

## MEDICAL RITES: 'PRIESTLY' POWER IN MODERN HEALTHCARE

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*Abstract: Patients and their families are often concerned to find a material cause for suffering rather than to accept the mystery of its ontological necessity. In modern healthcare settings, in which medicine is rightly based upon the reductionist empirical scientific method, spirituality is therefore likely to be seen as a bolt-on extra to medical care rather than as a truly alternative worldview. In this article I argue that suffering needs to be rehabilitated as an experience rather than a cosmic mistake, and that chaplains are better equipped than medical staff to offer this insight into transcendent reality.*

*Keywords: suffering, ritual, healthcare, liminality, chaplaincy*

### Introduction

*I don't understand why this has happened to her. She has always lived a good life: no drinking, no smoking, and she never hurt anyone. Why don't the bad people get cancer?*

In the pastoral care of sick and dying people, a frequently encountered belief is that there should be a connection between sickness and sin. Street wisdom says that if you do wrong, you should get punished; and if you get punished without doing wrong then God (conceived as divine caretaker) is culpable. This belief can affect spiritual healthcare at a number of levels:

(i) it may predispose patients to reject God, because He is perceived to be unfair;

(ii) it may undermine trust *a priori* in spiritual healthcare providers, who are seen as this God's representatives, in favour of 'more scientific' professional advisers who, while offering excellent advice and care in their own areas, cannot logically address the transcendent dimension of true spirituality from their professional foundation of reductionist empiricism;

(iii) it fails to bestow any real meaning on the experience of profound suffering that is taking place, because the very fact of a 'good' person suffering is illogical within this worldview. Questions of the type: 'Why has my sister got cancer while war

criminals live to a ripe old age?' carry a logic with which spiritual caregivers must grapple.

In this article I would like to offer some reflection on this connection of sin and punishment, and its consequences for medical and chaplaincy staff in healthcare today; and to advocate the continued importance of independent dedicated spiritual care as a balanced part of the healthcare project, even though it might seem like sound economics to train all staff in spiritual awareness and dispose of the chaplaincy department. A key issue is the materialist assumption that if there is no attributable cause for suffering, then it has no meaning.

### Religious origins

In a fascinating study, Walter Burkert (1996) explores a possible argument for the development of religious activity in humans, which process Burkert roots jointly in language and in biology (although anthropologists have varied views of the importance of language in human cultural development, see O'Murchu 2008, chap 10, for an accessible overview). The Neanderthals, who probably predated and then coexisted with *homo sapiens* before dying out as a group, left evidence of burial rituals from around 100,000 years ago, although it is difficult to research their significance without a reflective record. Opinions vary about the nature of Neanderthal 'language': a recent theory is that their use of primitive body marking implies the ability to interpret the signs painted (New Scientist 29 March 2008); while more

established research tends to favour a prelingual 'culture'. The possibility is – and it must of course remain a possibility in the absence of interpretive evidence – that Neanderthals were beginning to deal with the mystery of death at some level. However, with the development of full language in *homo sapiens* came a massive shift. Not only was there sharing of company, food, shelter, tools *etc*, but language permitted the sharing of a thought world also (Burkert 1996, p 24). It became possible to have traditions – not just reactive or proactive behaviour patterns evolved to deal with predators, food, or reproduction, but commonly held ideas, concepts and culture. Through art and, later, writing, these traditions could be passed down the generations with fidelity.

Although ritual may have been a form of early prelingual religious communication, the significance of language for developing religious belief cannot be overestimated. Once there is language then mystery can be named and considered, not just experienced or undergone. When something happens that cannot be explained in everyday terms, then it is possible with language to evoke the ultimate, whatever that might be; and communally to decide upon a response. The desire to engage with mystery is part of the human attempt to simplify a complex and chaotic world (today, sceptics speak dismissively of religion as a 'crutch' to get one through the hard times; but there is also recent neuropsychological research that suggests that human brains are hardwired to identify causality, see d'Aquili & Newberg 1999, chap 3). There are psychological survival advantages to religious belief: affliction is easier to bear if one believes in cosmic justice; and fear (which is biologically implicated in learning) can be rationalised and contained by using ritual to placate an ultimate being.

A primitive religious worldview might thus understand life on earth as subject to a mysterious deity who metes out rewards and punishment as 'he' sees fit. A connection is forged between death, sin, and systems of ritual sacrifice that leads to the offering of a representative on behalf of the people as a damage limitation strategy – a process that takes place in more contexts and more often than we like to admit in today's supposedly civilised society. René Girard's research on mimetic violence and scapegoating unveils a pattern of sacrifice taking place through the centuries (Girard 1986, 1995,

2001). This pattern is found in ancient literature (including scripture) and mythology, but also in modern examples of ethnic cleansing (see Volf 1996) and even media lynching. If no other cause can be found for suffering, there is a deep human satisfaction in linking it with divine punishment, and this connection re-emerges oddly in modern (agnostic) spiritual healthcare. *The search for a cause for suffering liberates us from the deeply disturbing possibility that life might be meaningless.* Beverley McNamara (2001, p 15) comments on the tendency for people to liken death to a communicable disease rather than a mystery, while Tony Walter (1994, p 12) discusses the 'deconstruction of death into discrete, identifiable diseases'. Pastorally our experience is often that families need to know what was written on the death certificate, as if that somehow rehabilitates the 'mysterious' death into normality.

### Rituals and guides

The work of Arnold van Gennep (1960) and Victor Turner (1969) on ritual practices continues to have interesting applications in anthropology today, particularly in the context of the background discussed above. Van Gennep identified what he termed 'rites of passage' – times of change and transition in human societies or individuals. Such rites are used for puberty, marriage, childbirth, death, any initiation such as receiving new members into the group, and so on. Rites of passage have three distinct phases: the preliminal, in which the person(s) separate from the group; the liminal, which is the time of transition and usually testing; and the postliminal, which refers to reincorporation of the changed person(s) into the group (the term 'limen' refers to a threshold or boundary). Typically, in so-called 'primitive' societies, there would be a liminal guide – usually a village elder or shaman – who has already gone through the rite and can educate younger members of the tribe. Our western and secular society has been through a period of sparse ritual activity during the 20<sup>th</sup> century following the postwar religious disillusionment, although anthropologists note that liminal (or liminoid substitute) rites now flourish in new places: gang culture and addictive behaviour being examples, while today's liminal guides might be counsellors, life coaches, psychologists, agony aunts and even reality TV show participants. A minority continues to view a priest, minister, or other religious leader as such a guide. Richard Rohr has written about developing new liminal rites for men in west-

ern culture to develop the male identity (Rohr 1996, 2003).

Many of the ancient fears about times of transition and chaos re-emerge when someone is sick, and forcibly separated from his/her normal activities. Hallstein (1992) has written about the chaplain as liminal guide, drawing parallels with the categories used by van Gennep: sickness signals a time of change and an entry into the unknown; a hospital is an unfamiliar place of challenge, where tests and trials and suffering is undergone; the outcome is transformation: either healing or death. Modern healthcare provides a completely new stage for these ancient practices, and being aware of the territory may help us in our pastoral engagement with patients and staff.

### **Medicine in late modern western culture**

The scientific revolution in the West was accompanied by an increasing dissatisfaction with religious explanations, or appeals to mystery, regarding life events. It is not science *per se* that struggles with faith but the process of empirical reductionism, which ironically was formed in part by classical theology. Essentially the strict classical theism that posits God as a perfect and omnipotent Other (developed from Greek philosophical thought, see, for example, Rudman 1997, chap 7) also incubated the development of a reductionist and dualistic material philosophy that underpins the modern empirical scientific process, although science itself is much more than this. The grand narratives of classical theism ran into difficulties as science uncovered more and more of the 'mysteries' of the world and gradually God conceived in this manner became an unnecessary explanation most of the time. Modernism can be described as the replacement of the classical theistic metanarrative with a new one: one that is utopian and scientifically rigorous, but ultimately frightening in its (supposed) objectivity (see Loughlin 1996, Chap 1).

Advances in medicine have multiplied, particularly in the state welfare era, producing a public fascination with medical science and its successes. Theorists note several significant shifts relevant to this paper, as follows.

(i) The elevated social status of doctors alongside the success of medicine (Brody 1992).

(ii) The development of the 'medical gaze' – sick people are understood as collections of symptoms that can be treated, and empirical reductionism is used as a diagnostic strategy (Walter 1994, p 92; McNamara 2001, p 15; Webster 2002, p 20). The 'whole life' dimension of the patient may possibly be neglected in the application of this often successful method of diagnosis (although the hospice movement seeks specifically to address this issue of fragmentation, by dealing with 'total pain').

(iii) The nature of the doctor-patient relationship. Brody (2003, chap 1) discusses the way in which consultations have changed from mutual discussions of the patient's condition to transactional interviews in which information is given by the patient to the professional expert; Brody notes that this consultation method works well for acute conditions but not for life-changing chronic states (*ibid*, p 17). Brody also notes a reactive shift towards narrative medicine since the late 1980s: a return to the hearing of the patient's story.

(iv) An altered view of serious illness and death – McNamara (*ibid*, p 15) comments that today, 'People think about living for as long as possible rather than living in preparation for an after-life'. Death is removed from normal experience to something that is dealt with by professionals (even in hospices, who supply not only medical care but bereavement, social, spiritual, and complementary care professionals also). The implication is that death needs professional input that is not available at home, and people frightened by the whole dying experience collude happily with this suggestion. Families can be both disenfranchised and demoralised by this shift, although less so in hospices than in hospitals.

None of these points is intended as a criticism of medical staff, who work under increasing levels of expectation from the wider public. But some unmasking of the various issues may help in terms of spiritual care, which we commonly understand as being about meaning, value and purpose; and which may take us outside the normal boundaries of causality with which traditional medical science, predicated upon a reductionist material philosophy, has been concerned. In particular, death is perceived as a failure of medicine and raises many of the issues.

Tony Walter (1996, chap 2) notes that few people today have a considered idea of the afterlife: certainly, they are not 'scared' into belief through fear of hell. Many are reluctant to discuss or engage with death until it comes close (McNamara 2001, p 16), although when it does arrive, it represents the unknown, and the ancient desire to have someone to guide one through the time of transition is undiminished. Putting together the pieces of the picture we have painted above, we might come up with something like this:

*I am facing a serious illness that threatens my survival. I am not sure who or what God might be, and if he is good, why am I sick? I may have sinned and incurred punishment in some way that I do not understand, but that isn't fair, so I don't trust God. He is not a good bet as an ultimate cause or reason in my view. However, medicine offers me a reason (diagnosis); a pathway forwards (treatment); hope (getting better); and an authoritative guide (doctor). I will therefore put my faith in medicine.*

Walter (1994, p 12) remarks that 'At the late eighteenth-century deathbed the doctor took control of the dying man or woman and from the priest. Death ceased to be a spiritual passage and became a natural process overseen by doctors'. This 'natural' process nevertheless retains some aspects of 'priestly' involvement, as follows.

(i) Authority: doctors are expected to have the answers (and often do) to very serious questions about life quality and value, and issues of ultimacy (birth, death). They are publicly accredited and have to serve a period of 'probation'. Once qualified, medical authority is widely respected, and there is no doubt that doctors have power (Brody 1992). Hippocrates emphasised the need for a physician to win respect and in *Decorum* notes that 'a physician who is a lover of wisdom is the equal of a god' (Jones, 1923). The nature of the encounter between doctor and patient can shape the whole dynamic of the subsequent relationship.

(ii) Mediation: it is the doctor who 'mediates' between the patient and the sickness or the patient and death; the doctor who has the access to special knowledge that can help. The doctor too has experience of being in this place before and therefore

to act as a liminal guide in this time of transition, and to perform the correct 'rites'.

(iii) Absolution: finally, it is the doctor whose practice makes us feel better; either by the onset of healing or through palliation of symptoms. We 'confess' our pain (and possibly our lifestyles) to the doctor; but after the appropriate 'rites' of treatment, and when the pain has receded, we are less aware of the need for a cause or reason and we find ourselves absolved from the 'sin' that has led to this condition.

In no way am I suggesting that doctors set out to become shaman-like figures in this way. However a serious engagement with materialist reductionism shows us that existential questions do not go away just because we are modern and enlightened people; they are just recast in different, more scientific, terms. The ancient need for a reason to make sense of chaos is still extant: and when medicine 'fails' the patient is left with the task of seeking a new explanation. Here is the absolute necessity for the chaplain: someone who within him/herself has engaged with suffering at a different level *and does not necessarily expect it to go away*. Perhaps the greatest problem with medicine, alongside its many excellent characteristics, is that it postpones one's engagement with suffering and ultimately limits life by deferring death.

### **Dealing with suffering: the need for dedicated spiritual care**

The distinctive offering of dedicated spiritual caregivers (chaplains) is the confession that suffering is neither extraordinary nor aberrant. It is not *necessarily* the result of sin (although it *might* be a natural consequence of certain actions); it is not a divine punishment; and it is never meaningless.

Theologians continue to debate the issue of suffering in relation to the existence of God, wanting to exonerate God from blame while retaining his 'worth'ship. This area is a fascinating and fruitful one but too large to cover here, except to remark that theodicies (attempts to excuse God from blame) are rarely helpful to people who are undergoing extreme suffering, maybe because they are too reductionist compared with the complex nature of the suffering itself. Stanley Hauerwas remarks that theodicy is a 'parasitic endeavour' that draws its energy from more positive modes of life (Hauerwas 1990, p 39). Seek-

ing a causal explanation is a modern method with which we attempt to rationalise the primitive religious instinct of man, which longs to domesticate reality and set boundaries round chaos so that existential fear can be contained. However, finding a cause does not necessarily supply meaning to the experience and may make things feel worse.

Hauerwas (1986, chap 1) notes that suffering is always a part of someone's life story. Suffering must happen to someone, in a certain setting. It does not just happen 'out there'. Philosophically, as soon as we locate something in a story we begin the process of interpretation, for each person's story is set in the bigger story of culture and ultimately in the story of reality itself. The 'big stories' or metanarratives we hold about those bigger contexts supply the interpretive criteria for the local story of suffering. Once we interpret, we add meaning, and so no suffering is without meaning because suffering is not an abstract occurrence. It is always contextual.

Christian chaplains (I cannot speak for others) understand reality as the location of the crucifixion, and thus all suffering has meaning, since our overall story of the universe has the crucified and risen Christ at the heart of God. We cannot remove Christ's experience from the Trinity; and we cannot remove it from the eternal experience of God; therefore suffering has ultimate meaning. Meaningless suffering, that experience identified by Frankl (1965) as so corrosive to the human spirit, actually does not exist: but without a transcendental and incarnated metaphysics we cannot begin to make sense of 'the shadow side' and to address that primitive fear of death with which we began. Materialist reductionism (the parent of medical science) can never do this: it yields excellent working answers a lot of the time but the meaning of suffering is not an appropriate question for it. To argue for holistic healthcare misses the point if authority is actually still invested in the outworking of empirical reductionism.

Furthermore, and recalling our starting point with the primitive link of sin and punishment, we can argue that Jesus Christ turns this worldly wisdom upside down. The link is hinted at frequently in scripture (OT and NT) – that God's blessing issues in good things while sin is materially or physically punished: yet we can argue that Jesus never con-

curs. In John 9 he explicitly states that the blind man did not sin, while in Luke 5: 17-26 (and parallel synoptic passages about the paralytic whose sins are forgiven), the story is not about a causal attribution of sickness to sin, but about being restored and healed from separation by one with the authority of God. Luke is also anxious to contrast the actions of Jesus with those of the temple authorities, whose agenda is rather different (see Green 1997).

Suffering can never be adequately addressed as a 'problem', for to do so invalidates it as an ontological imperative of existence in this world – and we have no other dwelling place. It can, however, be held as an experience. Chaplains who understand this from their own lives, supported by theological training, can offer a reflected depth of compassion to the sick and dying that can transform this transitional experience for patients alongside the many benefits of medical practice.

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