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Sacramental Resources Underused in Care

By FR. BRUCE T. MORRILL, SJ, Ph.D.

The innate human drive for survival — one's own, as well as that of those for whom we find ourselves (in any number of personal and social ways) responsible — contributes to human efforts to do something when a life is threatened. In the moment of medical crisis, that is, a turning point exerting urgency in changed conditions, the seemingly innate reaction on the part of all is: "What can be done here?" The moment of crisis is a moment of decision, a time neither for ruminating over the meaning of life and death, nor for initiating practices meant for long-term, sustainable nurturance of body and soul. That means, however, that all concerned in a given situation of dying — both medical and religious professionals, as well as the patient and loved ones — largely respond out of habits of mind and body, training and belief. While these may often conflict or at least vary as to priorities and expectations, I would argue that what characterizes the response of all is practicality: "What do we do now?"

The thought of a terminal prognosis no doubt brings to modern minds, first and foremost, the expertise of physicians and medical colleagues assessing the situation with a view to the appropriate practical steps to be taken. This is because we live in a society wherein biomedicine (a convergence of science, technology and economics) dominates and is esteemed as having the power to deliver practical results. We nonetheless would do well to recognize that the professional pastoral response —

whether by lay or ordained ministers — is no less practical and, moreover, when no further medical interventions are possible, becomes the primary form of care. Once the limit of biomedical practice has been reached, the vast majority of doctors withdraw abruptly, leaving the patient to the palliative care of nurses, the pastoral care of ministers and the loving care of family and friends. In the final stage of dying, hospital chaplains take up the key role in service not only to the patient, but also

to the other remaining caregivers.

Just as medical practice shifts once a patient's status changes from serious or critical to terminal, so also the pastoral-sacramental rites of the Roman Catholic Church shift from those comprising the pastoral care of the sick to the subsequent pastoral care of the dying. The rites of the church, as reformed after the Second Vatican Council, include a series of complementary and progressive sacramental and other prayerful rituals sensitive to the stages of illness and dying. The regrettable irony, however, is that, even now, some 40 years on, these rites are widely underused because they are misunderstood and, thereby, ignored. People and ministers fall back on awkward words promising to pray for the sick person or, if praying with the person, enlisting a few common prayers. However good those habituated prayers in themselves might be, they stand to be enhanced when they are part of the full — and pastorally flexible — rites for the sick and dying.

THE SACRAMENTS DISTINGUISHED

The sacrament of the Anointing of the Sick provides spiritual, emotional and



possibly even bodily strength and encouragement as soon as a person finds himself or herself struggling with life-threatening illness. Freighted with a history from the Middle Ages to this very day, the sacrament of anointing persists in the thought, imagination and practice of most Catholics — woefully, including some clergy — as “extreme unction,” that is, the anointing as “last rites,” signaling the moment of death. However, from its ancient origins, and even

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in the Counter-Reformation doctrine of the Council of Trent in the 16th century, this sacrament never was intended nor officially held simply to be the sacrament of the deathbed.

The sacrament of anointing is to be repeated whenever a person’s condition significantly declines.

The proper sacrament for the dying is viaticum, a special ritual form of celebrating the Eucharist, to be enacted as soon as possible once a person has entered the active-dying stage. Viaticum, whether administered by clergy or a lay minister, celebrates the Eucharist as food for the journey from this life into the next, that is, into the life eternal promised by Christ to those who eat his body and drink his blood, whom he will raise up on the last day (John 6:54). Viaticum likewise is repeatable and may be ministered daily until death. The ritual book *Pastoral Care of the Sick: Rites of Anointing and Viaticum* (Catholic Book Publishing Corp.) contains a variety of prayers and guidelines for pastoral visits complementing the sacraments of anointing and viaticum.

Why should Roman Catholics, ministers or laity, squander the remarkable treasury of pastoral (divinely compassionate, humanly shared) rites so carefully suited to the dying process? Further attention to the contemporary context will open into an argument for how pastoral ministers and rites (inviting analogous applications in other denominations) may robustly, albeit quietly, take their greatly needed roles at the time of death.

OUR DEATH-DENYING CULTURE

The prayers and rituals in the *Pastoral Care of the Dying* (USCCB Publishing, 2002), like all the sac-

ramental rites of the church, are for the salvation of people, specifically, healing (understood as salving, from the Latin root for salvation, *salus*) the fear and other sorts of psychological and spiritual pain that can arise in the dying process. Thus should viaticum and other elements of the rite normally function as part of a larger pastoral ministry, executed with attention to the needs of dying people and those around them.

The complexity of this medical and pastoral service has generated a growing body of resources in such disciplines as pastoral care and counseling and medical ethics. Anglican pastoral theologian Megory Anderson, founding director of the Sacred Dying Foundation in San Francisco, has gotten to the heart of the matter: “One of the challenges of the pastoral caregiver is that death is not as neat and clear-cut as one might expect.”¹ Not only are the pat-

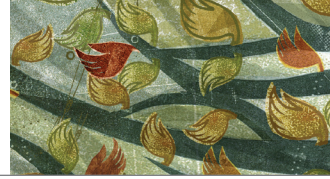
tern and duration of every death unique, often defying common expectations; but also the open-ended ambiguity intrinsic to each death is augmented by practices and attitudes fostered in the death-denying culture of late modernity.

Some cultural critics are skeptical of the claim that ours is a death-denying society, given the endless production of movies, television programs, books — science fiction, romance, fantasy, horror — involving the topic of life after death. That line of argument only betrays the denial entailed in most of the plots’ depiction of the dead as living, active agents continuing to interact (for good or ill) in this present world. For pastoral caregivers, theologians and ethicists, however, the denial in question concerns the painful process of dying, the agony of utter separation and the wrenching event of death itself.

“Suffering and death are facts of life,” argues Jesuit ethicist Fr. Peter Clark, M.Div., Ph.D., “yet most aspects of American culture foster denial of this ultimate reality. Many Americans do not think about death, talk about death, or even want to see it. We have become a ‘death-denying’ society. As a result, American culture has created a ‘conspiracy of silence’ when confronted with suffering and death.”²

Sadly, both health care professionals and friends and relatives often perform according to this cultural mindset as they interact with the mortally ill, a pattern of behavior that exacerbates the fear and isolation patients tend to feel in the wake of learning they are dying.

Many doctors and much of the general population tend to have unreasonable expectations for professional medicine’s ability to achieve cures in individ-



ual cases. The result, observed Fr. Benedict Ashley, OP, and Fr. Kevin O'Rourke, OP, is that doctors tend to disengage from a patient once death is inevitable. These two veteran ethicists compassionately contextualize this general pattern in a highly pressured medical industry whose front-line care providers experience high rates of alcoholism, divorce and suicide. Fear is the problematic emotion here, not only fear in the immediate situation — such as fear of failure in one's professional skills or in one's personal commitment to a patient — but also fear, ultimately, of death itself.

“Because health care professionals are human, they tend to retreat from any phenomenon that causes fear or wonder,” wrote Ashley and O'Rourke. “Death is such a phenomenon; it involves awe, fear, and mystery. For this reason, health care professionals, just like other people, are tempted to avoid facing the evil of death.”³

Family and friends largely participate in this conspiracy of silence, often avoiding conversations with the terminally ill about their prognosis and the time remaining.

Complicating reason and emotions is the growing phenomenon of “managed death,” whereby physicians and technicians deliberate over every new symptom of the dying person, availing themselves of the impressive advances in treatment as each symptom arises. The result is a significant drawing out of the dying process, often devolving into a lengthy or even indefinite period of the patient's hovering near death.

Not only in the medical culture, but also in Christian culture, religious emphasis on God's ability to “save” (here interpreted as “cure”) and a valorization of the patient's “fighting hard” aid and abet the denial of death. The actual realization of death's imminence tends then to come too late for meaningful, unpressured conversations, as well as for sacramental rites and prayer to take place with the dying person and loved ones.

ROLE FOR PASTORAL CARE

If medical professionals remain bound to the pattern of facing death only at the latest possible moment, then ministers and members of faith communities need to provide the care of guiding people who are dying and their loved ones through a more integrative (healing) dying process. The dying frequently suffer from fear of abandonment, pain of separation, grief over major losses in their life, loneliness and depression. The key to pastorally ministering to them, their loved ones and their professional caregiv-

ers is compassionate presence.

The pastoral minister needs not only to establish and sustain an empathetic relationship with the dying person, but also to foster and support mutual commitments of presence between the dying person and his or her family members, friends and the professional caregivers. For Christians, such dependence upon one another makes tangibly present — sacramentalizes — the complete trust Christ put in his Father, even unto death. Such ministry is not a matter merely of telling people Christ suffered with and for them. No, ministers must effect the presence of God's faithfulness unto death through words and actions — proclaiming short passages of Scripture, sharing Holy Communion, repeating simple litanies, conversing if possible, offering apposite prayers from the rich range in the ritual texts.

The sacramentality of the relationship is mutual. Veteran hospital chaplain Gerald Calhoun concludes, “For pastoral ministers the greatest satisfaction in accompanying the dying is not so much their growing in understanding what serious illness and death are all about, but rather that they're encountering the loving face of Christ in the fragility of their brothers and sisters.”⁴

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Given the weighty challenges the dying process, in the environment of modern medicine, poses to such mutual acts of presence, the healing pastoral mission of the church's sacramental-liturgical ministry, a powerful combination of words and actions, would seem to be all the more evident.

MINISTRY THROUGH STAGES OF DYING

Calhoun and Anderson both distinguish between the pastoral needs and, thus, approach, in the initial stages of ministry to the gravely ill person and the final stage (days or hours) when death becomes imminent. The optimal situation, Calhoun argues, is for the pastoral minister to establish a strong relationship with the person and his or her family as early as possible, namely, as soon as illness is diagnosed as serious. Such is the very criterion the church identifies for administering the sacrament of anointing the sick.⁵

Calhoun explains, “most of the crises in a person's

faith occur over a period of time when emotional and physical health is stable enough to concentrate on their relationship with God. . . . Often people encountering terminal illness experience a battle with God concerning the reason for their sickness and God's role in it. They also review their lives in an attempt to find meaning and purpose."⁶

Again, these are the very types of issues the sacrament of anointing intends to heal as part of a comprehensive pastoral ministry to the seriously ill person and his or her family and loved ones. The sacraments of penance and anointing of the sick, as well as ongoing services of Holy Communion, are all pertinent to

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this period in the person's seriously declining condition, even for those who have not been particularly active participants in the sacraments during their lives.

From her own extensive experience of ministry with the dying, Anderson articulates a cautionary observation about the reformed sacrament of anointing. She argues that the replacement of extreme unction with a sacrament for healing the sick often has caused the rite of anointing to parallel the biomedical model such that people look for either/or results: recovery or death. When properly practiced, however, anointing ritualizes what Anderson calls for in these initial stages of dying, namely, fostering a sense of hope for recovery even as prayer for healing must be open to the possibility of death. This is a healthier both/and approach, serving the reality that the person is caught between dealing with serious illness (with its possibility of death) and certain death.

"We must hold in our hands both realities: that all of us want to be made whole and well again; and that all of us must die, and to die we must be ready," she writes. "Holding both of those realities begs for a way to be present in that liminal stage."⁷

For these very reasons, I would argue for the wisdom in the church's prescription that pastors educate their people not to delay requesting the sacrament but, rather, to call for anointing as soon as it becomes clear that an illness is serious. Pastorally informed

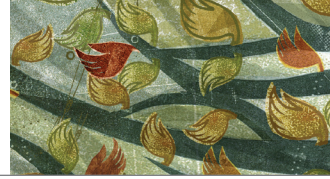
celebration of the sacrament, as well as ongoing pastorally sensitive visits to the seriously sick, and communion of the sick, are vital treasures to be drawn from the reformed tradition in contemporary service to people struggling between serious illness, with the innate hope for recovery, and the probability of death.

When the seriously ill person's body begins to shut down, he or she clinically enters "active dying." Anderson describes this period, which may last anywhere from hours to days, as a highly fluid space "where the soul wanders in and out of the body, with one part in the here and now, and the other part very clearly moving towards the afterlife. The dying often have visions, or conversations with people who are not tangibly present in the room."⁸

These characteristics of the final period give evidence for the church's wisdom in prescribing viaticum's celebration as soon as death becomes imminent, so that the dying person can be as aware as possible of the words and symbolic gestures and, thus, benefit cognitively, spiritually and corporeally from the sacrament. We can only imagine, indeed trust, the extent to which elements of the viaticum liturgy — eliciting both memories through baptismal and Eucharistic symbolism and expectation of the heavenly banquet — may play a role in the imagination and thoughts of the altering state of mind for the dying person.

Should the dying process continue for some time, the provision of viaticum "on successive days, frequently if not daily ... simplified according to the condition of the one who is dying,"⁹ offers further healing support to not only the dying person, but also family, friends and care providers.

Although the focal subject of the dying process is, of course, the terminal patient, still, the patient is not an autonomous subject navigating his or her own passage from this life, let alone an autonomous object of care, medical or pastoral. The entire reformed Catholic ritual process of *The Pastoral Care of the Sick: Rites of Anointing and Viaticum* carries out the Second Vatican Council's mandate that sacraments and other liturgical rites not be mechanistic gestures done to people but, rather, affective and caring ministry carried out with people. Nobody is an autonomous or isolated individual. Even if lying alone in a hospital bed, the patient holds memories of so many others, but when he or she is accompanied bedside



by family and/or friends, the web of relationships is immediate.

Those near to the dying person may themselves — out of fear of the distressingly (sometime shockingly) diminishing body, or lack of words to say, or pain from overwhelming grief, or emotional paralysis due to guilt or unresolved conflict with the dying person — pull back bodily or emotionally. This is why requesting the rites of anointing or viaticum should not be delayed, for the sacramental rituals explicitly bring a third party, an Other — God — into the situation.

By exuding quiet confidence in prayerful leadership, the minister of the rite (always a priest in the case of Anointing of the Sick, but possibly a deacon or lay minister for viaticum, as well as for the other rituals provided for the dying) provides an interpersonal space for people to be present to one another and even to sense divine presence among them. Words in the form of invocations, prayers, biblical passages, intercessions are spoken. Touch — hand-laying, rubbing, embraces or kisses as signs of peace — is effected. This is not to imply that all goes smoothly, without awkwardness, yet all the people around the dying patient are, through participation in ritual, givers and recipients in the moment. Individuals who otherwise might not know how to address or touch the dying person may be strengthened through the formality of ritual gestures.

Then, in the final stage of active dying, when the patient is hovering in and out of consciousness or not aware at all, the short prayers or repetition of simple invocations or even song are comfort and strength not only to the expiring loved one but also — perhaps especially — to those gathered round, who through the ritual support may well attain a sense that their loved one is in good, indeed, divine, hands.

AN EXHORTATION

For all our advanced medical technology, we late-modern Christians are nonetheless poorer at the time of death if we lack knowledge of the content and practices of faith that can bring meaning and healing, once cures are no longer feasible and only palliative care is possible. Here is the poverty of a death-denying culture, one that does not want to practice traditions because they would keep the reality of death on the horizon.

There is also the poverty of a church squandering the treasures of the post-Vatican II rites. Clergy and laity persist in using the Anointing of the Sick as a

deathbed ritual rather than a holistic rite intended to strengthen and encourage people at the advance of serious illness or, for the elderly, decline in overall condition.

As for viaticum and the many other resources in the *Pastoral Care of the Dying*, far more could be done to train lay ministers so that they might accompany the dying and those around them more fully. The laity must find the courage of their convictions in lamenting a lack of meaningful rituals for life passages by taking up liturgical and other prayer practices of the faith to form habituated bodies of worship.

The Gospel brings salvation to people, in whatever state of life, who acknowledge their profound need for God, embracing the challenging but life-generating truth that the God of Jesus is known only through humanly shared practices of word, sacrament and ethics.

Ongoing liturgical practice forms people in the paschal mystery of death and life or, in the words of the beautiful Russian Orthodox Resurrection chant, in the joyous faith in Christ's trampling down death by death.

FR. BRUCE T. MORRILL, SJ, holds the Edward A. Malloy Chair in Catholic Studies at Vanderbilt University, Nashville, Tenn. His books include *Divine Worship and Human Healing: Liturgical Theology at the Margins of Life and Death* (Liturgical Press).

NOTES

1. Megory Anderson, "Spiritual Journey with the Dying, Liminality, and the Nature of Hope," *Liturgy* 22, no. 3 (2007): 46.
2. Peter A. Clark, "The Transition between Ending Medical Treatment and Beginning Palliative Care: The Need for a Ritual Response," *Worship* 72, no. 4 (1998): 346.
3. See Benedict M. Ashley and Kevin D. O'Rourke, *Health Care Ethics: A Theological Analysis*, 4th ed. (Washington, D.C.: Georgetown University Press, 1997), 397.
4. Gerald J. Calhoun, "Ministry at the Time of Death," in *The New Dictionary of Sacramental Worship*, ed. Peter Fink (Collegeville, Minn.: Liturgical Press, 1990), 324.
5. See *Pastoral Care of the Sick: Rites of Anointing and Viaticum* (Washington, D.C.: National Conference of Catholic Bishops, 1983), nos. 8 and 97.
6. Calhoun, 320.
7. Anderson, 46.
8. Anderson, 42-43.
9. *Pastoral Care of the Sick*, no. 183.

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