

## PALLIATIVE CARE : A THEOLOGICAL FOUNDATION

### SACRAMENT OF ANOINTING & PASTORAL CARE OF THE SICK

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*Abstract: In the second of his articles, the author focuses on pastoral practice within the Roman Catholic community. Such practice involves a right use of the sacrament of anointing, as part of whole person care; a holistic response to a situation of total pain in a palliative setting. Carers need the personal and theological maturity to respond to the untidiness of life and the complexities of offering care without a subtle exercise of power. The aim is to offer love without preconditions, thus making Christ present to the sufferer. Such care is a calling for both clergy and laity, and must be theologically based in an understanding of the Church as the sacrament of Christ.*

*Keywords : sacrament; Roman Catholic; anointing; pastoral care; hospice; palliative care.*

#### **Introduction: The Sacrament of anointing in pastoral practice**

The rite of the ‘anointing of the sick’ is among the most successful of the liturgical reforms of the Second Vatican Council. The rite was thoroughly revised to bring out more clearly its original purpose as a sacrament for the sick and not only the dying.

Since the Middle Ages pastoral practice has relegated this ‘last anointing’ to the final moments before death. There was a strongly felt desire among the faithful that the priest be present to anoint the dying persons, not in order that they might recover, but to remit any remaining sins that they might have before their souls departed from this world for the next.

In the 16th century, the Council of Trent taught that the sacrament both forgives sins and relieves the sick, but until recently it continued to be associated by and large with the moment of death. The 1917 Code of Canon Law said that the sacrament could be administered to someone in danger of death (canon 940), and although not intended to restrict the anointing to those in “imminent” danger of death, that is how the law was generally observed.

Given this centuries long praxis it is indeed surprising that the reform of the sacrament has been so widely accepted. The new rite urges that the faithful be taught not to follow “the wrongful practice of delaying the reception of the sacrament” (*Pastoral Care of the Sick, 13.*) This catechesis has been successful, to the extent that the anointing is no longer widely associated strictly with dying. Unfortunately, neither an awareness of Viaticum (the Eucharist) as the true ‘last rite’ nor an appreciation that it can when necessary be administered by an extraordinary minister of the Eucharist (Eucharistic Minister), yet appear to be strongly rooted in pastoral practice.

The condition set forth for the reception of the sacrament of anointing is; anyone of the faithful whose health is “seriously impaired by sickness or old age”. It has become common pastoral practice to administer the sacrament to those undergoing surgery made necessary by serious illness, to the elderly who are visibly deteriorating, and even to sick people who have lapsed into unconsciousness when this is considered to be appropriate. The sacrament may be repeated in the course of a progressive illness. It presupposes that the situation is not concealed, but rather is brought to consciousness, and thus placed in the presence of a loving and merciful God.

## Total Pain and the Tenderness of Christ

The hospice movement has important things to teach us: not just information about pain and symptom control, crucial as these are, but the wisdom of what it means to be a human being. By being alongside sick people we learn our kinship with the frail and the wounded, our shared humanity and our common worth. We the strong have much to give our weaker brothers and sisters, but we also have much to receive, important lessons to learn. The world is not divided into needy sick and gracious carers; we must all take our turns in playing these roles. Once we have grasped this truth, we are much freer because we are able not only to accept one another, but also to value our own vulnerable humanity.

Dame Cicely Saunders, pioneer of the modern hospice movement speaks of total pain, by which she means that the physical agony of an individual is normally compounded by fear of death, loss of independence, conflict with loved ones and a state of spiritual anguish in which faith is stretched to breaking point, and hope seems little more than a child's fantasy. In recognising the psychosomatic unity of the human person the hospice movement pioneered the holistic care of the person in the palliative sense.

Those patients who gain access to hospice care are cared for by multi-disciplinary teams; doctors and nurses who deal with the physical problems, the social worker with financial worries and family conflicts, and the chaplain with the spiritual issues. It all sounds very neat and tidy. Sheila Cassidy (1994) in her book "Light from a Dark Valley" writes:

*"The trouble about the care of the dying, however, is that it is never neat and tidy. Cancer has no respect for internal boundaries, so that a palliative care doctor must be jack-of-all-trades, chest physician, psychiatrist, gynaecologist and Geriatric physician all in one. In the same way the physical and the psychological become inextricably mixed up, fear exacerbating pain and pain making people terribly afraid. Spiritual issues are likewise inseparable from physical and psychological ones, for a depressive illness can induce a pathological sense of guilt and the resultant sense of unworthiness can make the person feel that they are beyond the reach of God's love and mercy"*

This is the phenomenon of total pain of which Cicely Saunders speaks, a pain which demands that carers not only work in teams respecting each other's contribution, but are people who are "whole person" carers :- doctors and nurses who can cope with the "why me?" and chaplains who can hold a vomit bowl while listening to the outpouring of anguish, anger and fear.

To repeat what was said earlier, the rite of anointing presupposes that the situation is not concealed, but is brought to consciousness and thus placed in the presence of a loving and merciful God. That situation can be complex, both for sufferer and for carer. In the words of Sheila Cassidy; "the care of the dying is never neat and tidy." The sacrament of anointing the sick has to do with the discovery and revelation of the saving mystery of God within a serious illness, but when disaster first strikes, as I am sure most of us can testify, the first unavoidable, normal, and probably right reaction is self-pity. Courage disappears, we feel as though we are falling apart, and are deaf to everything but the cry of our own misery.

If we choose to see ourselves as the victims of some undeserved fate then all our actions will become governed by anger, bitterness and resentment. It is only in our powerlessness, bewilderment and fear that we can turn to God with an agonised plea for help, in our utter vulnerability. It is then and only then can grace begin to operate in us, and we can begin to take stock and listen to the inner voice.

Is it not true that when we are distressed we turn to the friend who knows what distress can be like? We seem to know that there isn't much point in going for sympathy, or for the deep down understanding that we crave, to those friends whose paths have always been smooth. We need empathy, from those who, in the facing of their own sorrows, have a maturity which others may lack.

*"But the prolonged journey was necessary since it is only the truth that you discover for yourself which has the power of truth. To be told something is seldom to know it, however numerous the instructors further, the more earnest they are, the less convincing"* (Stoter 1995)

The sick do not need, nor do they wish to hear our pious platitudes, but in the midst of all the untidiness

of existence and the all-consuming nature of pain, they do need to meet Christ in us. They need to be understood with that tenderness and compassion, that central and powerful emotion that epitomises the life and ministry of Jesus.

### **Spiritual Care : gift of unconditional love**

Spiritual care can be described as responding to the uniqueness of the individual: accepting the range of doubts beliefs and values just as they are. It means responding to the spoken or unspoken statements from the very core of that person as a valid expression of where they are and who they are. It is to be a facilitator in their search for identity on the journey of life and in the particular situation in which they find themselves. It is to lay all prejudice to one side, to respond without being prescriptive and without preconditions, acknowledging that each will be at a different stage on that spiritual journey.

In order to be able to offer spiritual care, the carer must be acceptable to the patient. Effective pastoral care of the sick is not achieved within a vacuum; it is achieved with the context of a caring relationship, where the recipient can accept the carer as someone who can be entrusted with all their needs, hopes and fears, pain and distresses and to whom they can entrust themselves totally. They are able to trust in this way because they recognise that their needs will be received and handled sensitively and that the carer has something to offer. The focus of care must be for the good of the patient without preconditions or any specific end in view. Spiritual care is then a gift of love offered without any preconditions. (Stoter 1991).

*“...the healing relationship is a meeting of two minds: the healer and the patient ... If you and the other person are both open, and then some kind of dialogue can take place... communication occurs naturally. From the patient’s point of view that is exactly what is needed!”* (Trung 1978)

The core of spiritual care is to value each individual for themselves and to accept them just where they are with their own particular needs and attitudes. One acceptable objective is to enable the individual to accept and value themselves and to make some meaning of the situation they are in, and to discover their own way forward on life’s journey in a way

that is acceptable and creative for them. “It should be the patient who defines the territory, not the care giver.” (Fiefer 1996) The temptation is to marginalise the dying, to convey a sense that they are finished or almost finished, their time is over, our time is now. This is so wrong ; the dying are living, just like us. They are still playing their part, and we must give them their rightful space, acknowledging that they are still full players, listening carefully to what they have to say to us, using all our powers to understand their words. Some things, messages of love, things of the spirit are too precious, too holy to be said outright.

*Through a caring committed presence people will discover:*

*That they are allowed to be themselves:*

*That they are loved and so are loveable.*

*That they have gifts, and their lives have meaning.*

*That they can grow and do beautiful things*

*And in turn be peacemakers in a world of conflict* (Vanier 1988)

### **Power, presence and the ministry of spiritual care**

The nature of spiritual need and spiritual care clearly indicates that the pastoral carer’s approach has to be through coming alongside the patient and sharing the journey of life at whatever point that person finds her/himself at that particular time. The patient is already on their particular path; the situation they find themselves in may mean that they are facing particular challenges, questions and decisions. They do not have a choice as to where they are, where they start from or the final destination ahead.

The carer on the other hand has a great deal of power: power to choose whether to share that journey at all; power to decide how far to go and when to pull out; and power to leave the path altogether if so wished. The carer also has the ability to define the territory making it impossible for the patient to follow his own personal journey, as this suggests that either the carer knows best what is right and where the traveller should go, or is going to insist on controlling every aspect of the journey. To embark upon this journey starting where the other person is, we must stand aside from our own journey and allow the itinerary or the agenda to be set by the patient. The agenda will need to be discovered afresh at each meeting; we can never expect to meet at the

same place as we left off. We will have met with new insights, seen new horizons and have moved into a new phase of the journey in the intervening time. We need to get into step with one another as we move along and share in the stage of the journey.

*“As has been said, the point of travelling is not to arrive, but to return home laden with the pollen you shall work up into the honey the mind feeds on.”* (Thomas 1993)

Carers who are prepared to enter this kind of healing relationship need to be aware of their own vulnerability and strengths in terms of meeting pain and suffering. The response of the carer is not necessarily in words, but in coming alongside the patient, listening, hearing what they want to say, and above all being with them. This means a level of commitment that cannot just be abandoned when the going gets tough; pastoral care of the sick in the palliative sense, is not for the faint hearted. In experiencing an overwhelming sense of helplessness, the temptation is for the ordained minister to hide behind his liturgical and sacramental role, rather than risking the genuine personal encounter. It is of fundamental importance to realise that not every priest or minister will have either the disposition, or possibly the level of personal maturity, or even the skills, required for this demanding ministry, and so the involvement of a team may be needed to provide the continuity of care in depth. St. Paul reminds us aptly of this:

*“There are many different gifts, but it is always the same spirit; there are many different ways of serving, but it is always the same Lord... The particular manifestation of the Spirit granted to each one is to be used for the general good....”* (1 Corinthians 12:1ff.)

Pastoral care of the sick need not and should not be the sole prerogative of the priest. We bring the whole of ourselves, our skills and personalities to relate to individuals needing care; we seek to see each individual as a whole person needing care in all aspects of their lives. This kind of care can require a range of skills which may be offered by different professional carers working in close liaison with the family, volunteers, friends and most essentially, with the patient. Spiritual care cannot simply be labelled as the domain of any one individual. Those of us who belong to Catholic Christian communities

all have a responsibility, if we participate in the ritual, to live out its reality in life. Ethics and sacraments in the Christian life are intimately bound together. If the Church is for us, the sacrament of Jesus Christ, we the Church carry on his work, we are his very continuation. (Dulles 1998)

“When we think about the people who have given us hope and have increased the strength of our soul, we might discover that they were not the advice givers or moralists, but the few who were able to articulate in words and actions the human condition in which we participate and who encourage us to face the realities of life. Preachers who reduce mysteries to problems and offer Band-Aid-type solutions are depressing because they avoid the compassionate solidarity out of which healing comes forth. But Tolstoy’s description of the complex emotions of Anna Karenina, driving her to her suicide, and Graham Greene’s presentation of The burned-out case of the Belgian architect Querry, whose search for meaning leading him to his death in the African jungle, can give us a new sense of hope. Not because of any solution they offered but because of the courage to enter so deeply into human suffering and speak from there. Neither Kierkegaard nor Satre nor Camus nor Hammarskjold nor Solzhenitsyn has offered solutions, but many who read their works find new strength to pursue their own personal search. Those who do not run away from our pains but touch them with compassion bring healing and new strength. The Paradox indeed is that the beginning of healing is the solidarity with pain. In our solution-oriented society it is more important than ever to realise that wanting to alleviate pain without sharing it is like wanting to save a child from a burning house without the risk of being hurt. It is in solitude that this compassionate solidarity takes its shape.” (Nouwen 1991)

### **Pastoral care : rooted in theology**

Pastoral care of the sick is essentially the responsibility of mediating the resources of theology through a ministry of listening, understanding and interpreting the needs of each pastoral encounter with the dying person (Lloyd 1995). It is a dynamic and demanding process, in which each expression of pastoral ministry is unique but not *ad hoc*, grounded in established resources but capable of flexible translation according to the needs of the moment.

We have at our disposal a rich resource of theoretical reflection and a multitude of skills based approaches to the practical realities of the pastoral care of the sick and the dying. Much greater attention is given to the skills required in the care and counselling of the dying and bereaved people, than to the theological basis for this as a pastoral activity. The understanding of such skills is largely derived from systematic study in secularly-based professions, using applied knowledge from social sciences, therefore the danger exists that pastoral care in this model could become indistinguishable from any other care or counselling, except that it is undertaken by those involved in pastoral care. Much has been written on the theology of suffering and much more on the theology of death, but little as far as I know on the theology of the pastoral care of the sick and the dying. If our ministry is to be authentically Christian it must have a theological foundation.

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