laypersons. Never intended for public proclamation, these letters serve as insight into the layperson's view of health and suffering in Early Christianity.[7] In the oldest letter, Barret-Lennard notes that the verb used in one of the earliest papyri, written by an Egyptian Christian is often translated as 'to heal' (θεραπευω). Barret-Lennard notes that this verb originally meant 'to do service' or 'to be an attendant' and could be used in a variety of contexts.[8] Barret-

[7] Barrett-Lennard, *Christian Healing After the New Testament*.

[8] Barrett-Lennard, 15.

Lennard also notes that this is the same verb used in the healing activity of Jesus and the disciples, while it was otherwise not a widely used descriptor for healing.[9] With this etymology, the use of the verb in the letter indicates an emphasis on attending to the sick, rather than physical healing. For the author of the letter, the proper response to suffering is to attend to the ill, reflecting a priority of attentive presence amongst the Early Egyptian Christians. The Egyptian Christian's letter both reveals an intentional imitation of Christ's healing ministry, as well as a greater intention amidst attending to the suffering sick by attentive presence.

In another papyri, the letter writer, Demetrius, writes of his "anxiety" that his master should be able to be at the bedside of the mistress of the house, "for this was what duty demanded."[10] Again, this reflects a common understanding that it is the duty of Christians to be present at the side of the sick. This presence does not seem to be for practicality purposes, but rather, for the benefits of being attentively present with an individual.

Barnett- Lennard suggests that the description of Antony of Egypt's healing ministry indicates that the total experience of encounter with the healer, involving discussion, prayer, and perhaps laying-on of hands, was seen to be therapeutic in itself.[11] The ministry was described in several papyri as such. Although a cure or physical

[9] Barrett-Lennard, 15.

[10] Barrett-Lennard, 21.

[11] Barrett-Lennard, 186.

improvement was not achieved in all cases, individuals seem to be healed by the encounter in itself. The attentive presence of the healer may have brought comfort or an affirmation of value, as the sufferer was heard and acknowledged. This apparent transformation indicates that the presence of Antony in the company of the suffering was healing in and of itself, as well as a recognition on the part of other individuals that this encounter in itself could provide healing that may not have been physical, and yet, they still found it important.

Reintegration into Community

As previously discussed, the isolating nature of suffering at a time when community may be needed more than ever can contribute even more to the suffering of individuals. In addition, as Porterfield points out in her extensive study of the relationship between healing and Christianity, Christianity in the Early Church took root amidst great strife, including dislocation, crowding, war, and intense poverty, leading to the breakdown of traditional communities and village networks.[12] This breakdown of traditional sources of community would make providing community even more crucial in attending to individual suffering, as individuals may have felt greater isolation to begin with.

[12] Amanda Porterfield, *Healing in the History of Christianity*, 1st edition (Oxford: Oxford University Press, 2009), 45.

The Apostolic Tradition

The *Apostolic Tradition*, also known as the *Egyptian Church Order*, is a church treatise that has been known to be an insightful source of knowledge about church liturgy and life in the early centuries of Christianity. The author, typically thought of as Hippolytus of Rome, writes, "Each deacon, with the sub deacons, shall attend on the bishop. They shall inform him of those who are ill, so that, if he pleases, he may visit them. For a sick man is greatly comforted when the high priest remembers him."[13] In the Biblical sense, when God "remembers," it is not meant that He has forgotten, but that He acknowledges and acts upon the covenant He has made with his people. In the same way, when the bishop "remembers" individuals in his diocese, he remembers his duties and in doing so, acts upon this covenant. This in itself implies a relationship, one that is required for a covenant to be made. This treatise clearly outlines practices of visiting the sick, not only to provide attentive presence and comfort to the sick, but to remind the sick of the church community surrounding them. Perhaps it is this recognition that enables the comfort the author describes; to be remembered means one is in relationship with others. As such, remembrance serves to both reintegrate the suffering individual into community, as well as provide comfort and hope, other important characteristics of Jesus' and the Early Church's healing ministry for the suffering.

[13] G. J. Cuming, *Hippolytus : A Text for Students* (Bramcote [England] : Grove Books, 1976), 27.

St. Gregory of Nazianzus and Seeing the Poor

St. Gregory of Nazianzus, the fourth-century Bishop of Constantinople, in *Oration 14*, speaks of weeping when he thinks of "the fact that most people cannot stand to be near them, or even look at them, but avoid them, are nauseated by them, and regard them as abominations"[14] By "them" St. Gregory means the sick and suffering individuals of the community, especially lepers. Gregory's statement that many could not stand to be near the suffering displays a clear turn from the teachings and ministry of Jesus Christ, which closely encountered, both physically and spiritually, the suffering. However, St. Gregory's concern and clear desire that individuals embrace and engage with suffering individuals does echo the works and words of Christ. The tension between these two responses indicates that Early Christians were not unified in their responses to suffering.

"To them a kind benefactor is not someone who has supplied their need but anyone who has not cruelly sent them away."[15] Gregory recognizes the importance of community to suffering individuals above any resources provided to the suffering individual. Again, this is not simply to point out the importance of community, but to encourage Christians to intentionally include suffering individuals in their own communities as the bare minimum to which they are called. The use of the word "cruelly" very clearly outlines Gregory's opinion of sending suffering individuals away.

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[14] St Gregory of Nazianzus, *Select Orations*, trans. Martha Vinson (S.l.: The Catholic University of America Press, 2017), 45.

[15] Nazianzus, 47.

Instead, Gregory insists upon providing suffering individuals support and community. As was discussed in the previous chapter, a lack of community can be a major source of suffering, and therefore, reintegration into community can be a profound way to encounter and heal individuals who are suffering.

Leprosariums

However, broad generalizations about the provision of community in Christian healthcare cannot be made. For example, lepers were often isolated and shunned from Christian communities. The previously discussed passage from Gregory of Nazianzus' *Oration 14* speaks to this incidence. When Gregory writes, "the fact that most people cannot stand to be near them, or even look at them, but avoid them, are nauseated by them, and regard them as abominations," he provides a firsthand account of the Christian response to lepers and the subsequent social isolation of suffering individuals[16] While an understandable reaction for prevention of disease, it isolates the suffering individual, perhaps only increasing his or her suffering.

Leprosariums were places to which lepers were sent, and have been controversial in historical analyses. While the intent seems to be to isolate individuals with leprosy for safety of others, in a review of the experience of leprosariums, the authors conclude that the canon of the Third Lateran Council, held in 1179, does not seek to incarcerate or isolate individuals with leprosy, but to provide them with chapels to worship and provide

[16] Nazianzus, *Select Orations,* 45.

a community within which they might live.[17] It could be that different communities had differing intentions in creating leprosariums, and such would be understandable. However, this reflects inconsistency in reintegration of suffering individuals into community for the Early Church. If the purpose is isolation, then community restoration is clearly not being sought. However, if the intent is to provide a safe and meaningful community amongst suffering individuals, this may seem to reflect a desire to practically and safely reintegrate suffering individuals into community.

Comfort and Hope

In absence of treatment for many diseases, one must ask what healers of the Early or Medieval Church could offer the suffering individual in their care. Many of the aforementioned characteristics of care can result in comfort and hope instilled in the patient. Comfort and hope can often be provided through a reminder of belonging to and remembrance by a community, as well as the gift of an attentive presence. In addition, in light of the New Testament and Resurrection, Christian healthcare providers were able to provide comfort and hope of a life after death and redemption.

Athanasius on Antony of Egypt

In writing about Antony of Egypt, Athanasius notes a particular method of healing utilized by the ascetic:

> He encouraged those who suffered to have patience and to know that healing belonged neither to him nor to men at at all, but only to God who acts whenever

[17] Timothy S. Miller and Rachel Smith-Savage, "Medieval Leprosy Reconsidered," *International Social Science Review* 81, no. 1–2 (2006): 16 .

> he wishes and for whomever he wills. The ones who suffered therefore received the words of the old man as healing, and learned not to dwell on their infirmities to be patient. And the ones who were cured were taught not to give thanks to Antony but to God alone. [18]

In this passage, Antony is noted not to have always provided a physical cure or treatment in attending to "those who suffered," but clearly provided comfort and hope to the suffering. Athanasius notes that healing was still received by the suffering. In addition, Antony of Egypt's healing ministry was highly praised and exalted by prominent leaders in the Church, like Athanasius. Early suffering Christians recognized the value in Antony's method of healing and attending to the suffering and sought this method of healing amidst suffering. Therefore, it must have been effective in healing some aspect of the suffering, even if it was not of physical benefit, as Athanasius distinguishes between cure and healing. The words of Antony were healing in themselves, allowing the patient to not dwell on their illness, perhaps indicating comfort has been provided.

St. Gregory of Nazianzus

Gregory of Nazianzus mentions a duty of caring for the sick as an opportunity to "counsel fortitude; offer encouragement."[19] Again, these were not simply suggestions, but necessary components of attending to and caring for the sick. Fortitude, a virtue which entails courage and fearlessness in the face of pain or danger, can be seen as a

[18] Barrett-Lennard, *Christian Healing After the New Testament*, 222.
[19] Nazianzus, *Select Orations,* 60.

comfort and a forerunner to hope. In addition, Gregory writes of providing encouragement to the suffering individual. If the point of encouragement is to restore hope, then Gregory is doubling down on his prioritization of providing comfort and hope to the suffering individual. The list of tasks in caring for the sick resembles a list of works of mercy, further echoing the list Jesus himself offers and providing further evidence that the Early Church was using the example of Jesus in the methods and characteristics of its healing ministry.

Physical Touch

"Laying on of Hands"

Irenaeus, a Bishop of Lyon, describes that some, who have been given the gift of healing, "heal those who are sick by laying on their hands"[20] The "laying on of hands" is an important action in Early Christian encounters with the suffering. Again, it seems unnecessary that God would only heal a suffering individual if the individual was being touched by another. Therefore, the action has to have a different significance. As explored previously, such could be important in providing comfort, as well as establishing intimacy and reminding the suffering individual of the community surrounding him or her. Whatever the effect, it is clear that the Church recognized the importance of touch in attending to the suffering.

[20] Irenaues, *Adversus Haereses 2.32.4, in* Exorcism and the Healing of the Sick, trans. Reginald Maxwell Woolley (London:SPCK, 1932), 15.

In Acts 28:8, Paul lays his hands on Publius' father, and he was healed. In many Biblical cases of laying hands on the suffering, the indication is that the action somehow transmits or fills the individual with the Holy Spirit. In the case of the restoration of Paul's sight by Anani'as, this connection seems clear. Anani'as tells Paul that he has been sent "that you may regain your sight and be filled with the Holy Spirit." However, I do not think this contradicts another consequence or motivation for physical touch of the suffering. Again, God cannot be limited by one human's ability or willingness to touch another. The Holy Spirit may be communicated through physical touch, and such would seem the best way, as physical touch indicates a community and connectedness which the suffering individual is a part of. This is compatible with the received Holy Spirit, as well as physical touch being used for conveying community and support.

Dressing of Wounds in Gregory of Nazianzus

Gregory of Nazianzus writes, "Basil had his sick, and the dressing of their wounds, and the imitation of Christ, cleansing leprosy not by word but in deed."[21] Gregory seems to indicate that Basil believed imitation of Christ could not simply be spoken of in a metaphorical sense, but Christ's healing ministry called Christians to practical ministry in the Kingdom of God present on Earth. Basil demonstrates that even he, as bishop, is not above changing the bandages of suffering individuals. As most can easily understand, is not the most pleasant job. However, Basil seems to find it extremely

[21] Saint Gregory Nazianzen and Saint Ambrose, *Funeral Orations (The Fathers of the Church, Volume 22)* (CUA Press, 2010), 81.

important, much of which I believe is not necessarily due to the physical health benefits, but from the healing benefits of physical touch. Porterfield notes that Basil would greet the sick in his hospital with a kiss and his practices of personally attending to the wounds of the sick would be emulated by monks for centuries following his death.[22]

In addition Gregory includes "bandage wounds" in his listing of acts necessary to the healing ministry.[23] Bandaging wounds necessarily entails physical touch and proximity to the patient. Gregory's inclusion of bandaging wounds is not simply a suggestion, but an inclusion that, accompanied by his encouragement to be physically present, encourages an accompaniment that is intimate and fearless. In a time when germ theory was beyond the horizon and leprosy was a common ailment, a willingness to be physically present and even touch the ill is a significant suggestion, as well as one that echoes Jesus' ministry.

Reaffirmed Wholeness and Value

Accounts of Holy Men

In Miller's account of the beginning of hospitals, he notes the hagiographical account of a holy man named Sampson. Sampson "not only considered his patients worthy of the care prescribed by the rules of his profession, but also shared food with

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[22] Porterfield, *Healing in the History of Christianity,* 53.

[23] Nazianzus, *Select Orations,* 60.

them."[24] Despite profound illness worthy of hospitalizations and most likely, profound suffering, Sampson acknowledged the worth of patients, worthy not only of proper care, but of friendship and accompaniment in the breaking of bread. Sampson understands his patients as whole and worthy, and likely encountered and treated them as such. This understanding is important in encouraging and affirming individuals who are suffering, and can alleviate some of the suffering associated with feelings of inadequacy that may accompany suffering.

Theology of the Early Church

However, theological views of sickness in the Early Church did not always view individuals suffering from sickness as "whole." Antony of Egypt, described previously as comforting and attending to individuals, also wrote extensively about the ascetic way of life and the ways in which it can free an individual from sickness. Through asceticism, Antony wrote, an individual could attain prelapsarian health, that which was free from sickness and illness.[25] This idea could indicate that sickness and illness only exists in individuals who do not have a strong enough religious practice or life, thereby potentially demeaning suffering individuals. One can imagine that this would be particularly dangerous in monastic communities if a monk were to fall ill. However, in an attempt to provide an answer to why suffering and illness exist, it is an understandable theory to

[24] Miller, *The Birth of the Hospital in the Byzantine Empire,* 43.

[25] Andrew Crislip, "Asceticism, Health, and Christian Salvation History:: Perspectives from the Earliest Monastic Sources," in *Thorns in the Flesh*, Illness and Sanctity in Late Ancient Christianity (University of Pennsylvania Press, 2013), 36–58.

consider. Although, I argue, this view of suffering does not follow from Christ's own healing ministry, and in fact, contradicts the very heart of his work.

St. John Chrysostom contradicts Antony's theology, by declaring that the holy could fall ill and that such would serve many purposes, including consoling those who have also fallen ill and as a revelation of God's power.[26] Therefore, illness cannot be an indicator of sinfulness, as even the greatest saints could fall ill. No one is able to gain prelapsarian health and avoid suffering. Although I agree with Chrysostom, I hesitate to assign specific meaning to illness and suffering. Despite this hesitation, Chrysostom's acknowledgment of worth and sanctity despite suffering is an important declaration. The disagreement between these two Early Church theologians demonstrates the difficulty the Early Church had in affirming the worth and value of suffering individuals in the face of trying to theologically explain suffering.

Conclusion

The Early Church embraced the centrality of healing to the Church's ministry, and relied upon many of the characteristics found in Jesus' healing encounters to attend to suffering individuals in the Church. As such, these characteristics are effective at attending to suffering, as well as feasible ways for Christians to imitate Jesus. Ministry to suffering individuals is not confined to Jesus Christ, but finds a place throughout the entire ministry of the Early Church. In the following chapter, I will analyze the ways in which the Church and world currently utilize or abandon these characteristics.

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[26] John Chrysostom, *The Homilies of S. John Chrysostom,Archbishop of Constantinople, on the Statues, or to the People of Antioch,* (Oxford, 1842), 4–27.

CHAPTER FOUR

Healing in Current Healthcare

As was done with the Early Church, I will study the present day delivery of healthcare as it pertains to the specific characteristics that have been derived from Jesus' encounters with suffering in the Gospel of Luke. While not all examples of care will be studied, many of the prominent movements within the healthcare community will be considered, as well as their effects on the provision of care with the previously discussed characteristics (attention, reintegration into community, provision of comfort and hope, physical touch, and reaffirmed value and wholeness). Several movements will impact multiple characteristics of care and have been categorized under the primarily affected characteristic. Common themes of technology and clinical constraints contribute to the ways in which these characteristics are seen in the modern delivery of healthcare, and therefore, the ways in which physicians faithfully encounter suffering. I will analyze each characteristic and a few particular ways in which these characteristics are maintained or lost in modern healing practices.

Attention

Clinical Listening

If attention is active passivity, a wait for the receiving of truth, then listening would serve as a fairly good measurement of this characteristic. While listening, physicians are not as actively engaged in searching for answers through technology,

patient charts, or physical exams. Rather, they listen in the hopes of receiving pertinentclinical information from the patient. This information could be key symptoms, priorities in treatment, or another piece of insight which could change the direction of diagnosis or treatment for the well-being of the patient. However, studies have demonstrated that physicians are typically all too eager to interrupt patient concerns, with the average patient being interrupted after approximately 23.1 seconds.[1] It must be noted that this is not due to the patient being finished speaking or asking the physician a question. Rather, it is a redirection of the conversation by the physician. In order to redirect the conversation, a physician must be thinking of the direction in which he or she would like the conversation to move. Therefore, rather listening and waiting for what might be heard, the physician is actively formulating opinions while the patient is speaking, fitting the narrative of the patient into a preconceived conclusion. If the physician was attending well, he or she would wait until the end of the patient's concerns, simply listening to the patient and hearing his concerns.

In addition, clinical visit times average around 15 minutes, a number which continues to decrease.[2] Physicians may feel constrained by this time limit on visits and motivated to "get to the point" rather than allow patients to vocalize concerns fully, some of which the physician may find irrelevant, but may also be extremely pertinent in the

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[1] Ronald M. Epstein et al., "Soliciting the Patient's Agenda: Have We Improved?(The Patient-Physician Relationship)," *JAMA, The Journal of the American Medical Association* 281, no. 3 (January 20, 1999): 283.

[2] Epstein et al.

patient's care. In addition, physicians may be moving between patient rooms, further fragmenting the limited time they have with each patient. The problems of other patients or the overbearing load of work to be done may demand even more attention from the physician. Raymond Barfield, a pediatric oncologist, speaks often of the need to listen to patients, as a physician can learn what really matters to the patient and the ways in which this can impact potential treatment. Barfield states, "I tell people that I consider myself a guest in their story, and that I am there to listen to them so that I can figure out how I can help them the most."[3] Barfield's perspective runs contrary to the seemingly typical clinical approach. However, it also indicates that there is inherent value in listening to patients in modern healthcare that provides valuable insight for treatment.

Again, Simone Weil's virtue of attention entails a complete emptying of oneself for the reception of reality from the outside or other.[4] This concept necessarily entails attention from the object itself in order to receive the object in its full reality. In *The Listening Heart*, A.J. Conyers labels the modern era as one of distraction.[5] Conyers describes the craftsman, a creator concerned with the quality of the work, in contrast with the modern worker, concerned with the reproduction of that work in an efficient manner. Conyers describes the modern worker as "distracted" by the abstractions of the object of

[3] Carl Weisner, "The Miracle in Front of You: Raymond Barfield On Practicing Medicine With Compassion," *Duke Divinity School* (blog), January 30, 2016, https://tmc.divinity.duke.edu/newspeople/the-miracle-in-front-of-you/.

[4] Weil et al., *Waiting for God*.

[5] A. J. Conyers, *The Listening Heart* (Spence Publishing Co, 2006).

the work, rather than the object of the work itself, meaning attention is not given to the object itself, but either tangential or false images. These abstractions are somewhat related to the object of the work, but draw attention away from the true end and object itself. Conyers argues that modernity is not designed for attention, that Weil's ideas run contrary to modern culture. In the case of an interrupting physician, the physician may be merely devoted to the illness at hand, rather than the wholeness of the patient and his concerns. The abstraction may be the illness itself, rather than the human in which the illness is manifest. Conyers suggests that distraction is inherent to our culture, that many times either only the spiritual or seemingly abstract pieces of a human can be taken seriously or the bodily and materialistic concerns. Both of these remain abstractions of the human, neither fully realizing the wholeness of an individual.

Technology

In addition to these obstacles to attention, the mere presence of technology, such as a smartphone, reduces cognitive capacity and pulls attention away from the task at hand. Research has indicated that distraction may occur when the stimulus, in many cases a smartphone, aligns with an individual's goals, perhaps communication with loved ones, even though it is not relevant to the task at hand.[6] This could mean a physician feels his phone notification which he knows is a loved one responding, and his attention goes to this stimulus even though it does not help accomplish the task immediately at hand,

[6] Randall W. Engle, "Working Memory Capacity as Executive Attention," *Current Directions in Psychological Science* 11, no. 1 (February 1, 2002): 19–23, https://doi.org/10.1111/1467-8721.00160.

namely, attending to the patient. This particularly affects an individual's attention as it pertains to cellphones. Many physicians carry cellphones in their pocket without actively thinking about it. A study conducted on undergraduate students indicated that the mere presence of a cellphone in a backpack significantly impacted the individual's cognitive functioning, including attention, that is available for the task at hand.[7] The consumption of cognitive functioning by increasing cognitive load has been shown to result in the use of "system 1" processing: relying on intuitive and heuristic-based systems, rather than "system 2" processing which relies on analytic and deliberative processes.[8] While both of these have a place in clinical decision making, it seems that analytic and deliberative processes may need to take charge in practicing medicine. This fragmentation of attention by the mere presence of cellphones does not bode well for the ability of physicians to properly attend to the suffering of patients.

In the medical field, diagnostic technology lends to the kind of distraction described by Conyers.[9] Rather than a person made of both spiritual and physical domains, the patient becomes a collection of scans, blood work, and diagnostic tests. Each of these

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[7] Adrian F. Ward et al., "Brain Drain: The Mere Presence of One's Own Smartphone Reduces Available Cognitive Capacity," *Journal of the Association for Consumer Research* 2, no. 2 (April 1, 2017): 140–54.

[8] Jonathan St. B. T. Evans, "Dual-Processing Accounts of Reasoning, Judgment, and Social Cognition," *Annual Review of Psychology* 59, no. 1 (2008): 255–78, https://doi.org/10.1146/annurev.psych.59.103006.093629.

[9] Conyers, *The Listening Heart*.

put distance between the physician and patient, providing more abstractions of the patient, and therefore, greater opportunity for distraction from the patient himself. The patient becomes a conglomerate of numbers and images, rather than an embodied person, physical and spiritual. Conyers believes that true attention requires an attendance to both of these realms, that the patient must be viewed as more than a sum of scans and diagnostic testing.[10] However, it can be seen that the abundance of diagnostic technology and tests make this more difficult in practice.

Electronic Medical Records

Abraham Verghese, in his reflections on physical exams and touch, concedes that "an anthropologist walking through our hospitals in America wouldn't be blamed for concluding (on the basis of where physicians spend the most time) that the real patient is in the computer, while the individual in the bed is a mere placeholder for the real patient."[11] Verghese anecdotally summarizes the reality of the introduction of electronic medical records and other technology into the clinical visit; technology may serve as a distraction, rather than beneficial tool for both physician and patient.

Specifically, electronic medical records (EMRs) have become a widespread tool designed to streamline patient records and allow for communication between the entire healthcare team. A study done with Israeli primary care encounters demonstrated that

[10] Conyers.

[11] Verghese, "A Touch of Sense."

physicians gazed at the computer about 25-42% of the time spent with a patient.[12] This was shown to be negatively correlated with physician engagement in psychosocial question asking, emotional responsiveness, and scoring of patient-centered communication during the visit. Keyboarding was also negatively associated to physician and patient engagement in dialogue as well.

However, some studies have reported positive benefits of electronic medical records. In a study by Lee et al., patients reported that physicians often used computers and EMRs as communication and educational tools, showing graphs or charts that helped inform the patient about different aspects of his or her health.[13] This could be seen as a helpful resource in providing comfort to the patient in helping her better understand her health and alleviate some anxiety related to not understanding her own condition. Approximately 88% of patients reported in the Lee study that a sensitive or serious topic would cause the physician to stop using the computer and pay full attention. These moments are often the kind that necessitate full attention, and if EMRs are not pulling attention away from these conversations, it must be considered that they may not be negatively impacting a physician's ability to be attentively present. In addition, EMRs

[12] Ruth Stashefsky Margalit et al., "Electronic Medical Record Use and Physician-Patient Communication: An Observational Study of Israeli Primary Care Encounters," *Patient Education and Counseling* 61, no. 1 (April 2006): 134–41.

[13] Wei Wei Lee et al., "Patient Perceptions of Electronic Medical Record Use by Faculty and Resident Physicians: A Mixed Methods Study," *Journal of General Internal Medicine* 31, no. 11 (November 1, 2016): 1315–22, https://doi.org/10.1007/s11606-016-3774-3.

increased the comfort of patients in the proper documentation and communication of health information.

Overall, studies concerning EMRs have demonstrated mixed results on the physician-patient relationship and a physician's ability to be attentively present with patients. Some of this may be due to the patients involved and their perception of technology and expectations of care. As such, modern physicians may have to consistently consider the individual patient and actively attempt to be attentively present with each one.

Reintegration into Community

Social Isolation in Healthcare Settings

Social isolation has become a large concern amongst the medical community in recent years. Studies have demonstrated countless times that social isolation only worsens disease and outcomes.[14] While this may lead to an increased effort to reintegrate patients into community primarily for the reason of outcomes rather than the alleviation of suffering, the result may be the same.

[14] See Caitlin E. Coyle and Elizabeth Dugan, "Social Isolation, Loneliness and Health Among Older Adults," *Journal of Aging and Health* 24, no. 8 (December 1, 2012): 1346–63., Erin York Cornwell and Linda J. Waite, "Social Disconnectedness, Perceived Isolation, and Health among Older Adults," *Journal of Health and Social Behavior* 50, no. 1 (2009): 31–48., or Samuel G. Smith et al., "Social Isolation, Health Literacy, and Mortality Risk: Findings from the English Longitudinal Study of Ageing.," *Health Psychology* 37, no. 2 (February 2018): 160–69. for more information regarding the broad effects of isolation on health. The breadth of the effects is far too expansive to articulate in this paper.

However, one must question if social isolation is becoming a concern because it is more frequent and intense than previously experienced. Isolation due to disease transmission may be happening at higher rates, simply because the methods of transmission are known now and isolation is a necessary step to prevent transmission. For cases of disease like cystic fibrosis, patients must be separated to prevent cross-infection. The necessity of these interventions is evident, yet isolation seems to exist in settings without necessity for it.

The isolating nature of the hospital, in general, is quite evident. Patients are away from their homes and normal communities. If the patient is a long-term patient, they may not have access to faith communities and worship services or other support systems to which they may otherwise have access. However, this may reflect a larger concern over the purpose of a hospital, and therefore, the kind of care that should be delivered. If the purpose of the hospital is simply a short-term stay and cure, then the formation of community and social support may be less of a priority. However, some patients may have to experience longer hospital stays for illnesses such as cancer, transplant operations, or traumatic injuries. Therefore, the suffering of such patients, often removed from a community that aids in coping with the illness, remains unaddressed if the hospital is viewed in such a way. The reality of hospitals, regardless of intended or ideal function, necessitates an awareness of the suffering of such individuals.

Although routine and support can disappear with hospitalization and increase the suffering of the patient due to a lack of community, patients may also have less social support to begin with, when compared to previous generations. The Administration on

Aging reported that 29% of non-institutionalized older persons lived alone in 2010.[15] As the population of older individuals increases in the next few decades, it becomes important to intervene in order to prevent the negative health effects associated with social isolation and to attend to the suffering of isolated individuals by introducing them into community. The purpose of reintegration into community is not simply to maintain the level of community the individual had before illness, especially if the patient had limited support. Instead, the purpose is to introduce the patient into meaningful community that is able to comfort and offer support in the face of suffering, in order that the individual may suffer less or cope with the suffering better.

In particular, programs have found it necessary to focus on elderly populations, providing volunteers and hospital staff to visit with and provide support to patients. Programs like the Purposeful Visit Program (PVP) have provided opportunities for social engagement for patients in the hospital who may otherwise have none.[16] The PVP program was designed to have volunteers visit with older patients in order to reduce the isolation of the patients. The program was found to elicit positive responses from patients in the study, in line with what other studies have found regarding other volunteer programs. In addition, other hospitals have adopted "befriending" programs, particularly for chronic care patients, in which volunteers are used to befriend mostly elderly and

[15] Coyle and Dugan, "Social Isolation, Loneliness and Health Among Older Adults."

[16] Bill Mramor et al., "Purposeful Visits for Hospitalized Older Adult Patients," *Journal of Gerontological Nursing* 41, no. 3 (December 10, 2014): 42–48.

socially isolated individuals. One such service was found to be recommended and worthwhile by 100% of patients enrolled in the service.[17] The service in the study matched long-term patients with volunteers who would come to visit with them on a weekly basis throughout their stay. The patients and volunteers would become familiar and many patients indicated a feeling of friendship with the volunteer that was assigned to them. These services are clearly effective and mostly rely on volunteer participation. As a marker of reintegration into community, the typically long-term relationships that exist between patient and volunteer serve to attend to the suffering of isolated individuals well.

Support Groups

The creation of support groups, typically centered around individual topics such as parents of children with Down Syndrome or chronic pain, could be viewed as the formation of communities for individuals who are suffering. As previously discussed, the reintegration into community may lead to significant healing of suffering. Online communication makes membership in these types of groups even easier. A study conducted by Heuval et al. found that group programs increased the seeking of social

[17] Louise Peardon et al., "The Use of Innovative Methods Designed to Relieve Social Isolation in Patients with Chronic Heart Failure; Volunteer Befriending, Forums and a Newsletter," *European Journal of Cardiovascular Nursing : Journal of the Working Group on Cardiovascular Nursing of the European Society of Cardiology* 9, no. 3 (September 1, 2010): 181.

support by stroke patients.[18] Not only do the groups provide community, and often, community that deeply understands the suffering of the individual, but they encourage patients to seek additional community involvement.

Often, physicians are able to refer patients to such support groups, especially if the patient does not have an abundance of social support. Many hospital systems, such as the Mayo Clinic, have reference materials for patients looking for a support group.[19] While these may be helpful to patients, less data exists on how often physicians refer patients to these kinds of group programs. A study conducted with family medicine physicians found that for dementia patients, "physicians were somewhat aware of organizations such as Alzheimer societies, were less aware of what these societies do, and rarely referred patients or families directly to them."[20] The same study found that the offices of the physicians did not maintain any up-to-date lists of resources or groups. The existence of such groups offers the possibility of community formation for suffering

[18] Elisabeth T. P. van den Heuvel et al., "Long-Term Effects of a Group Support Program and an Individual Support Program for Informal Caregivers of Stroke Patients: Which Caregivers Benefit the Most?," *Patient Education and Counseling* 47, no. 4 (August 2002): 291–99.

[19] "How to Choose the Right Support Group," Mayo Clinic, https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/support-groups/art-20044655.

[20] Mark J. Yaffe, Pam Orzeck, and Lucy Barylak, "Family Physicians' Perspectives on Care of Dementia Patients and Family Caregivers," *Canadian Family Physician* 54, no. 7 (July 2008): 1008–15.

individuals. However, the lack of provider knowledge and referrals often means that patients are not benefiting from these communities.

Provision of Comfort and Hope

Comprehensive Medical Teams

As discussed in the previous chapter, healing in the time of the Early Church occurred mainly in a religious or monastic context. Hospitals began with the monastic movement, and many healers were spiritual "physicians" as well. Chaplains have served in the U.S. in a military capacity since the authorization of an army chaplain by Congress in 1771.[21] In the first half of the twentieth-century, professional organizations for chaplains began to develop, and presently, approximately 10,000 chaplains in the U.S are in full-time practice or training programs and provide 10 to 15 million hours of counseling each year.[22] This has expanded beyond military chaplains, and chaplains now practice in hospitals, nursing homes, and many other healthcare sites. In addition, patients indicate a desire for visits with chaplains. A study at the Mayo Clinic in Minnesota, Arizona, and Florida indicated that 70% of patients wanted a chaplain visit, with the most important reason for requesting being a reminder of God's care and presence, as well as

[21] Harold G. Koenig, *Spirituality in Patient Care : Why, How, When, and What* (Templeton Press, 2013).

[22] Koenig.

to provide prayer or scripture reading.[23] Thus, the development of chaplaincy can be seen as a positive development in providing comfort and hope to patients. The reminder of God's care and presence may alleviate anxiety and unrest for the patient, in turn, alleviating suffering. Chaplains have become important in the absence of community clergy visiting the sick, as they may have large congregations or simply do not view visiting their sick congregants as part of their job. In addition, approximately one-third of Americans are "unchurched," meaning they have not attended a religious service in the last six months and may not have any clergy to visit them.[24] While this serves as an excellent reason for the existence of chaplains in medical settings, it is also symptomatic of the lack of a supportive faith community for many in society.

While the development of complex medical teams has radically changed the role of the physician in providing healing, it does not exempt the physician from addressing non-physical healing during a clinical visit. Only around one in five hospitalized patients receives a visit from a chaplain and family members receive even fewer opportunities to visit with chaplains.[25] Harold Koenig suggests that healthcare providers should be assessing spiritual needs as well as they are equipped to do in the absence of a chaplain.[26]

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[23] Koenig.

[24] Koenig.

[25] Koenig.

[26] Koenig.

This seems to be especially important in instances where there is no chaplain available, a common occurrence in the healthcare system of the United States.

Medicine as Theodicy

While not exactly a clinical occurrence, medicine as a theodicy has become a prominent cultural belief. Theodicy, the attempt to justify the existence of suffering in a world governed by a good and all-powerful God, has been a prominent concern among Christians over the last few centuries. Stanley Hauerwas, in *Naming the Silences,* argues that Christians seeking an explanation of suffering in the light of an all-powerful and good God have made a profound theological error in beginning this search.[27] Hauerwas draws upon stories of childhood illness and death to argue that medicine has simply become a way to fill the silence caused by such suffering with noise, that society has made medicine the response to suffering, the hope for an end to it. Hauerwas utilizes Peter Devries' novel, *The Blood of the Lamb*, a story about Don Wanderhope and the illness and death of his daughter Carol, as a case study in the theodicy of medicine. In the novel, Wanderhope's daughter is diagnosed with leukemia, and through several setbacks, is placed in a clinical trial for new treatment. Wanderhope places all of his hope and faith in the research surrounding this new treatment, a treatment that ultimately fails. Hauerwas concludes:

> It is the world of science that teaches us to explain illness and suffering as the result of physical processes that have gone wrong. All that is required to make our world right is the increasing development of our intelligence and knowledge. In

[27] Stanley Hauerwas, *Naming the Silences* (W.B. Eerdmans, 1990).

> the name of development we are now ready to offer up our children to the priests of this new hope, believing as we do that finally a "cure" will be found.[28]

In the case of Don Wanderhope in *The Blood of the Lamb*, he wrestles with the idea of God in the face of a daughter suffering, and ultimately, dying from leukemia.[29] Don attempts to find comfort in a new clinical trial, trusting in physicians to cure his cherished daughter of her illness. As Hauerwas describes above, Wanderhope seemingly offers his child up to the priest of the new hope, physicians. Don encounters another father with a daughter in the ward, Stein, and amidst their discussion, the true merits of medicine according to Stein are articulated. Wanderhope begins:

> I changed the subject by jerking my head once more toward the research building before we turned the corner out of its sight. "We've got that to be grateful for, maybe even pious about. Ten years ago our children wouldn't have stood a chance."
>
> "So now death by leukemia is now a local instead of an express. Same run, only a few more stops. But that's medicine, the art of prolonging disease."
>
> "Jesus," I said, with a laugh. "Why would anybody want to prolong it?"
>
> "In order to postpone grief."[30]

Stein's conclusion that medicine purely serves to postpone grief pushes against traditional views that medicine perhaps serves to heal. In a later chapter, Wanderhope posits that perhaps, "blessed are they that comfort, for they too have mourned."[31]

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[28] Hauerwas, 36.

[29] Peter DeVries, *The Blood of the Lamb* (Boston: Little, Brown & Co., 1969).

[30] DeVries, 183.

[31] DeVries, 246.

Wanderhope describes the mourner's bench upon which many sit "in undeluded friendship."[32] Wanderhope, and DeVries as an author, seem to find comfort and hope in the recognition of the finite and of suffering in which each person has participated, rather than the blind faith in medicine and science to cure all sufferings. However, according to Hauerwas, this is not often the comfort that is offered. Rather, offerings of human intellect that will one day overcome suffering are given to soothe the soul, offerings that ultimately disappoint and fail with the finitude of humans. In addition, the modern medical model reframes healing as solely dependent upon cure, disappointing those that live without hope of cure or remediation of suffering. This can be seen as an obvious failure on the part of both medicine and culture to provide comfort and hope to all who suffer. It both neglects a significant population of patients with incurable illnesses and gives finite, and ultimately, disappointing sources of hope for suffering individuals.

Medicine as theodicy does not seem to be simply perpetuated by physicians. Rather, it seems to be engrained in the very culture of the modern world. As such, it becomes easier to recognize the many ways in which society as a whole neglects the provision of true comfort and hope to suffering individuals. Without this hope, suffering can persist and even grow. Anxiety about the future and the unknown of the present only serve to amplify suffering. In this way, medicine as theodicy hinders the ability of healers to truly encounter and heal the suffering individual.

[32] DeVries, 246.

Physical Exams

Anecdotally, the physical exam seems to be "going out of style" for physicians. With limited clinical time with patients, physicians do not seem to have time to do an entire physical examination, and in turn, may lose the diagnostic skills associated with physical exams. Not only does this have an effect on the overall healing of the patient, but actually may have clinical effects. In a 1992 study at Duke University, 63 internal medicine residents listened to three common heart murmurs that had been programmed into a mannequin.[33] Although conducted in ideal conditions with as much time as desired, about half could not identify two of the three murmurs and over two thirds missed the other murmur. With the dawn of imaging that is often much better at diagnosing certain conditions, the place of the physical examination may still seem outdated within medicine. However, as previously discussed, patients find many positive benefits in the physical touch of a healthcare provider, enhancing the doctor-patient relationship and providing a reminder of community and comfort.

A literature review conducted by Rousseau and Blackburn demonstrated that from 1960 to 2008, no definitive articles relating to touch between physicians and patients in medical education or medical care were published, disregarding a few letters to the editor

[33] S. Mangione and L. Z. Nieman, "Cardiac Auscultatory Skills of Internal Medicine and Family Practice Trainees. A Comparison of Diagnostic Proficiency," *JAMA* 278, no. 9 (September 3, 1997): 717–22.

and articles on empathy and compassion that mention touch as an aside.[34] This seems to demonstrate a disregard or lack of interest in touch in the physician-patient relationship that correlates with the gradual disappearance of the physical exam.

In addition, physical touch decreases with the advent of mandatory isolation for infections such as *Clostridium difficile* and antimicrobial-resistant pathogens. Although a physical barrier must be present, Rousseau and Blackburn argue that such are "poor excuses, as a gloved hand still imparts the feeling of caring and concern… Touch has that distinct ability to transcend the obligations of disease and obstacles of technology."[35] The knowledge of disease transmission seems to only increase the distance placed between provider and patient, as well as the occurrence of physical examination. While this is not necessarily bad, as it prevents disease transmission, but it does necessitate the awareness of physicians to the lack of physical contact and a way to compensate for this deficit.

Virtual Medicine

Telemedicine, the administration of clinical visits or medicine through remote and technologically-aided means, has risen in use over the last decade. In the U.S., 72 percent of hospitals and 52 percent of physician groups had telemedicine programs in 2016.[36]

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[34] Paul C. Rousseau and Gerald Blackburn, "The Touch of Empathy," *Journal of Palliative Medicine* 11, no. 10 (December 1, 2008): 1299–1300, https://doi.org/10.1089/jpm.2008.0174.

[35] Rousseau and Blackburn.

[36] Melinda Beck, "How Telemedicine Is Transforming Health Care," *Wall Street Journal*, June 27, 2016.

Telemedicine can vary in practices, from Skype sessions to online chat rooms or forums. Telemedicine has been hailed as a solution to physician shortages in rural areas. Indeed, telemedicine is able to provide specialists, such as psychiatrists, in areas with great need and even larger deficits in care. For specialties such as psychiatry, it may seem appropriate, as the physical exam is not heavily relied upon in this specialty.

However, there remain obvious effects of telemedicine on physical touch in the physician-patient relationship. Telemedicine altogether eliminates the possibility of physical touch in its use. Oudshoorn explains that patients are expected to be "diagnostic agents" in their own healthcare.[37] The physician may get the diagnostic benefits of a physical exam, but the reminder of community, the affirmation of value, and the provision of comfort may all be lost with the loss of physical touch.

On a practical note as well, patients may be less equipped to identify subtle differences in a physical examination; untrained eyes are typically worse than those that have been tuned to these differences. For example, while a physician may be able to detect the subtle differences between a fluid-filled abscess and a solid tumor, a patient might not be attuned to these differences. Telemedicine could have devastating effects on the typical benefits of physical touch within the physician-patient relationship, both diagnostically and from a holistic care perspective.

[37] Nelly Oudshoorn, "Diagnosis at a Distance: The Invisible Work of Patients and Healthcare Professionals in Cardiac Telemonitoring Technology," *Sociology of Health & Illness* 30, no. 2 (March 2008): 272–88.

Reaffirmed Value or Wholeness

With the secularization of most medical care, the reaffirmation of wholeness or value seems to have less of a priority than concrete clinical action. It is no longer considered the "job" of the physician to attend to the whole entity, but to attend to the body of the individual. However, this characteristic is remarkably difficult to measure in the clinical experience. Cultural phenomena can act as signposts for general feelings toward the suffering individual, yet do not always reflect individual clinical action of physicians. For example, culture tends to value the young, beautiful, and active body, idolizing this figure and aligning personal expectations of health with this ideal. However, this does not mean that physicians place these expectations upon elderly patients and treat them as less because they do not reflect this ideal. Rather, these expectations may guide the path of care and lead physicians to treatments that direct the patient towards the goal of this ideal. Likewise, many other cultural values, some of which will be discussed below, influence treatment in subversive ways which are not clearly stated by healthcare providers.

Physician-Assisted Suicide

Physician-assisted suicide, also known as euthanasia or physician-hastened death, is a marker of medicine and culture's current view of the value and wholeness of suffering individuals. Rather than a view of life as gift and an inherent value to life of all forms, physician-assisted suicide identifies life that simply does not have worth enough to continue. In the year 2016, 48.9% of individuals whose suicides were reported in Oregon under the "Death with Dignity Act" cited a fear of becoming a burden to their

friends and families.[38] While this is not a direct statement of a feeling of lost value or worth, it does seem to indicate that the gift of life and the wholeness of that life is not worth the potential burden upon family members.

This practice is also seen as a way to "help end suffering," meaning life cannot outweigh "intractable" suffering. In a culture which values the young body in perfect health, it seems to become increasingly easier to gawk at aging and the diseases that accompany the process. S. Kay Toombs regards these ideals of youth and vitality as "unrealistic" and concludes that they "inevitably devalue the elderly."[39] These cultural values of perfect health and youth inevitably influence the delivery of healthcare. Toombs marks it as significant that public attitude and policy seem to suddenly accept that there is something that could be classified as a "life not worth living."[40] For Toombs and many Christians, life is a gift from God regardless of the utilitarian use of that life or its contributions to society. Ezekiel Emmanuel, a prominent bioethicist, has declared that after the age of seventy-five, he wishes to receive no healthcare, even a flu shot, that would contribute to a longer life, as he would not be of use to the world anymore, with

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[38] Public Health Division, "Oregon Death with Dignity Act: Data Summary 2016," *Oregon Health Authority*, 10 February 2017, http://www.oregon.gob/oha/PH/PROVIDERPARTNERRESOURCES/EVALUTIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf.

[39] S. Kay Toombs, *How Then Should We Die?* (Elm Mott, Texas: Colloquium Press, 2017), 18.

[40] Toombs, *How Then Should We Die?*

diminished creative and rational powers.[41] The idea that suffering must somehow be outweighed by contribution is wholly contrary to an affirmation of wholeness or value even while suffering. The very weighing of suffering against cultural values, such as productivity, seems to indicate it has a negative value, and therefore, the sufferer inherently has less value.

In addition, patients in the same study cited above indicated loss of autonomy, lessened ability to participate in activities, and loss of dignity as the top three concerns leading to their decision to end their lives.[42] While this is a practice that is clearly occurring and impactful in a concrete manner pertaining to mortality, an additional concern is the cultural implications for the value and dignity of individuals who are suffering, namely, that dignity or value is inherently lost with suffering. Toombs describes the pervasive attitude that perhaps those suffering, especially at the end of life, are no longer "persons" in the eyes of society.[43] In this line of logic, a death with suffering is not dignified. This shows a clear deficit on the part of medicine and culture in affirming the dignity, value, and wholeness of suffering individuals, especially those with terminal illnesses. It also seems to be an indication to individuals who choose to live and

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[41] Ezekiel J. Emanuel, "Why I Hope to Die at 75," *The Atlantic*, October 2014, https://www.theatlantic.com/magazine/archive/2014/10/why-i-hope-to-die-at-75/379329/.

[42] Public Health Division, "Oregon Death with Dignity Act: Data Summary 2016."

[43] Toombs, *How Then Should We Die?*, 19.

continue to suffer that their lives carry less dignity precisely because they suffer. Toombs writes:

> When the choice of dying a natural death is portrayed as one that will inevitably involve unbearable, unmitigated pain and "torture" for the one who is terminally ill and for those caring for him or her, it becomes ever more difficult in the public imagination to recognize that it is possible to retain one's dignity and to find meaning in the face of the challenges of terminal illness and disability[44]

In this way, modern culture, perhaps unintentionally, sends a message to the suffering individual that speaks against a Christian belief in the inherent dignity of all humans created in the image of God. While physicians are not the individuals typically initiating interest in this type of practice or suggesting it, simple participation in it reflects a basic belief in the values and implications of the practice. Arguably, this is not a practice that reaffirms the worth or value of the suffering individual. Rather, it seems to undermine the worth and dignity of individuals.

Spiritual Histories and Assessments

The practice of taking a spiritual history or assessment has become more prominent in recent years. While in the monastic communities described in the previous chapter this may have taken precedent and come quite naturally, spiritual histories have become less natural in many clinical conversations. As such, tools have developed to properly and succinctly measure spirituality and its importance in the care of the patient. In addition, chaplains may take on some of the spiritual care, lessening the need for physicians who are not trained to do so to address spiritual needs. The FICA Spiritual

[44] Toombs, *How Then Should We Die?*

History Tool, created by Dr. Christine Puchalski in 1996, attempts to understand the key elements of the patient's faith that are essential for the physician to know in approaching healing the patient.[45] Other spiritual assessments, such as FAITH and HOPE, seek to do much of the same. These assessments recognize that the patient is much more than a body, and whether or not the patient wishes for her faith beliefs to influence her care, it acknowledges wholeness and reminds both the physician and patient of such.

Although spiritual assessments seem to indicate an increased emphasis on the whole patient, it is a completely different matter to assess if this makes an impact on the delivery of care and the spiritual care of suffering individuals. A study conducted with Missouri physicians and residents found that less than 20% of physicians discussed spiritual concerns other than fear of death in more than 10% of patient encounters.[46] While it may be due to chaplain involvement, only 22% of the same group of physicians reported frequent referral to a chaplain for hospitalized patients. Similarly, 22% reported frequent referral to a priest, rabbi, or other religious leader. Despite the apparent lack of addressing spiritual care, a study conducted among practicing U.S. physicians found that most (81%) believed that patients with unresolved spiritual issues had greater levels of pain and that physicians should address spiritual concerns, as well as physical concerns

[45] S. Kay Toombs, *How Then Should We Die?* (Elm Mott, Texas: Colloquium Press, 2017), 19.

[46] M. R. Ellis, D. C. Vinson, and B. Ewigman, "Addressing Spiritual Concerns of Patients: Family Physicians' Attitudes and Practices," *The Journal of Family Practice* 48, no. 2 (February 1, 1999): 105.

(88%).[47] This survey may indicate an increase in physician interest in attending to spiritual matters, which should be accompanied by increased training to do so. However, the results of this interest remain to be seen in the widespread system of healthcare. While the development of spiritual assessment tools may indicate an increased acknowledgment of the wholeness of the person, body and soul, the actual practice of addressing spiritual concerns of the patients does not seem to reflect this.

Conclusion

How then are modern healers to encounter suffering? I have described some ways in which current healers encounter suffering faithfully. However, there are obvious gaps and serious issues that must be addressed in the provision of care. In many ways, modern healers are constrained by the economic, cultural, and practical realities of the modern healthcare system. In addition, modern healers do not fail in all aspects of attending to suffering. However, constraints cannot be an excuse for total abandonment of properly encountering suffering patients. In the following chapter, I will outline the ways in which the modern healer can approach suffering in the lives of his or her patients in accordance with attention, provision of comfort and hope, reintegration into community, reaffirmed value and wholeness, and physical touch.

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[47] Chris L. Smyre, et al., "Limits and Responsibilities of Physicians Addressing Spiritual Suffering in Terminally Ill Patients," *Journal of Pain and Symptom Management* 49, no. 3 (2015): 562–69.

CHAPTER FIVE

Encountering Suffering: Recovering the Movement

System versus Individual Formation

As discussed in the previous chapter, the modern systems of healthcare do not seem to promote many of the important characteristics of ministering to suffering that have been discussed. In this chapter, I will discuss various ways in which these characteristics can be integrated into practice and cultivated by healthcare professionals. Rather than proposing large-scale changes to the healthcare system, I will propose ways in which the individual can cultivate these characteristics within the seemingly broken healthcare system. Although many individuals may agree that the healthcare system, particularly in the United States, necessitates reform, such changes are beyond the scope of this examination.

While some of the suggestions involve concrete actions physicians can take to encounter and heal suffering, others require a spiritual reorientation and to cultivate the inner life of the individual. Both are equally as necessary to encounter suffering as a faithful Christian. These practices, such as the cultivation of attention, may be possible and helpful for non-Christians as well. Again, these are practices and aspects of healing that are orientated towards care, instead of cure. Suffering is often much more than physical, and therefore, requires a physician or healer to attend to these other domains.

Attention

As previously described, attention is the full emptying of one's preconceptions and thoughts to allow for the full reception of reality and truth from sources outside of oneself. It involves a personal disposition which is reflected in clinical action, such as eye contact and listening. Yet, it remains an active passivity of sorts, rather than a specified clinical action in and of itself. I will describe a few practical ways in which the habit of attention can be formed or encouraged, as well as reflections on the spiritual work that must be done to cultivate attention. Attention is foundational to the other described characteristics, as it is through an understanding of the reality of the patient's suffering, achieved through attention, that a physician can begin to truly encounter and heal suffering. Therefore, many of the practices described to cultivate attention will apply to the other characteristics and will be necessary in fully integrating those characteristics into practice.

The Clean Slate

The use of full attention, as described by Weil, undoubtedly requires personal formation prior to entering the patient's room. In clinical practice, it is important to walk into clinical appointments without a preconception of how the appointment will go or potential diagnoses or treatments that may work for the patient. This "clean slate" approach to entering an exam room may even extend to setting aside previous encounters and thoughts about the patient's disposition or abilities. Patients have the ability to surprise, to change, and to grow. Dietrich Bonhoeffer, in *Life Together*, speaks of the freedom that attention without prejudice contains, freedom from "constantly scrutinizing

the other person, judging him, condemning him, putting him in his particular place."[1] It is this freedom that the physician must encounter before entering the exam room. This may mean setting a culture in which the medical team does not complain about patients upon their arrival or lament over the return of "difficult" patients. Instead, this freedom offers to the patient, a clean and hospitable slate; such a slate is the only possibility for being truly attentive and receptive to potentially pertinent clinical information and understanding the full reality of the suffering individual in front of one.

Academic Study

Weil, in her descriptions of attention and higher education, claims, "teaching should have no aim but to prepare, by training the attention, for the possibility of such an act. All the other advantages of instruction are without interest."[2] Perhaps Weil is not entirely writing off higher education for the attainment of knowledge, but she understands the ends of knowledge to be the cultivation of attention, which can ultimately be directed towards others and God. Fortunately, for many in the medical field, continual learning is not often an issue. With years of medical training and studying, as well as continued medical education, physicians should have a solid foundation for developing

[1] Dietrich Bonhoeffer et al., *Life Together*, Book, Whole (US: Fortress Press, 2015), 93.

[2] Weil et al., *Gravity and Grace*.

attention through study. However, this type of learning is not always the best for cultivating attention.

Oftentimes, the learning medical professionals would be classified as "ratio." Josef Pieper, in *Leisure the Basis of Culture*, distinguishes between "intellectus" and "ratio."[3] Ratio is learning that is investigative, deductive, and scientific at its core. Intellectus involves a waiting, a receptivity, that is inherently attentive. Intellectus is often employed in contemplation, whether this is theological, philosophical, or simply the contemplation of a beautiful painting. For Pieper, both of these concepts must work together to produce understanding. For the physician, this makes great sense in a clinical setting. Ratio is required and uses the information received through intellectus to differentially diagnose or determine best treatment or care. However, the medical system is equipped to teach all the facilities of the intellect required to exercise ratio, while it does not always prepare students for intellectus thinking. Therefore, physicians must individually cultivate this through contemplation and academic studies that may not relate to medicine, but simply build these faculties, much like strengthening a muscle. This strengthening of habit comes through repeated use of this "intellectus" mode of studying, of contemplating and waiting for truth. The physician must make this way of thinking an intentional practice in order for it to become habit, for the "muscle" to be strengthened.

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[3] Josef Pieper and Alexander Dru, *Leisure, the Basis of Culture* (Indianapolis: Liberty Fund, 1999).

Prayer

Perhaps one of the most important suggestions for the Christian physician hoping to encounter suffering faithfully, prayer is the key to attention. In addition, prayer provides the reorientation that many of the aspects of healing, as described previously, require. For Weil, unmixed attention is prayer.[4] In prayer, one awaits truth, beauty, and goodness from God. In the book of Job, Job laments, and accuses God of many things. At the end of the book, God emerges and questions where Job was when the earth was created, when life was set into motion. Job has not changed God's mind with his petitions and lament; Job has been changed profoundly by his own lament and God's response. Rather than somehow changing God's mind with one's petitions, like Job, humans, not God, are changed by our encounters. Christians receive the gifts of truth, beauty, and goodness in prayer, in waiting for God. As T.S. Eliot writes,

> I said to my soul, be still, and wait without hope
> For hope would be hope for the wrong thing; wait without love
> For love would be love of the wrong thing; there is yet faith
> But the faith and the hope and the love are all in the waiting.
> Wait without thought, for you are not ready for thought:
> So the darkness shall be the light, and the stillness the dancing.[5]

Eliot's admonition to his soul to wait and to be filled with goodness, rather than searching for it, is the disposition that best reflects attention. Eliot finds what he has previously sought when he stops seeking it. Such is a reflection of humanity's fallibility and an

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[4] Weil et al., *Gravity and Grace*, 117.

[5] T.S. Eliot, "East Coker" IV, *Four Quartets*, in *T.S. Eliot: The Complete Poems and Plays* (New York: Harcourt, Brace, Jovanovich, 1971), 127.

exercise in humility which attention requires. Perhaps Eliot's poem is a fitting prayer for the physician who wishes to be attentive, as prayer ought to be at the center of the practice of attention. If perfected attention is prayer, then it is the best method for practicing and developing a habit of attention. Therefore, it should be a priority in the physician's cultivation of attention and interior life.

An Orientation of Enough

Humility plays a large role in attention, the appropriate confidence in oneself, that who one is remains enough. When one can concede that one is enough, one can turn one's attention towards being a recipient of gift, rather than actively fighting to prove worth to oneself or others; one can freely acknowledge the gift of truth, beauty, and goodness and accept them as gift, rather than something one can attain oneself. In a competitive field, appropriate humility is difficult. This waiting and humility cannot be confused with a lack of diligence. It does not mean every effort is not put into providing patients excellent care. On the contrary, an orientation of enough both allows the physician to receive from the patient and allows the physician to ask for help when needed, as the physician understands that she is enough and is confident enough to ask for help without it feeling demeaning. This "orientation of enough" is simply a relaxation from the striving and seeking that plagues our culture; it entails a basic understanding that one will never know everything and be able to solve every problem. This orientation is, ultimately, one of peace, which allows for greater communion with others and reception from them.

Henry Nouwen writes, "Anyone who wants to pay attention without intention has to be at home in his own house – that is, he has to discover the center of his life in his own heart. Concentration, which leads to meditation and contemplation, is therefore the necessary precondition for true hospitality."[6] Nouwen compares one's heart and mind to one's home. In order to invite reality to penetrate one's minds through attention, one must first be comfortable in one's "home." This comfort derives from a contentment with what one has accomplished and all that one is, a contentment which can wait in humility for a gift from the other, described above as an "orientation of enough." Nouwen illuminates the path to this orientation: prayer and contemplation. It is through careful cultivation of a prayer life that one may find peace in being enough, seeking help, and receiving the gifts from another.

Patient, Not Technology as Focus

Studies have demonstrated that use of technology can encourage relationship between patient and physician, and therefore, can make a patient feel attended to and valued. A systematic review found that multiple studies reported EMRs as aiding in "communication, clarification, and discussion." [7] In these studies, many of the physicians used EMRs as a tool for education and sharing of information, as well as a storage for

[6] Henri J. M. Nouwen, *The Wounded Healer: Ministry in Contemporary Society*, 1st edition (Image, 2013).

[7] Maria Alcocer Alkureishi et al., "Impact of Electronic Medical Record Use on the Patient–Doctor Relationship and Communication: A Systematic Review," *Journal of General Internal Medicine* 31, no. 5 (2016): 548–60.

notes and data. As a mediator of interaction, the distancing that technology causes can be mitigated and, potentially, minimized. However, while it can be used to mediate communication, one must be aware of the risks of technology for attending well to suffering. A continuous reminder that the human being is the patient, rather than the computer, must be on the mind of a physician who uses EMRs.

If possible, the use of a clinical scribe may aid greatly as a practical action to increase physician attention while still utilizing an EMR. One such study interviewed patients, scribes, and physicians, and feedback was found to be positive, especially as it related to the physician's attention.[8] The collective response to clinical scribes from the three populations in the study was positive.

> One patient described, "with computers, the concentration is on the computer screen and not on the reactions of the patients." The scribe's presence helped remove the computer as a distraction. One patient declared, "I felt like I was being attended to by a person… I felt more cared for today, than I have [in the past] …I think it matters when somebody is talking to me and not to a computer." … Another physician stated, "I'm able to talk directly to the patient, which improves my listening ability, which improves my diagnostic ability, 'cause I'm listening to the story, I'm not looking at a computer."[9]

The use of a scribe allowed a physician to pay full attention to the true object that warranted the attention, the patient, rather than an abstraction of the patient found in medical records. Scribes come with concerns over proper documentation and

[8] Chen Yan et al., "Physician, Scribe, and Patient Perspectives on Clinical Scribes in Primary Care," *Journal of General Internal Medicine* 31, no. 9 (2016): 990–95.

[9] Yan et al.

communication, but, if properly trained, offer a wonderful opportunity for the physician to have fewer distractions in the exam room.

If a physician is unable to utilize a scribe, attention can be refined through a habit of minimal note-taking during clinical visits. If a physician can simply write down only the most important points during the clinical visit, greater attention can be paid to the patient, rather than the computer or EMR. After the physician has left the room, these notes can be added to the EMR or patient's medical chart. While this may require more time, it may have a profound impact on the physician's attention, and therefore, the healing of the patient.

On a very practical note, leaving one's cellphone in an office or car could contribute to attending well to patients. As was discussed in the previous chapter, the mere presence of a cellphone distracts individuals, whether or not it is receiving notifications.[10] The modern era is one of constant communication in a multitude of forms, some helpful and others not. The cellphone is helpful for some, but such communication is not a priority when there are patients to be seen. As one study demonstrated, putting distance between one and one's cellphone frees up attention for the task at hand.[11] Therefore, it seems to be a simple practice, but impactful all the same, to leave one's cellphone in an office or other place that is not one's pocket or hand.

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[10] Ward et al., "Brain Drain."

[11] Ward et al.

The Ministry of Holding One's Tongue

Bonhoeffer reminds Christians that "the ministry of listening has been committed to them by Him who is Himself the great listener and whose work they should share. We should listen with the ears of God that we may speak the Word of God."[12] As a physician, one may have to learn the art of holding one's tongue. As the keepers of much information during the clinical visit, it may become difficult to listen, rather than speak. However, by holding one's tongue, there are practical and spiritual benefits.

As previously discussed, patients most likely will not take up a significant amount of time if allowed to finish speaking at the beginning of the clinic visit.[13] However, by allowing the patient to speak, one may make them feel valued and heard amidst suffering. By listening, one may be giving the patient room for lament. In the Book of Job, Job's friends sit in silence for seven days with him as he grieves his great losses. Job's lament that follows causes his friends to respond with justification and reprimands. There is no room for the scream of Job in the cacophony of voices that attempt to justify or explain his suffering. It is in his lamentation that Job joins the tradition of lament that is common in the Bible and Jewish tradition. Lament is not simply a cry into a void, but a cry against perceived injustice to a God whom one believes is good and loving. Lament is important in understanding one's narrative, an aspect that will be discussed in depth below. When one is allowed to lament, one may find comfort and hope in the reorientation of one's

[12] Bonhoeffer et al., *Life Together*.

[13] Epstein et al., "Soliciting the Patient's Agenda."

soul, as Job did. Lament can be balm for the suffering individual through the provision of comfort and hope. However, this lament is only possible in the exam room in the silence and attention of the physician.

Conforming to Imago Dei

For most of this analysis, I have focused on the ways in which physicians can model care after Christ, seeing themselves as co-practitioners with Him. However, Christ not only practices alongside physicians, but in attending to the suffering the physician can see Christ looking back at her in the eyes of the sufferer. The *imago Dei* stares back at her, encouraging her to receive its full truth. Christians must acknowledge the embodied reality of humans, who are inherently, physical images of God and his glory. Conyers concludes:

> The biblical writers – the prophets and the Apostles – knew that ultimately we become conformed to that to which we most faithfully "attend." And to say that we are made in the *imago Dei*, means that that is the image for which we are made to conform. Attentiveness, faithfully engaging the truth, is the beginning and the true mark of progress of a genuinely human life. It is also the process out of which a human community comes into being. For the ends toward which we each are drawn, proves finally, to be the ends toward which we all are drawn in our several ways. Thus the openness of life toward the truth is also the openness of life toward one another.[14]

Humans are made and called to act as the images of God. Conyers argues, in accord with Scripture, that individuals conform to that which they attend. Humans are made in the image of God, and therefore, ought to attend most faithfully to the image of God. It is this image which is found in the other, in suffering patients and in the physician herself. As

[14] Conyers, *The Listening Heart*, 127.

such, Conyers encourages attentiveness to each other and a subsequent openness. The first step to attending to the image of God is to recognize that the image of God resides in every person, including the suffering individual. The physician, in attempting to conform to the image of God, must attend to the image of God in the sufferer. Jesus Christ suffered greatly in his Passion. The suffering individual reflects the image of God in a unique way, and therefore, one which must be attended to.

When attending to the image of God, one must set aside prejudice or assumptions, as one must with all attentiveness. Dietrich Bonhoeffer, in *Life Together*, describes the effects of allowing the image of God to be shown in others, rather than shaped by our own preconceptions.

> Now he can allow the brother to exist as a completely free person, as God made him to be. His view expands and, to his amazement, for the first time he sees, shining above his brethren, the richness of God's creative glory. God did not make this person as I would have made him… I can never know beforehand how God's image should appear in others... But God creates every man in the likeness of His Son, the Crucified. After all, even that image certainly looked strange and ungodly to me before I grasped it.[15]

Bonhoeffer encourages Christians to be attentive, in line with Weil's description, and open to receiving the reality of the image of God in another, uncorrupted with one's own preconceptions or thoughts over the ways in which this image is presented. This may allow one to see God's glory, even amidst great suffering and weakness. One does not presume that God's glory is found in majestic power alone, but instead is revealed as well in the fragility of human life, especially in the suffering individual. Therefore, the

[15] Bonhoeffer et al., *Life Together*.

physician must not bring preconceptions in seeing the image of God in the suffering individual.

Not only should the image of God be recognized and received without preconception, but full attentiveness to this image, and therefore, the patient, entails reverence. C.S. Lewis exhorts the Christian to remember the image of God in his neighbor and to stand in awe of it. Lewis writes, "Next to the Blessed Sacrament itself, your neighbor is the holiest object presented to your senses. If he is your Christian neighbor, he is holy in almost the same way, for in him also Christ *vere latitat* – the glorifier and the glorified, Glory Himself, is truly hidden."[16] When the Christian physician can recognize imago Dei in the suffering patient, it can and should transform the ways in which she sees the patient. In the face of God, reverence and silence ensue. Likewise, the physician should be reverent in the face of imago Dei, in all humans, including the suffering patient. This orientation and reverence towards imago Dei ought to induce greater attention from a physician.

Reintegration into Community

Attention and Asking the Right Questions

As with many of the traits that will be described, reintegration into community depends upon an understanding of the patient himself. The physician may not know if the patient has a robust or absent support network if this has not been a question asked during

[16] C. S. Lewis, *Weight of Glory*, HarperCollins REV ed. edition (HarperOne, 2009).

the visit. While this may be documented by a social worker or another member of the healthcare team, the physician may be the first point of contact to assess this. If attentive enough, the physician may not need to directly ask, but the level of support or community may be inferred from various stories or signs from the patient.

However, there are various instruments available to the physician or social worker to assess social support.[17] Instruments such as the Social Support Scale (SSS) measure interactions and relationships through patient responses to nine items, while scales like the Satisfaction with Social Network scale (SSNS) measure the patient's perception of social support. While varied and plentiful, these scales provide a starting point for both conversations around social support and a basic understanding by the physician of the patient's social network. These surveys can be administered by social workers or filled out with the other paperwork the patient may be required to complete. In either case, it is important for the physician to review the results of the assessment. Otherwise, it is much more difficult to understand, and therefore, intervene to reintegrate the individual into community and relieve social suffering.

To Whom Shall They Turn?

Once a physician has determined that a patient may need additional support, it is essential that the physician is knowledgeable about the resources available and be familiar with each. Providing information to the patient about such resources is critical.

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[17] See C. A. Heitzmann and R. M. Kaplan, "Assessment of Methods for Measuring Social Support," *Health Psychology : Official Journal of the Division of Health Psychology, American Psychological Association* 7, no. 1 (1988): 75–109. for a thorough evaluation of the many social support scales in use in clinical practice.

These resources can be individuals who are able to connect the patient with a larger community or a structured community itself.

One such resource is the Church. To avoid proselytizing, it is vital that the physician understands the patient's religious beliefs prior to referring an individual to a church. There is potential for concern when there seems to be a significant power differential between the provider and patient. However, if the patient's religious preferences are evaluated through tools such as FICA, which looks at the faith, the importance of beliefs, community, and impact on care, this concern may be alleviated, as the physician can align resources and suggestions with the patient's beliefs.[18] The FICA tool may be filled out when the patient is doing paperwork, with the nurse, or with the physician. In any of these cases, doing the assessment is not enough. The assessment is not for the gratification of the patient, but for the physician to have information to act upon and discuss with the patient.

A church may or may not be a deep and abiding community through suffering that can even alleviate the potential suffering caused by lack of community. Each church is bound to be different, and a physician can refer to the chaplain, if one is available, or another knowledgeable member of the healthcare team to try and find a good match for the patient. However, the physician must first be aware that the patient is enduring suffering from a lack of a spiritual community or a community in general; this awareness

[18] Borneman, Ferrell, and Puchalski, "Evaluation of the FICA Tool for Spiritual Assessment."

can only come from attention to the patient, prioritizing the assessment of a patient's spirituality, and following up on the results of the assessment.

In the case of the non-religious patient, and even many religious patients, support groups may be an excellent resource. As discussed in the previous chapter, support groups often encourage members to seek more social support beyond the group itself.[19] Referral to a support group may induce this same behavior in a patient, ending isolation and the suffering that stems from it. In this case, it is the duty of the physician to be aware of and knowledgeable about the various support groups in the area, or to have a designated healthcare team member, such as a social worker, able to refer patients to these resources.

The Presence of the Medical Team

While providing the patient with outlets, such as support groups or church communities, can lead to healing and community integration, such action does not exempt the provider from acting as a supportive presence to the patient. Daniel Sulmasy writes:

> Health care professionals need to do everything they can to heal the fear and regret of their patients. They need to let the dying know that even as the bonds that connect them to the community of the living are in one sense dissolving, in another sense they remain closely connected to those who will remain and even to

[19] van den Heuvel et al., "Long-Term Effects of a Group Support Program and an Individual Support Program for Informal Caregivers of Stroke Patients."

> those who have gone before and those who are yet to come – connected through a network of compassion and love.[20]

While the physician may not be able to ensure physical healing, she may be able to remind the patient of the medical team's constant presence amidst the pain and suffering, presence which serves as consistent community through the network of compassion and love that Sulmasy describes. Amid uncertainty or even certainty of pain and death, the presence of the medical team may act as a soothing balm that one may not have to suffer or die alone or with strangers.

This may be especially necessary amidst great suffering that cannot be healed or cured. When medicine runs out of resources, perhaps the greatest consolation is a reminder that, like Job's friends at the beginning of the book, the healthcare team will be present amidst the suffering. As DeVries writes, "Again the throb of compassion rather than the breath of consolation: the recognition of how long, how long is the mourners' bench upon which we sit, arms linked in undeluded friendship, all of us, brief links, ourselves, in the eternal pity."[21] In the face of defeat or uncertainty, the physician can sit on the mourners' bench with his patient, arms linked in friendship.

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[20] Sulmasy, *The Healer's Calling: A Spirituality for Physicians and Other Health Care Professionals*, 82.

[21] DeVries, *The Blood of the Lamb*, 246.

Community Roles

In addition to the formation of community, restoring the specific role the sufferer holds in the community may be vital. Eric Cassel writes, "By middle age, the roles may be so firmly set that disease can lead to the virtual destruction of a person by making the performance of his or her roles impossible. Whether the patient is a doctor who cannot doctor or a mother who cannot mother, he or she is diminished by the loss of function."[22] While Cassel's assessment that the person is diminished by the loss of the community role may be extreme and demeaning to the sufferer, it may aid in understanding just how important roles are to the individual. Therefore, ensuring that the sufferer is not enduring unnecessary suffering from a lack of fulfillment of roles. This may mean physicians seek interventions that, while do not cure the individual of the disease, enable her to fulfill roles that she found fulfilling, such as caring for children, working in a garden, or leading a Bible study. Restoration to these roles may be possible without cure and may necessitate novel and personalized treatment. However, if the physician is unaware of these roles, restoration may be impossible. Therefore, it may be helpful to ask what activities the patient finds most meaningful and discern whether it is possible to direct treatment in a way that makes these activities possible.

In addition to the restoration of roles, the sufferer may be able to find fulfillment and healing in new roles. Jean-Dominique Bauby, the former editor of French *Elle*, was

[22] Cassel, "The Nature of Suffering and the Goals of Medicine."

forty-three years old when he suffered a massive stroke that left him "locked-in."[23] Unable to communicate or move any body part besides his left eye, Bauby was left with a profoundly different life than before his stroke. Towards the end of his book, *The Diving Bell and the Butterfly*, Bauby concludes, "I have indeed begun a new life, and that life is here, in this bed, that wheelchair, and those corridors. Nowhere else."[24] Although Bauby is not able to edit the pages of *Elle* or play outside with his children, Bauby recognizes that he has a new role, a new life, in the hospital. Rather than a resignation to fate, Bauby's recognition comes with a sense of renewal, of healing. In finding a new role, Bauby encounters profound healing for the suffering which plagues him throughout most of his book. In the same way, physicians may help direct patients towards new roles in the community that the sufferer may find fulfilling.

Provision of Comfort and Hope

Honesty and Uncertainty

Although seemingly the opposite of comfort, uncertainty can play an important role in medical care and the provision of comfort and hope. A.J. Conyers writes, "It is the acknowledgment of a reality- an awakening and a strengthening – rather than the anesthetic of wishes. Intuitively, when we are faced with the honest picture of our

[23] Jean-Dominique Bauby, *The Diving Bell and the Butterfly: A Memoir of Life in Death*, trans. Jeremy Leggatt (Knopf Group E-Books, 2008).

[24] Bauby, 129.

situation – our limits, our mortality, and our pain – we begin to think we are on to something. Truth is the prerequisite of hope."[25] Perhaps uncertainty is not mutually-exclusive with hope or comfort. Rather, it may be the truth of the situation which brings ultimate hope and comfort. Medicine is ultimately limited, and it often demonstrates these limitations in the face of immitigable suffering or pain. Therefore, it is in the face of suffering that physicians must admit uncertainty. However, uncertainty without comfort does not induce hope. Physicians, while admitting that they may not know, must also remind the patient of the sustained presence of the medical team, as well as of the diligence of the team to do all that it can to heal the patient. Admitting uncertainty in healthcare requires great humility of the physician. Consistent prayer for humility and practicing humility in other settings may set up a physician well for the time in which he is uncertain.

Narrative Formation

Thomas Long draws upon Alasdair MacIntyre's ideas of human life narratives to discuss narrative unity in clinical experiences.[26] Long notes that life is not based merely upon chronological events, but rather, there must exist a greater unity within this narrative. Long posits that it is this framework of unity into which treatment, illness, even death must fit.

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[25] Conyers, *The Listening Heart*, 127.

[26] Thomas A. Long, "Narrative Unity and Clinical Judgment," *Theoretical Medicine and Bioethics* 7, no. 1 (1986).

> To seek a patient's well-being is to presuppose some framework of meaning already in place. Lowering an elderly patient's temperature or controlling his urinary tract infection is not necessarily a contribution to his well-being. The patient may feel better physically, yet be even more unhappy than before his hospital admission. The clinician who seeks the patient's well-being is necessarily constrained by the narrative unity into which he or she has entered. When physicians fail to perceive such unity in their patients' lives (assuming it is present), then clinical medicine, however scientifically well-founded its judgments may be, can enhance patient well-being only by accident. The situation is graver when patients themselves lack any sense of narrative unity, for medicine becomes impotent to bring about or enhance patient well-being, even by accident, if there is no "intelligible narrative" to ground questions about "better or worse" treatments.[27]

Long asserts that it is essential not only for the patient to possess a spiritual unity, but for the physician to understand this operational framework and the ways in which it relates to treatment and care. In this way, the patient's goals are taken into account and well-being can actually be pursued.

Hans Reinders posits that one of the greatest sources of anxiety for patients is the gap between the past and present that is found amidst illness.[28] It is this gap which causes anxiety and suffering for many as they struggle to understand how the gap between the "before" and "after" can be bridged. Reinders points out that in the midst of disaster, God promises that "in Christ 'all things hold together.' This means that there is a place to go when trying to bridge the gap between the 'before' and 'after.'"[29] It is this promise that Reinders defines as God's Providence. If this is so, then the bridge in the narrative is

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[27] Long, 120.

[28] Reinders, *Disability, Providence, and Ethics: Bridging Gaps, Transforming Lives*.

[29] Reinders.

contingent upon Christ and is an indication that suffering is not separation from, but an experience which brings the sufferer intimately close with God. While the physician may not take the time to theologically explain the unification of the sufferer with Christ to her patients, a recognition of this theology can allow for the prioritization of the formation of a "healthy" or meaningful narrative by the patient. The physician recognizes the importance of this narrative and pays greater attention to the ways in which the narrative is expressed by the patient. It perhaps also equips the physician to begin to process patient narratives and her own narrative through this understanding of Christ as the ultimate bridge and sustained promise of the story.

As part of narrative formation, not only can the patient find a bridge between the past and future, but may be able to connect his narrative with that of others or with a greater narrative that points to hope beyond this life. This is the key of narrative formation in healing and encountering suffering. Narratives are not useless or simply gratifying; narratives bind us together and to a God who has a story as well. In connecting with others, individuals may find hope in the outcome of the other's narrative or in simply forming a type of communion within the narratives themselves.

Pope St. John Paul II writes, in *Salvifici Doloris,* "Sacred Scripture is a *great book about suffering.*"[30] From Genesis to Revelation, suffering abounds in Scripture. Jesus Christ suffers. He sweats blood, is scourged, abandoned, and hung on a Cross to die. If a

[30] Pope John Paul II, *Apostolic Letter Salvifici Doloris of the Supreme Pontiff John Paul II to the Bishops, to the Priests, to the Religious Families and to the Faithful ... Church on the Christning of Human Suffering*, New edition edition (London: Catholic Truth Society, 1984).

patient's narrative perhaps becomes cohesive in the light of an all-loving God who brings justice and peace to the suffering, that the world we see is not the end, perhaps hope will be abundant. For the patient, the suffering may point to both the pain and hope of the Cross upon which salvation and joy rest, from which love erupts endlessly. This is not an easy task. It does not suddenly take away suffering, but it may be a way for the patient to make sense of suffering in a meaningful manner, one which allows him to cope and, ultimately, find hope in the midst of suffering.

However, communicating this to patients is another matter, beyond simply understanding that this narrative and theology can bring hope to patients. Often, this may be the chaplain's role to spend greater amounts of time working through these ideas with the patient. In this case, it is the duty of the physician to recognize the need for a referral to a chaplain, one who can work through these complex narratives and theology with the patient. This may also be an opportunity to refer an individual to a church community, if deemed appropriate.

Then, how does a physician encourage narrative formation in patients? First, simply allowing the patient to speak and articulate the changes in his life may contribute to the formation of a cohesive narrative. Again, this may entail the virtue of attention and the action of listening. The silence that the physician leaves may be filled with lament or the patient working through the story and meaning of his illness. A physician may also encourage journaling or counseling, both of which often naturally encourage narrative formation. In addition, support groups often allow for the sharing of narratives and, in the

process, connections between these narratives. All three of these activities serve as excellent resources for the physician to point patients to.

Reaffirmation of Value and Wholeness

Changing Expectations

Modern culture covets the perfect body, one that is youthful and fit. Thomas Reynolds describes this covetousness in North America as a "way of fetishizing beauty and virility," one that establishes a "cult of normalcy."[31] Bodies which do not conform to this "cult of normalcy" are considered "disordered." Medicine and treatment are usually geared towards this sense of "normalcy", and when the "disordered" body cannot be conformed to this standard, medicine expresses frustration and exhaustion, or goes to greater lengths to accomplish this goal. As a result, many patient's wishes are either ignored in the pursuit of this "perfect health," leaving suffering unattended, or the patient is subjected to more intense treatment that may only increase suffering. Eric Cassel, in "The Nature of Suffering and the Goals of Medicine," recounts the case of a breast cancer patient whose suffering was only increased by the treatment, as the treatment left her unable to sculpt and with a more masculinized appearance.[32] However, treatment was aimed at the cure of the disease, the pursuit of a "healthy" body. In the process, the

[31] Thomas E. Reynolds, "The Cult of Normalcy," in *Disability*, vol. 45, Christian Reflection: A Series in Faith and Ethics (Waco, Texas: The Center for Christian Ethics, 2012).

[32] Cassel, "The Nature of Suffering and the Goals of Medicine."

patient's goals and values were sacrificed. Perhaps the goal of medicine is not the pursuit of this coveted body, but the well-being of the patient. The change in expectations, from perfect to well-being, reorients the goals and the means to achieve them in a way that affords the patient dignity and hope for healing.

Rather than an end to suffering or cure of disease, a physician can aim for the well-being of the patient, a goal which ultimately is set within the patient's own narrative and value-based framework. In the case of Cassel's example, the wishes of the patient would be accounted for in determining treatment, rather than assuming the best route was the one that led to a cure. When the physician is able to recognize cultural expectations and values placed upon perfect health, the physician can truly understand and account for the sources of the patient's suffering in the treatment of the illness, as the goal is not blindly pursuing health, but the pursuit of the patient's well-being.

Partnership and Voice

Perhaps one of the most effective ways to remind the sufferer of value is by valuing her voice in her own healthcare. This can be done in a multitude of ways. First, as was discussed with attention, simply listening to patient concerns can make them feel heard, and allow the healer to know the values that the patient vocalizes. In both Cassel's example of the woman with breast cancer and Long's example of the hospitalized elderly man, the importance of this partnership becomes clear.[33] Allowing the patient to act as a

[33] Long, "Narrative Unity and Clinical Judgment"; Cassel, "The Nature of Suffering and the Goals of Medicine."

partner in care may make a healer aware of specific goals that relate to other discussed characteristics, such as fulfilling community roles or even the ability to continue a hobby. Goal-setting with patients is an important aspect in determining the best line of treatment for a patient. While this should not turn into consumerism, with the patient completely dictating care, it does acknowledge the individual's value and participation in his own body and healthcare.

In addition, this partnership speaks to a covenant, of sorts, between the physician and the patient. At many practices, patients are handed sheets listing both patient rights and responsibilities. In William May's analysis of the physician's relationship, he concludes that the physician's relationship with a patient is more like covenant than contract.[34] This covenant is marked by "generosity, love, and fidelity."[35]A covenantal partnership, in which both contribute to the care of the patient, is required between physician and patient. This rejection of total paternalism allows the patient to be heard and valued. While the simple act of hearing a patient's goals and concerns may relieve suffering, greater suffering may also be avoided by determining treatments which respect the goals, values, and priorities of the patient.

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[34] William May, *The Physician's Covenant*, 2nd edition (Lexington, KY: Westminster John Knox Press, 2000).

[35] Anthony L. Suchman, Patricia Hinton Walker, and Richard J. Botelho, *Partnerships in Healthcare : Transforming Relational Process* (Rochester, N.Y.: Boydell & Brewer, 1998).

Physical Exam

The administration of a physical exam is key to the engaged nature of physical touch in the clinical visit. As was discussed previously, physical touch is an important indicator of comfort and concern to the patient. While a physician might not take the time to do a full-body exam, taking a minute or two to do a brief physical exam may comfort the patient. Whether the comfort comes from a reminder of the presence of others amidst suffering, or from a knowledge that the medical team is doing all that it can to heal, such comfort is necessary and soothing for the suffering soul.

In addition to the physical exam, a simple touch of the hand or shoulder may be warranted, and may provide comfort and hope to the suffering individual. Roger Kneebone distinguishes between a "gnostic" and "pathic" touch, with the former being touch intended to relay diagnostic information and the latter with the intent of communication and comfort.[36] Kneebone recognizes the changing place of "gnostic" touch in diagnosing patients, but warns against the loss of "pathic" touch in care, as it remains as important as ever. Perhaps physicians must recover the attitude of the Early Church, one in which to "lay hands" on someone was seen as essential to healing, not for diagnostic reasons. Diagnostic technology makes "gnostic" touch seem antiquated, but should not make physical touch, especially "pathic" touch seem to be the same.

[36] Roger Kneebone, "Getting Back in Touch," *The Lancet* 391, no. 10128 (2018): 1348–1348.

Embodiment

It must be recognized that patients themselves are embodied, and the physicality of their lives is important, and not secondary, to the spiritual dimensions. The power of touch reminds both physician and patient of the very real embodiment of each human. Daniel Sulmasy writes:

> A clasp of the hand will often be enough. Like the woman who touched the garment of Christ, and like the patients who touched the toe of the statue at Johns Hopkins, the sick look for healers. If Christian clinicians are healers, then they will know not just a faceless crowd of nobodies, but the embodied somebodies who have touched them. They will, in turn, be touched by the power of the Holy One.[37]

Sulmasy compares the role of "pathic" touch in the clinical visit to the recognition of the hemorrhaging woman by Jesus. To Jesus, she is not simply a faceless human; she is an embodied woman whose touch has intimately connected healer and sufferer. In turn, Christian clinicians should recognize the power of touch to connect embodied creatures. This embodied nature must be reflected upon and understood by physicians. Rather than a prescription of when touch is appropriate and the methods for doing so, this kind of communication requires an orientation of the soul, one which understands and values embodiment and relationship. Although this seems a vague suggestion, the practical aspect is a constant orientation of prayer, an orientation which calls upon God for understanding, as well as the charity to attend to the sick, a corporal work of mercy. Considered a corporal rather than spiritual work of mercy, caring for the sick is inherently physical. Therefore, it remains essential to remember that, even when

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[37] Sulmasy, *The Healer's Calling: A Spirituality for Physicians and Other Health Care Professionals*, 84.

considering suffering that is non-physical, that the body, and therefore, the entirety of the person, matters.

Conclusion

The cultivation of these characteristics and dispositions is not easy. However, as outlined above, there are practical steps that individual physicians can make in order to encounter the suffering of their patients faithfully and fruitfully. For many of these practices, attention is the key starting point to recognizing the areas in which the physician can faithfully encounter and heal the suffering of patients. In addition, many require a deep recognition of the embodied image of God in each patient, conferring reverence that ought to pervade all encounters with patients. Such an orientation sets the physician up well to seriously and faithfully sit in the presence of suffering individuals.

CHAPTER SIX

Conclusion

In the previous chapters, I have attempted to articulate practices for modern day healthcare practitioners that reflect the model of Jesus Christ in attending to suffering individuals. In Chapter Two, I identified key aspects of healing into through which Christ encounters suffering and heals in the Gospel of Luke: attention, reintegration into community, affirmation of value and wholeness, provision of comfort and hope, and physical touch. In Chapter Three, I traced the utilization of these characteristics in the Early Church, from Basil's careful attendance to the bandaging of wounds to Gregory of Nazianzus' exhortations to attend well to lepers. However, as discussed, the Early Church struggled theologically with the interactions between holiness and health, as well as the isolation and fear of lepers. In Chapter Four, I described the five aspects of healing as variably rejected or utilized by the modern healthcare system, with many rejected by both systemic and cultural trends. Finally, I described key practices for physicians to cultivate lives and practices that faithfully encounter the sufferer and utilize these aspects of care to facilitate healing.

It is these practices that may help physicians to orient their practices around faithfully encountering suffering, to counter the deficit noted earlier by Larchet, a profound lack of resources for individuals to cope with or heal amidst suffering.[1] In the

[1] Larchet, *The Theology of Illness*.

midst of great suffering and a confrontation between immitigable pain and a lack of resources to cope with it, these practices may be the key to healing for many patients, and a fruitful spiritual exercise for the physician.

Future Directions

Clearly, the variations of suffering are infinite and even similar events or illnesses are borne and understood differently by different individuals. There are many aspects of healing, far more than could be discussed, many of which may be the responsibility of individuals outside of the healthcare system to address. For example, the role of clergy in addressing the spiritual health of ill parishioners is an important discussion and one that needs to be addressed by individuals in the field. Other discussions concerning nursing, palliative care, and social work and their interactions with suffering must be continued and expanded upon. In addition, interfaith dialogue and the ways in which physicians and patients of different faiths may walk alongside one another remains to be discussed. There are evidently many branches and questions within this field, all of which remain important, but simply beyond the scope of this discussion.

In addition, the practices described are simply some of many; there remains no single pathway to any of these aspects or actions of encountering suffering. I have simply chosen prominent and practical ways for individuals to cultivate this method of encounter. At the heart of each of these is a habit of prayer, of continually receiving truth and, more importantly, grace from God. Specific habits of prayer were not a focus of the discussion, but many Christian denominations offer different forms of prayer that will

contribute to a physician's cultivation of an interior prayer life. Prayers of humility may be of particular importance, especially for the physician looking to learn and grow.

Another limitation of this discussion is the scope of change that has been proposed. The practices I have outlined are specific to the individual. Admittedly, large-scale changes to the operation of the healthcare system are necessary in order to provide suffering individuals with the greatest chance for healing. Issues such as poverty-induced disease, lack of access to healthcare, and shortening clinical visits are driven by systemic processes, rather than individual physicians, yet all have an immense impact on the suffering of individuals all over the world. These changes are simply beyond the scope of this discussion, but nevertheless, gravely important for future discussion.

The Walk to Golgotha

Physicians are called to bear witness to suffering. However, the physician cannot merely stand in the crowd, watching a patient bear the weight of suffering so great it bends the back. The physician must walk along the Way of the Cross, the path to Golgotha with others.

This pathway is filled with individuals who are bearers of *imago Dei*, and one must attend to them as one would to Christ. For Christ reminds us, "just as you did it to the least of these who are members of my family, you did it to me" (Matthew 25:40). Physicians must walk alongside Christ in the sufferer each day. In this journey, grace and ultimate meaning are exposed amidst the ultimate suffering. As Nicholas Wolterstorff writes in *Lament for a Son*, "Suffering is down at the center of things, deep down where the meaning is. Suffering is the meaning of our world. For Love is the meaning. And

Love suffers. The tears of God are the meaning of history."[1] In the Christian tradition, suffering and joy are not mutually exclusive; both are present in abundance in the Cross. In Christ, humanity and life find ultimate meaning, and in Christ, is found the greatest suffering. In walking the path to Golgotha, one may encounter Christ in the *imago Dei* of the wounded patient, and in this image, find deep and fulfilling meaning.

But the physician will inevitably fail and fall. She will look the other way in indifference or preoccupation, eyes fixed away from the Way of the Cross. She will neglect to carry the weight of the Cross, allowing it to bear down upon the sufferer. But in everything, there is grace. In failure, Daniel Sulmasy prays:

> Bless me, Father, I am a frail human being. I need to be reminded of God's love for me, a wounded healer who isn't exactly perfect (despite what his patients seem to think). I need to hear words of reconciliation and peace. I am threatened, in a radical sense, by my inadequacy to the task of healing. And I need to be saved from this.[2]

Sulmasy's prayer is one which all physicians must echo. Along the path to Golgotha, there are falls and failures, but the God of infinite grace offers reconciliation and peace, if only one cries out to Him.

C.S. Lewis concludes, "the cross comes before the crown and tomorrow is a Monday morning. A cleft has opened in the pitiless walls of the world, and we are invited

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[1] Nicholas Wolterstorff, *Lament for a Son*, 1st edition (Wm. B. Eerdmans Publishing, 1987), 90.

[2] Sulmasy, *The Healer's Calling: A Spirituality for Physicians and Other Health Care Professionals*.

to follow our great Captain inside."[3] Along the Way, one may recognize Christ dually beside her, both in the ways in which she practices medicine and in the image borne by each patient. Great glory and grace wait in the Cross, but the suffering cry out, so the physician must help bear the yoke, walk the path to Golgotha, and faithfully encounter and heal the suffering along the way.

[3] Lewis, *Weight of Glory*, 45.

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