

THE UNIVERSITY OF CHICAGO

LAYING DOWN ONE'S LIFE:
AUTONOMY IN THE TIME OF MEDICALIZED DEATH

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DEDICATION

This work is dedicated in loving memory of Debra J. Gora and to the people of LaSalle Street Church.

ACKNOWLEDGEMENTS

Our loved ones are forever leaving us, even as they live within us; their “histories of freedom,” as this dissertation argues, create new and liberating possibilities for our own. I was just two chapters into this dissertation, awaiting the immanent birth of my first child, when my friend Heather Miller Rubens called to gently break the dreadful news: my doctoral advisor, Jean Bethke Elshtain, had died. Elshtain died “in saddle” (to borrow a phrase from St. Francis). When her deteriorating health prevented her from flying to the conference where she had promised her presence, she, true to her determined nature, took a cross-country train trip instead. She was riding the rails in service to scholarship when her heart began to fail. I am profoundly grateful for her life and her example, and thankful for the intellectual courage she tried to instill in me.

Years of graduate seminars at Chicago had predisposed me to anticipate the objections of careful readers around every turn—an important critical practice, but one that could become paralyzing when it came time to advance my own argument. In my mind’s eye, I sit in Elshtain’s office articulating potential criticisms of the work on which I had yet to embark. I see her cheerfully waving away potential detractors and dispensing advice to the effect that “one must simply strive to serve [God] wittily/ in the tangle of [her] mind.” I take this image with me. Her classes on “Politics, Ethics, and Terror,” and “Ethics and Embodiment” spurred my thinking on the freedom of a Christian within the limits and possibilities of bodily life; these ideas animate the work before you.

In truth, I owe many of the aforementioned critical habits of mind to William Schweiker. Well-nigh legendary for his reputation for (methodological) “slicing and dicing,” the ethics seminars I took with him were by turns exhilarating and terrifying for their rigor. He agreed to assume the responsibilities of advising my dissertation after Elshtain’s death, and while he could have done so in

a perfunctory way, he welcomed me into full community with his cadre of doctoral candidates. He became an able *Doctorvater* to me, after I felt like a *Doctormutter-less* child; I am deeply thankful for his guidance and support.

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Scholarship begins when interest attaches to observation. It is, in other words, personal. I have dedicated this work to my late aunt, Debra Gora, who struggled with multiple sclerosis for several decades and who succumbed to her disease in what we commonly consider “midlife.” Debbie graciously housed me when I began my graduate work at the University of Chicago. While living with her, I witnessed firsthand the very real and deleterious effects that weak human ecologies inflicted on her health and her autonomy, as well as the genuine grace and virtue amidst adversity that she exhibited in coping with her disease (and that my parents also displayed in caring for her until her death). I also dedicate the pages that follow to the people of LaSalle Street Church, a congregation that prides itself on its history of “taking on trouble”—I am thankful to belong to a

community in which so many people strive to take on responsibility for their corner of the world, and I hope this work might represent a new avenue for more vital community.

My parents Marlene and Jack Harrington have encouraged my scholarship since its inception; I thank them, along with my sister Stephanie Harrington Ozment, for their long-suffering support. I am grateful to my in-laws, particularly Dennis Dykstra, whose enthusiasm for, and encouragement of, this work helped me to get over the final hump. The women of my soul care group, Corinne Shannon, Christa Clumpner, Sandie Johnson, Melinda Croes, and Christine Evans have been unstinting cheerleaders. My husband, Jeffrey Dykstra, has championed my project to whomever will listen. Our two inimitable sons were born to us in the midst of my writing, and while their appearance on the scene slowed the process down considerably, their delightful existence has compounded the significance of this work's major themes, especially that of generativity—the extension of love through time. To Jeff, Piers, and Henrik, my very near-neighbors: I love you dearly, and I pray that you will always know the deep and abiding freedom that accompanies love's increase and expansion.

EPIGRAPH

The young girls have only strangers to parade before,
and no one sees them truly;
so, chilled,
they close.

And in back rooms they live out the nagging years
of disappointed motherhood. Their dying is long
and hard to finish; hard to surrender
what you never received.

Their exit has no grace or mystery.
It's a little death, hanging dry and measly
Like a fruit inside them that never ripened.

God, give us each our own death,
the dying that proceeds
from each of our lives:

the way we loved,
the meanings we made,
our need.

For we are only the rind and the leaf.
The great death that each of us carries inside,
Is the fruit.

Everything enfolds it.

Rainer Maria Rilke, *Rilke's Book of Hours: Love Poems to God*, III, 2-6.

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INTRODUCTION

The twentieth century, particularly its second half, witnessed a practice of medicine that had become newly powerful. Technologies and techniques including vaccines, antibiotics, dialysis, the heart-lung machine, mechanical ventilators, antiviral drugs, organ transplant, and the advent of intensive care medicine proved both life-saving and life-extending. The availability of these interventions reshaped the expectations of citizens of affluent nations with respect to their lifespans as well as to end-of-life care. In these nations, death became “medicalized”—apart from accidents or sudden deaths, it became almost impossible to die apart from some kind of medical management. In 1974, Eric Cassell observed that “the facts and the artifacts of the death of the body” had become “the vehicle for [human] interchanges,”¹ eclipsing traditional moral and religious concerns with dying and death. In this same period, the autonomy movement in medicine arose amid a general restructuring of social authority; widespread suspicion of traditional forms of power, including medical paternalism, took root. From the mid-1960s, proponents of autonomy sought recognition for their conviction that much more is at stake in the medical encounter than medical issues alone, and they sought to secure respect for patient prerogatives in the course of medical care. With respect to dying, patients and their surrogates—perhaps at their most vulnerable and enfeebled—were asked to choose the point at which death would no longer be opposed.

This dissertation is a work in constructive Christian ethics that originated from the observation that even as efforts to secure “patient autonomy” grew from the 1960s onward, dying persons became, concomitantly, more “managed” than ever by increasingly comprehensive (here, “totalizing”) forms of medicine that purported to meet patients’ biological, psychological,

¹ Eric J. Cassell, “Dying in a Technological Society,” *The Hastings Center Studies*, vol. 2, no. 2, Facing Death (May 1974), 33.

sociological, and spiritual needs. While ‘autonomy’ is a rather protean concept—indeed, a concept that many Christians find suspicious because they associate it with sinful self-assertion—I argue that when rightly understood, ‘autonomy’ fuses the deep forms of freedom and responsibility that are at the heart of Christian life; furthermore, the Christian witness attests that these qualities should increase over the lifespan—they have a special reference to death. Nevertheless, while Christians practice a faith premised upon the sacrificial death of Jesus Christ, and even claim to celebrate his death as paradigmatic for their own lives, one observes that these confessions seem to have little practical relevance for most contemporary Christians, who participate in practices of medicalization and receive the ministrations of “biopsychosociospiritual” medicine at similar rates to their non-religionists.

My aim in this work is to recover death as a nodal point and a touchstone for faithful Christian living. I argue that a free and responsible, “maturely autonomous” death ought to be a goal of living that is cultivated and supported within Christian congregations. I take “mature autonomy” to include moral, socially-activated psychological, and spiritual components that I will advance through the practical theologies of Don S. Browning (1934-2010), an American Protestant, and Karl Rahner (1904-1984), eminent German Catholic architect of the Second Vatican Council. I have chosen these thinkers for the distinctive and productive ways in which they grapple with the dis-integrating features of contemporary culture that make it difficult to conclude one’s life with freedom and responsibility. To that end, Browning offers a psychoanalytically sophisticated ethics of the life cycle, as well as a potent defense of the role of the congregation in bringing loving and self-giving persons to maturity. Rahner is more existentially attuned to the contemporary demands of freedom and responsibility imposed upon the contemporary individual; he attends to the necessity of personal spiritual development which may culminate in an “individual ethics” capable of meeting

the present situation. Both thinkers point to the possibility of “maturely autonomous” deaths that may be understood as genuine consummations, with generative consequences for the survivors.

Autonomy discourse arose within a time of increasing pluralism and social fragmentation; the prospect of becoming maturely autonomous is a demanding task that calls for these contemporary facts of life to be met with an increase of freedom and responsibility. In the first chapter, I demonstrate that the medicalization of death is a political matter: medicalized death serves as a *modus vivendi*, or “way of getting along” amidst the myriad pluralisms of contemporary life—in short, our culture participates in death-denying practices that help us to defer and to evade the existential and religious demands of death by focusing patients and their families on a series of medical interventions cloaked under the banner of “autonomous choice.”

In chapter two, I make an historical-comparative analysis in order to illustrate the ersatz morality that inheres in the medicalization of death. After analyzing the philosophical roots of biomedical autonomy which hail from a selective harmonization of the deontological theory of Immanuel Kant and from John Stuart Mill’s treatise on personal liberty, I argue that the dominant conception of biomedical autonomy privileges Mill’s focus on personal liberty while minimizing the patient duties implicit in Kant’s moral theory. I then turn to compare contemporary practices (or “liturgies”) of medicalized death with the *Ars moriendi* (“art of dying”) tradition that began in the fifteenth century in order to claim that the dying persons described in the latter evinced more “autonomy” in their dying than many persons today, whose autonomy is supposedly protected under biomedical auspices.

In the third chapter on Don Browning, I move to take seriously the social activation of both psychological and moral autonomy. Browning’s early work on the psychology of human flourishing utilized Erik Erikson’s developmental and egoic psychology to work out a characterology of “generative man” (later, the generative person) which represented a widening ethic of care he

thought consonant with a normative Christian anthropology. In this chapter, I capitalize on a progressive notion of psychological autonomy that is reiterated throughout life-cycle stages and which ideally culminates in a preponderance of integrity in the last stage of life. This chapter both contributes to a more robust understanding of psychological autonomy and reflects back onto the social and political milieu that empowers individuals to assume free responsibility for their lives and deaths, or fails to. I work to integrate the socially-activated psychological autonomy in Browning's early work with his later works on moral thought. I contend that Browning's fundamental practical theological method provides a blueprint for congregational communities of moral discourse: when Christian communities recognize that their confessions of faith bear little resemblance to lives as they are lived, deaths as they are died, and medical decisions as they are made, Browning's practical theology proposes a way for congregations to function as communities of moral discourse that may empower congregants to bring their confessions and actions into closer alignment. As a site of moral discourse as well as a place where the generations strengthen one another through mutually viable rituals of recognition, the congregation is a vital place where maturely autonomous freedom and responsibility are fostered.

I turn to Karl Rahner in the fourth chapter to examine the possibility of a legitimate Christian spiritual autonomy. In this chapter, I take up the apparent conflict of striving to be "a law unto oneself" (the traditional understanding of 'autonomy') with the faithful Christian goal of "doing the will of God." In this chapter, I privilege Rahner's practical and sapiential essays on Ignatian spirituality and discernment to claim that Rahner saw no conflict between "theonomy" (the will of God) and genuine human autonomy. Rahner's transcendental theology held that humans may be "hearers of the Word"—that they may prayerfully receive individual directives from God that constitute their highest possibilities. I argue that Rahner's Ignatian spirituality consists in "an individual ethics" and this understanding has great significance for medical decision-making (which

might, according to this method, appear highly idiosyncratic). The concept of mature autonomy is further deepened in this chapter, but this time, in an existential direction. I claim that Rahner's theology affirms the traditional goals of the autonomy movement, holding the individual inviolable according to his conception of a legitimate Christian existentialism, but that his thought profoundly deepens these biomedical understandings of autonomy by proposing the existence of individual duties or responsibilities that are discoverable in prayer, along with a fuller understanding of freedom that includes freedom of spirit, freedom from attachments, and the freedom to posit oneself in an increasingly integrated way.

In the final chapter, I work to synthesize a vision of mature autonomy that incorporates the psychological, moral, and spiritual components of autonomy raised in the works of Browning and Rahner. Of particular importance is how to relate the highly socially-activated nature of the autonomy that comes through Browning's work with the individual-existential autonomy described in Rahner's. While affirming the inalienable freedom and responsibility that an individual has for his or her life before God, I argue for the significance of vital basic communities and for the forms of love that awaken personal freedom and responsibility, as well as for the vital communal ritualizations that scaffold and sustain mature autonomy throughout the lifespan.

CHAPTER 1:

MEDICALIZED DEATH AS A *MODUS VIVENDI*

In the course of Western history, human death has been variously construed as the calm leave-taking of an individual from his or her community, a time of personal religious judgment, a wrenching occasion for grief and mourning for surviving loved ones, and more contemporaneously, as “forbidden” or taboo—a threat to the pursuit of human happiness that must be repressed.¹ As of late, death in the United States has taken on a more public character, having become laden with social and political implications. We are doubtless aware of the demographic “graying of America,” and likely have some familiarity with statistics about the large proportion of health care dollars spent in the last months of life. Tensions were laid bare early in the Obama administration when efforts toward health care reform sparked panic about “death panels” revealing some citizens’ fears that “unproductive” members of society might be dispatched by proxy, or rather, slated for medical non-treatment. Proposals that physicians be reimbursed to discuss with patients their end-of-life care wishes in advance of need were likewise met with vocalized suspicion, as though a meeting designed to promote patient autonomy as it has come to be understood in the biomedical literature might itself commit the patient to an early grave. It appears that Americans who have come to understand their physicians as professionals who “strive officiously” against death simply prefer not to contemplate defeat.

¹ Philippe Ariès, *Western Attitudes Toward Death: From the Middle Ages to the Present* (Baltimore: The Johns Hopkins University Press, 1974).

Such political skirmishes suggest how thoroughly death has come to be apprehended as a medicalized phenomenon in our culture.² They reveal the presupposition that justice lies in being able to have all the stops pulled out on one's own behalf within a nation that is loath to talk about limits to healthcare and finds the prospect of transparently articulated rationing anathema.³ It is therefore a matter of political and moral significance to inquire about the understanding of the self that is invoked, and to the ideal of "autonomy" that pertains, when freedom is taken to consist in "a claim to equal consumption of medical services" tacitly expected to culminate in an equal 'clinical death.'⁴

In Book III of Plato's *Republic*, Socrates is portrayed as scrutinizing the political implications of medical management, criticizing the chronic incapacity and prolonged dying that fastidious medical regimens were making possible in his time on the grounds that excessive attention to the body made an individual incapable of fulfilling his or her role within the city.⁵ Plato paints the overreliance of free men on doctors and lawyers as an unseemly failure to order one's life virtuously, and as a threat to personal and political freedom. He evidences, too, a proleptic grasp of what has

² To be sure, these debates highlight very real concerns about health care inequities that have ample historical precedent. The advent of kidney dialysis saw an initially limited number of machines made available to individuals from the same socioeconomic milieu as that of the members of the public committee who selected them, to choose just one example of the 'bourgeoisie sparing the bourgeoisie' in what were clearly life-or-death decisions. David Sanders and Jesse Dukeminier, Jr. "Medical Advance and Legal Lag" p. 378, quoted in Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics* (New Haven: Yale University Press, 1970, 2002), 248.

³ A 2013 Pew Forum analysis notes that a growing minority of Americans (31 percent) say that medical professionals should always do everything possible to save a patient's life—up 16 percentage points since 1990. These percentages vary greatly when broken down by race and religion; 61 percent of black Protestants say that even in the case of incurable disease and great pain, they would tell their doctors to do everything possible to save their lives—these numbers are doubtless related to the genuine injustices and racial disparities and poor health outcomes that minority patients have experienced in the practice of medicine. Recall that 2009 talk about (fictitious) "death panels" originated with members of the Tea Party who rejected federal efforts to cover the medically uninsured, ostensibly because access to medical care would need to be limited if it were extended to others. Pew Research Center, "Views on End-of-Life Medical Treatments," November 21, 2013. <https://www.pewforum.org/2013/11/21/views-on-end-of-life-medical-treatments/> accessed April 11, 2019.

⁴ Ivan Illich, *Limits to Medicine: Medical Nemesis: The Expropriation of Health* (London: Marion Boyars, 1976), 197.

⁵ Plato, "Republic III" in *Plato: Complete Works*, ed. John M. Cooper (Indianapolis, IN: Hackett Publishing, 1997), 403d-410e.

come to be known as “medical hermeneutics” or the “ethics of diagnosis”⁶ when recounting to his interlocutors how persistent complaints, often resulting from bad habits and/or a poor life-style, proliferate when they get diagnosed—that is, *named*—by a physician who confers a socially-recognizable reality on the ailment that functions to absolve the patient from responsibility for his health, and legitimates ongoing treatment that directly or indirectly excuses the patient from the work that is his to do.⁷ Socrates suggests to Glaucon that the growing need among free men for skilled doctors and lawyers foretells their diminishing agency and indicates a troubling heteronomy:

Don't you think it's shameful and a great sign of vulgarity to be forced to make use of a justice imposed by others, as masters and judges, because you are unable to deal with the situation yourself?⁸

Nearly two and a half millennia later, Ivan Illich wrote a sociopolitical critique of medical “nemesis” (that is, the fateful counterpart of hubris in Greek thought) in a society that had dispensed with historical qualms about extending medicine’s reach to death. The concept of *iatrogenesis*, or “healer-induced harm”, has been recognized since antiquity; from it we derive the bioethical principle of nonmaleficence, now colloquially referred to as “do no harm.” The value of this principle is easy enough to understand if one recalls the bloodlettings of centuries past and the toxic side effects of chemotherapies administered to cancer patients today. Physicians who live with a cultivated awareness of the reality of the harms they can inflict in the course of the healing enterprise remind themselves not to vanquish their patient in the war against disease. At its best, the principle of nonmaleficence gestures to the vision of health one seeks to attain, or to maintain.

⁶ See José Luis Peset and Diego Gracia, eds., *The Ethics of Diagnosis* (Dordrecht: Kluwer Academic Publishers, 1992).

⁷ Plato, Republic III, 405d-407c. See also Talcott Parsons, “The Sick Role and the role of the Physician Reconsidered,” *The Milbank Memorial Fund Quarterly. Health and Society*, Vol. 53, No. 3 (Summer 1975), 257-78.

⁸ Plato, Republic III, 405a-b.

Clinical forms of iatrogenesis constitute an important and readily recognizable component of medical nemesis; Illich includes them in his critique, situating them within the complex nodes of professional allegiances and the public authorities that sustain them.⁹ His fundamental concerns, however, are social and cultural iatrogenesis, which he defines, respectively, as “impairments to health...due to those socio-economic transformations which have been made attractive, possible, or necessary by the institutional shape health care has taken”¹⁰ and, even more provocatively, that which “sets in when the medical enterprise saps the will of people to *suffer their reality*.”¹¹

By “health,” Illich intends the “degree of lived freedom” that individuals exercise, a word “used to designate the intensity with which individuals cope with their internal states and their environmental conditions.”¹² This understanding of health incorporates the inherent limitations—indeed, the anguish—of the human condition, but also emphasizes the freedom of the individual to exercise responsibility for his or her life, to shape his or her environment, and to care responsibly for others, even through periods of suffering, diminishment, and death. On this reading, the healthy person is characterized by an autonomous vitality; she retains her powers of perception, subjectivity, and self-definition, and engages health care resources insofar as they catalyze her internal resources for healing.

⁹ A dated, but illustrative example is drawn from the mid-nineteenth century: the first gynecologist to use antiseptic procedures in his wards (to great success in the reduction of puerperal fever) was dismissed and ostracized by his colleagues, who were offended at the idea that physicians could be carriers of death, and continued to eschew hand washing for some time thereafter. Illich, *Limits to Medicine*, 20-21 n. 28. With respect to modern end-of-life care, Arthur P. Wheeler indicates that cardiopulmonary resuscitation (CPR) is frequently iatrogenic (and ineffective) when used in attempt to save and sustain life among the terminally ill. Arthur P. Wheeler, “Suffering and Pain: The Body Beleaguered and Besieged” in Jean Bethke Elshtain and J. Timothy Cloyd, eds., *Politics and the Human Body: Assault on Dignity* (Nashville: Vanderbilt University Press, 1995), 116.

¹⁰ Illich, *Limits to Medicine*, 40.

¹¹ Illich, *Limits to Medicine*, 127, emphasis mine. Cf. the positively utopian, if not religious definition of health promoted by the World Health Organization: “a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity.”

¹² Illich, *Limits to Medicine*, 242.

Like Plato, Illich advanced the inherent tension between autonomy and medicine, forwarding the thesis that beyond a therapeutic threshold, demand for medical care itself becomes iatrogenic, injuring not only the physical health of individual patients, but crippling and fragmenting the entire social milieu. He argued that medical hubris becomes a nemesis to the health of the polity when individuals begin to doubt that they are capable of doing for themselves that which was formerly mastered, or at least coped with, at home and within their communities:

Social iatrogenesis is at work when health care is turned into a standardized item, a staple; when all suffering is 'hospitalized' and homes become inhospitable to birth, sickness, and death; when the language in which people could experience their bodies is turned into bureaucratic gobbledegook; or when suffering, mourning, and healing outside the patient role are labeled a form of deviance.¹³

Contemporary life in the United States is routinely limned by prenatal diagnosis and by the wry, half-conscious expectation that one's final months or years will take place in a nursing home, so that medically unsupervised birth, sickness, and dying often appear countercultural if not negligent. When each stage of life is perceived to bear within itself specific risks that require medical monitoring and potential crises that necessitate emergency medical intervention irrespective of the potential for cure, Illich judges that health, understood as a particular kind of autonomy, has been "expropriated."

The "expropriation of health" is functionally synonymous with "medicalization," here defined as "a process by which *human problems* come to be defined and treated as medical problems."¹⁴ In the foregoing, I have indicated that medicalization bears a complex relationship to the apprehension of reality, and thus, to human freedom and responsibility. I argue that in the absence of a substantive consensus about the meaning of death—the counterpart to pluralism with

¹³ Illich, *Limits to Medicine*, 41.

¹⁴ John Z. Sadler et al., "Can Medicalization be Good? Situating Medicalization within Bioethics," *Theoretical Medicine and Bioethics* 30 (2009): 412, emphasis mine.

respect to the meaning of life—twenty-first century Americans grasp for a common authority: a church who grounds her art on scientific foundations, and holds out the possibility of technological salvation. Medicalized and professionally managed death have become a *modus vivendi*; in our morally and religiously pluralistic society, medical values have come to be regarded as morally “neutral.”

Bonnie Miller-McLemore writes,

[M]odern interpretations of death have tended to neglect the moral component, focusing instead almost entirely on technical, physical, and psychological aspects...We lose sight of the idea that death entails a web of moral obligations and responsibilities for all parties involved and raises issues of ultimate judgment about the moral and religious significance of our lives.¹⁵

It is my contention that Americans acquiesce to the medicalization of death as “a way of getting along” through a liminal situation to which they once would have brought their own personal resources, shaped by religious understandings, and held within particular communities and cultural practices.

In what follows, I echo Illich in suggesting that the reappropriation of health, freedom, and responsibility becomes possible when contemporary practices are interrogated with respect to the values they posit as normative and as alternative practices, commitments, and interpretations are brought into view. By averring that medicalized death is a “*modus vivendi*?” I intend to draw attention to the ways in which medical practices and institutions that purport to serve a morally pluralistic society make pretensions to value-neutrality, but are in fact “value disguising.” In light of that goal, I will offer a descriptive ethics, followed by an analysis of the norms and values presupposed therein. I will then evaluate the rise of autonomy as a preeminent principle of biomedical ethics, with particular emphasis on the shortcomings of advance directives and living wills as instruments of

¹⁵ Bonnie J. Miller-McLemore, *Death, Sin and the Moral Life: Contemporary Cultural Interpretations of Death* (Atlanta: Scholar’s Press, 1988), 3.

autonomy. I will also examine the ethical naturalism of the “death acceptance” movement that underlies many contemporary palliative understandings of death and dying. Finally, I will turn to a literature review of some classical works in Christian medical ethics in order to situate my contention that the moral life of the “patient” requires more adequate attention amid the realities of medicalized dying in the twenty first century. It is my contention that the moral life of the patient has been given only spotty attention since death became intensely medicalized in the latter part of twentieth century; any appraisal of patient ‘autonomy’ requires a retrieval of these important conversations.

MEDICALIZATION AND DEATH-DENIAL

Ours is, it has been argued, a death-denying culture. Geoffrey Gorer contended that death had replaced sex as the last taboo.¹⁶ When pressed, many Americans express a preference for a death that is sudden—quick and painless—and preferably in one’s sleep. Persons naturally wish to avoid suffering, debility, and the enormous expense of intensive hospitalization, but there is also a touch of the Epicurean in such statements. Many Americans ardently hope that when “death is here,” *they are not*. Yet, in former times, the thought of an unprepared-for death induced anxiety and dread. Before the 1979 edition, parishioners praying the Litany in the Anglican Book of Common Prayer would have entreated the Lord to deliver them from sudden death. Catholics continue to anticipate the administration of last rites, including penance, anointing, and Viaticum. It is my contention that personal and ecclesiastical concerns to prepare for death manifest recognition of the moral significance of human life. I propose to demonstrate that the anthropology implied by preparation and penance is more consonant with Christian ethics than the death-eschewing preferences to which I alluded. These practices presume that the human is a moral agent, both culpable and free.

¹⁶ Geoffrey Gorer, *Death, Grief, and Mourning in Contemporary Britain* (New York: Cresset Press, 1965).

Many have posited that death has great moral significance as the limit toward which we live;¹⁷ Philippe Aries proposed “a permanent relationship between one’s idea of death and one’s idea of oneself.”¹⁸ Over the centuries, war, plague, and the hazards of childbirth have prompted various considerations about what it means to learn how to die or to meet a “good” death. Nevertheless, the expressed preferences of late twentieth and twenty-first century Americans to die a sudden death may reflect cultural dissolution as well as confusion. Contemporary medical practice has portrayed death as an experience that can be made optional or perpetually postponed, reshaping the relationship of persons to their finitude, and to one another. Lydia Dugdale has articulated four factors that help to explain why Americans are ill equipped for the experience of dying:

First, dramatic technological advance has obscured the distinction between death and life and has confounded the layperson’s ability to know whether death is imminent. Even when medical professionals agree that a patient is dying...the patient and family often remain unaware. Second, our unwavering faith in technology’s abilities has prevented us from wrestling with the reality of death. Third, the secularization of Western culture has marginalized the role of religion in preparing individuals for death. Fourth, physicians—as the new intermediaries between life and death are notoriously inadequate at discussing end-of-life issues with their patients.¹⁹

These four factors presuppose the medicalization of death that I will characterize in short order, but it is important to note that the factors that leave Americans ill-equipped in the face of life’s end have themselves interfaced with highly unstable understandings of “a good death.” In his historical study on the ethics of the deathbed, Shai Lavi demonstrates that at the turn of the nineteenth century, “euthanasia” signified “a pious death blessed by the grace of God.”²⁰ For

¹⁷ I focus on Karl Rahner’s transformation of this Heideggerian theme in chapter 4.

¹⁸ Aries, *Western Attitudes toward Death*, 106.

¹⁹ Lydia Dugdale, “The Art of Dying Well,” *The Hastings Center Report* 40, no. 6 (November-December 2010): 22-24.

²⁰ Shai J. Lavi, *The Modern Art of Dying: A History of Euthanasia in the United States* (Princeton and Oxford: Princeton University Press, 2005), 1.

Methodists who had witnessed the deaths of those who predeceased them, and who had well prepared to meet their own,

the final hour was a time of great exultation, in which the dying person, surrounded by family and friends, would approach the end like a fearless soldier ready to die a triumphant death.²¹

Detailed narratives or “spiritual biographies” from that time were quite unlike the obituaries of today in that they focused on the final hours and days before death, which were understood to recapitulate the essence of the individual’s life.

Death was a moment of truth in which the dying person and those attending the deathbed faced the ultimate truths of Christendom: immortality of the soul, sin, and God’s saving grace. Like the Gothic cathedral, dying could make visible the relation between man and God, heaven and earth.²²

Lavi relies on the reciprocal relationship between the Heideggerian categories of art and technique to explain the rapid historical shift in the way that death appeared to individuals within these successive life worlds. At the turn of the nineteenth-century, physicians were absent from the deathbed, having taken leave of the dying upon their determination of medical futility.²³ This would not last long. At mid-century, signs pointed to the fact that dying itself had become a medical concern and a process that physicians felt obliged to attend, and soon after, to assist. While the medical hastening of death was and remains mostly illegal in the United States and around the world, physicians in the last third of the nineteenth century took it upon themselves to administer anesthetics like chloroform and sulphuric ether that would facilitate a swift and painless death. Lavi argues that the professional discretion of physicians routinized what the law did not allow, that is,

²¹ Lavi, *The Modern Art of Dying*, 5.

²² Lavi, *The Modern Art of Dying*, 9-10.

²³ This leave-taking has roots in the Hippocratic Oath, and was intended to safeguard the reputation of the physician’s reputation as a healer. Robert M. Veatch, *Death, Dying, and the Biological Revolution* (New Haven: Yale University Press, 1989), ix.

the hastening of death. In less than one hundred years, the ideal of triumphant, holy dying had given way to the valuing of a quick and painless death.

Lavi is quick to point out that both the “art” of dying represented by the Methodist deathbed event and the “technique” manifested in the physician’s assistance presuppose “the wish to transform dying into a doing,”²⁴ but that, I argue, is where the similarities end. In that span of less than a century, the understanding of death underwent a major shift, from the consummation of life before God and one’s community to a physical process to be eased by pharmaceuticals and presided over by a watchful physician. The borders of medical practice and the physician’s self-understanding were enlarged to encompass the management of the final liminal situation, and the dying person came to be apprehended as a patient at the end of his or her life.

To be sure, the early twenty-first century life world is not that of the late nineteenth century. Americans die differently now, usually after lengthy struggles with chronic diseases which, thanks to modern medicine, themselves follow several decades of life that most nineteenth-century Americans never reached. Many live long enough to join the ranks of the “frail elderly” or to be afflicted by dementia. The suffering that often attends the end of life today must be neither minimized nor romanticized. Nevertheless, I contend that an important shift in self-understanding has resulted from the widespread apprehension of death as a technical event exclusive of a moral and spiritual reality. I will argue that for those who would intend life as Christians, who would receive life from God as gift and task, it is incumbent to consider one’s ultimate self-disposition and to ask how death may be enacted freely, responsibly, and faithfully. I intend to consider the meaning and value of autonomy from the perspective of Christian ethics within a cultural context of medicalized death.

²⁴ Lavi, *The Modern Art of Dying*, 8.

Near Death, Frederick Wiseman's documentary filmed in Boston's Beth Israel Medical Intensive Care Unit, is striking for its six-hour duration; the film immerses the viewer within the somber confines of the ICU, allowing the spectator to follow the chronic decline of several elderly patients along with their interactions with physicians, nurses, and their families.²⁵ The members of the medical staff are clearly intelligent, and come across as exceptionally thoughtful. And yet, they readily admit the paucity of their powers of prognostication and the limits of their abilities to ward off death. Time is a scarce commodity in these noisy, sterile halls, but the physicians are attuned to their patients' needs for more of it—more time to come to a decision, more time to decide what one wants to do or try, more time to assess whether a particular intervention will purchase more of the precious asset itself and perhaps the chance to leave the hospital—given enough time, however, the question is usually rendered moot.

The physicians' penchant for employing the language of 'patient choice' manifests concern for patient autonomy, at least as it has come to be understood in the last several decades. Phrases like "you're the boss" pepper their conversations—a phrase that rings rather ironic, given that the patients are immobilized with central lines and intravenous drips, and struggle to communicate through oxygen masks or while on respirators. Nurses attempt frank and compassionate discussions with patients about their medical options, however, the untrammelled opportunity to be surrounded by family and loved ones does not appear to be on the menu. Patients labor toward their deaths largely alone while their pulses are monitored remotely by the panopticon²⁶ of the nurse's station.

²⁵ Frederick Wiseman, *Near Death*, DVD, Documentary (Zipporah Films, 1989).

²⁶ Michel Foucault analyzed how Jeremy Bentham's surveilling institutional design spread to hospitals, ensuring that they, like prisons, would serve to extend "the disciplinary society" and to render persons automatically docile, "assuring the automatic functioning of power." *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan (New York: Vintage Books, 1977, 1995), 201, 211-12.

The nurses closely regulate family visits, noting that visitors are often difficult to manage and tend to “get in the way”—of what, one might ask—ostensibly the professional management of dying. Some family members express the wish to be called only when their loved one experiences a change in medical status.

Chief among the keywords in the documentary (along with “choice,” “chance,” and “time,”) is “comfortable.” Families plead, and physicians promise, to keep the patient “comfortable.” This watchword extends to care of the family, too; one physician takes out his script and offers to prescribe a grief-blunting pharmaceutical to a woman whose husband’s death is imminent. Even grief is apprehended physiologically when a physician acknowledges that one woman’s decision to discontinue treatment and her ensuing death might trigger a heart attack in her surviving husband. One family member admits her essential unpreparedness when she confesses that the situation is “too real.”

PRELIMINARY ANALYSIS

The ICU is host to countless “limit situations;” a motorcycle accident, aortic separation, or a pulmonary embolism could land one within its sterile walls; it is, for many, the site where human finitude and guilt are terrifyingly exposed. Here, relationships are rent, and opportunities for interpersonal reconciliation are, *prima facie*, foreclosed. Love and grief mingle with hope and anxiety as human lives come to their consummation among environs that are for most persons far removed from the site of everyday life. Wiseman’s film illustrates that in recent decades the ICU has become a

location for caring for those afflicted not only by accidents and emergencies, but for those who are passing through what Paul Ramsey termed “the acceptable death of all flesh.”²⁷

In Wiseman’s film, the hospital is seen to perform the role of the asylum, sheltering persons on the outside from the harsh realities of physical and existential suffering that might disturb the relative equanimity of the everyday world. The ICU masks the alienation and fragmentation of families and communities by offering a professionally ordered realm oriented to clinical judgment. Out of earshot of patients and their families, physicians tacitly acknowledge the medical futility of many “cases,” and voice no real confidence that these patient-persons will return to health (medicine’s traditional goal) or even be discharged from the hospital, and yet the hospital is seen to perform an important custodial function for family members and friends who cannot afford, personally or professionally, to keep company with their loved one throughout his or her lingering death.

Patients and their families, who were once asked to consent to potentially life-saving interventions are later asked to make choices about their discontinuation. One is seemingly asked to assent to one’s non-being, or the non-being of one’s loved one, in exchange for a turn to comfort care:

Wife of patient: “So if he stops breathing, we just let him stop breathing?”

Physician: “Mmhmm.”

Wife of patient: “That’s so weird.”

²⁷ Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics*, Second Edition (New Haven: Yale University Press, 1970, 2002), 129. Today, fewer Americans are dying in the ICU than in the 1970s; these statistics vary greatly by region in the United States. A Stanford Medicine website states that 60 percent of Americans still die in acute care hospitals; 20 percent die in nursing homes. Only 20 percent of Americans die at home while 80 percent say that they would like to. I take up the role of church communities in changing end-of-life practices in chapter 5. <https://palliative.stanford.edu/home-hospice-home-care-of-the-dying-patient/where-do-americans-die/> accessed April 15, 2019.

As medical staff reflect upon the plight of their patients, they hint at medical overtreatment and acknowledge the socialized costs of “doing everything [medically]” for patients. Yet several nurses and physicians confess that even with the benefit of their medical training and experience they would not know what to choose if they were in the situation of their patients or their families. In this environment, hope and trust are calibrated to the statistical likelihood of a body’s responding favorably to a medical intervention. Prognostication of death’s immanence is reduced to a sort of diagnostic positivism when a physician explains to a family member that the patient’s “numbers” are “all we can go by right now.”

This preoccupation with medical indications serves an evasive function, according to Eric J. Cassell: “The mechanical events involved in a body becoming dead, which occur in the technical sphere, are confused with the process of dying, which occurs in the moral sphere.”²⁸ The passing of the person involves moral problems, including conscience, the knowledge of what is right, and the nature and obligations pertaining to relationships that are undergoing a profound severance. The depersonalizing tendency of the modern hospital is to obscure “the moral content of the passing of the person by using the facts and artifacts of the death of the body as the vehicle for [human] interchanges.”²⁹ The patient, as person, is passed over before he or she has passed away.

As Lavi’s ethics of the deathbed presupposes, the technique endemic to hospital management of death limits the extent to which the dying individual may personally reveal anything about the fullness of his or her life. In Wiseman’s film, one observes that dying is privatized in the sense that the individual is withdrawn from his or her usual community, but also exposed, along with his or her intimates, to the gaze of persons who were strangers theretofore.³⁰ Spontaneous

²⁸ Eric J. Cassell, “Dying in a Technological Society,” *The Hastings Center Studies*, vol. 2, no. 2 (May 1974), 33.

²⁹ Cassell, “Dying in a Technological Society,” 33.

³⁰ Cf. Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Vintage Books, 1994).

expressions of grief are self-regulated in light of the hospital's own rhythms and out of consideration for nearby patients who are themselves struggling mightily. The institution values regularity and order, and persons are implicitly homogenized under the regulation of technique. Mill's strain of autonomy that would safeguard individual expression functions under a highly constrained and foreign life world.³¹

Those portrayed as "near death" in Wiseman's film are elderly, but they do not command the respect that elders traditionally have, and they are not so revered, but rather managed like children. Unlike the Methodist deathbed scene, the agency and moral authority of the dying person is presumed to lie in the past. The physician's authority is derived from the hope that reckoning with death may yet be deferred and that suffering in all its dimensions can be relieved. In the absence of adequate religious preparation for death, patients and families turn to the "technological priesthood." In the words of William F. May,

The family looks to [the physician] for a medical miracle, wrapped up in a Latin mystery, and accompanied by authoritative instructions on how to behave, so that 'everything may be done that has to be done.'³²

I do not deny that persons are vulnerable in the face of death, or that advanced age and chronic illness induce dependency and reduce agency. However, if autonomy in common parlance and in biomedical understandings signifies self-determination and the opportunity to decide for and about oneself in fundamental ways, ethics must reckon with the extent to which medical reformulation of liminal experiences, especially death, "decisively affects the ways in which individuals can accommodate them at the level of meaning...[and] behave with respect to others."³³

³¹ John Stuart Mill, *On Liberty*, ed. Gertrude Himmelfarb (London: Penguin, 1974), 119ff.

³² William May, "The Metaphysical Plight of the Family," *The Hastings Center Studies*, Vol. 2, No. 2, "Facing Death" (May 1974), 28.

³³ Paul A. Komesaroff, ed., *Troubled Bodies: Critical Perspectives on Postmodernism, Medical Ethics, and the Body* (Durham and London: Duke University Press, 1995), 4.

RESPECT FOR PATIENT AUTONOMY

The principle of respect for patient autonomy was a pivotal development in the history of biomedical ethics. Traced to the 1960s, the principle sought to protect patients from medical overtreatment as well as the paternalism of physicians whose own professional codes had until that time advocated benevolent management of their charges. The principle followed closely on the biomedical revolution that began in the 1940s and '50s with the introduction of chemotherapy and the invention of the ventilator, shortly followed by the heart-lung machine. The development of cancer treatments and advanced life-support technologies along with possibilities for organ transplantation marked off a vast new role for medicine. Human death did not seem as inevitable as it once had. Philosophies of medicine had previously concerned themselves with the establishment and maintenance of "health," but now the delaying of death appeared as a viable prospect for the profession. It was against this background of biomedical and social revolution that respect for patient autonomy emerged in the United States amid growing distrust of traditional modes of authority and celebration of personal liberty.

Proponents of autonomy argued that medical experience does not equip one to assess the burdens of treatment for another person, who may differently value the prospect of future life based on individually held beliefs and priorities; furthermore, medical skill does not necessarily confer superlative talent in terms of moral decision-making. They argued from proto-standpoint theory that unique patients might assess the benefits and burdens of a particular medical intervention quite differently than their physicians would.

While I will examine the multiple roots of patient autonomy in greater detail in the next chapter, autonomy's derivation is well-known: "*autos* ('self') and *nomos* ('rule,' 'governance,' or

‘law’).”³⁴ It will suffice here to say that in the parlance of medical ethics, autonomy involves *liberty* and *agency*, and at minimum encompasses “self-rule that is free from both controlling interference by others and from certain limitations such as inadequate understanding that prevents meaningful action.”³⁵ With respect to medical interventions, autonomy entails a patient’s *authorizing* a medical intervention (or its cessation). Such authorization requires that individuals be sufficiently informed about their medical condition, privy to the potential benefits and burdens of a proposed medical intervention, and aware of pertinent alternatives.

Terminal illness and impending death posed early challenges to the ascendance of respect for autonomy within the practice of medicine. A great majority of mid-twentieth century physicians indicated that they would withhold a terminal diagnosis from their patient in accordance with Hippocratic duty, which pledged the physician “to work ‘for the benefit of the sick according to my ability and judgment.’”³⁶ These physicians subordinated truth telling to the “no harm” principle; they considered truthful disclosure of serious illness a harm that would itself produce suffering, fear, and anxiety. The paternalistic physician understood himself as bound to prevent his patient’s physical and psychological harm.³⁷

Robert M. Veatch contends that by the late 1970s, surveys had begun to reveal a sea change in physicians’ own attitudes and practices with respect to informing patients about their terminal illnesses; physicians became far more likely to share a poor prognosis with the patient. In the decades theretofore, surveys revealed that physicians overwhelmingly opted not to disclose a diagnosis of terminal illness to a patient on a number of grounds, including the assumptions that

³⁴ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, seventh edition (New York: Oxford University Press, 2013), 101.

³⁵ Beauchamp and Childress, *Principles of Biomedical Ethics*, 101.

³⁶ Robert M. Veatch, *Death, Dying, and the Biological Revolution: Our Last Quest for Responsibility* (New Haven: Yale University Press, 1989), 141.

³⁷ Veatch, *Death, Dying, and the Biological Revolution*, 168-69.

patients could not handle the decision-making responsibility that such disturbing news would engender and that the pall of death would spoil what life remained. Beauchamp and Childress indicate that in some legal jurisdictions, “therapeutic privilege” may still be invoked if a physician makes a “sound medical judgment” that disclosure would produce anxiety or stress in a depressed, emotionally drained, or unstable person.³⁸

Veatch explains how one may arrive at a policy of “benevolent deception” through various combinations of consequentialist and deontological ethical theories, depending on how beneficence is construed.³⁹ While clinical judgment is oriented to the well-being of a unique patient, the presumptive invocation of therapeutic privilege in decades past can be seen to have relied upon morally significant anthropological assumptions: that patients could not bear the truth, that adversity is ultimately destructive to one’s quality of life, that the truth about one’s condition does not liberate, that vulnerability precludes responsibility, and that with respect to death, there is nothing for which to prepare. Physicians, as a professional group, once reified the notion that benefit flows from participating in a death-denying culture. Early proponents of autonomy vociferously denied this latter contention, along with physicians’ pretensions to special authority in psychological matters—the idea that ignorance could stave off anxiety, for example.

Proponents of autonomy took moral offense at the routine practice of depriving patients of relevant information about their conditions. Lies and omissions had the potential to cause harm in the economic realm; they denied persons the opportunity to put their affairs in order and perhaps to reconcile with family members. Ultimately, they denied persons the liberty to prepare for death, personally and religiously, and to make responsible choices to that end. Proponents of autonomy

³⁸ Beauchamp and Childress, *Principles of Biomedical Ethics*, 127.

³⁹ Veatch, *Death, Dying, and the Biological Revolution*, 168-173.

were correct to aver that these paternalistic practices violated the dignity of humans by prematurely pushing the dying from the realm of moral actors, depriving them of a rational basis from which to exercise freedom and responsibility.

One should not underestimate, however, the novelty and complexity of conditions under which these decisions had to be made in the second half of the twentieth century. Where death once came to persons “naturally,” inevitably, and unbidden, the proliferation of life-prolonging medical interventions made it necessary for someone to choose the point at which death would no longer be opposed. Those who made recourse to an ostensibly value-neutral “medical indications” policy aimed to keep this decision in the hands of physicians—the so-called “medical man’s burden” (Paul Ramsey was, at least sometimes, a proponent of this view).⁴⁰ Questions about patients’ competence and capacity for self-determination at the end of life also mingled with psychological concerns following Elisabeth Kübler-Ross’s influential *On Death and Dying*. Kübler-Ross and the psychoanalytically-trained emphasized the power of denial in the face of death—among terminal patients and physicians alike.⁴¹ More recently, J. David Velleman has argued that medical professionals’ preoccupation with autonomous choice in the form of medical options is frequently burdensome; he contends that the wills of seriously ill patients are usually impaired, and that these persons may come to experience “the right to die,” that is, the right to refuse medical treatment, as a duty to die when autonomy is construed as incompatible with dependence on others.⁴² In the spirit of beneficence, he calls on physicians to shoulder the responsibility that many had relinquished to

⁴⁰ Paul Ramsey, *Ethics at the Edges of Life: Medical and Legal Intersections* (New Haven: Yale University Press, 1978), 156-159.

⁴¹ “Since in our unconscious mind we are all immortal, it is almost inconceivable for us to acknowledge that we too have to face death.” Elisabeth Kübler-Ross, *On Death and Dying* (New York: Macmillan, 1969), 42.

⁴² J. David Velleman, “Against the Right to Die,” in Lynn A. Jansen, ed., *Death in the Clinic* (Lanham: Rowan and Littlefield, 2006), 49-65. John Hardwig argues that one may have a duty, not merely to forego additional medical treatment, but to commit suicide in order to avoid burdening the younger generation. John Hardwig, *Is There a Duty to Die? And Other Essays in Bioethics* (New York and London: Routledge, 2000), 119-136. Compare Gilbert Meilaender, “I Want to Burden My Loved Ones,” *First Things*, Issue 16 (October 1991), 12-14.

patients: “In order to avoid doing harm, then, we are sometimes required, not only to withhold options, but also to take the initiative for withholding them.”⁴³

ANTICIPATORY DOCUMENTS AND THEIR DISCONTENTS

I turn now to examine some of the empirical grounds for dissatisfaction with anticipatory documents because the discontents can help to illustrate the narrow conception of autonomy that reigns in contemporary biomedical discourse. In the medical setting, autonomy refers almost exclusively to informed and competent decision making that secures respect for one’s technical choices, whether to have every effort expended on one’s behalf or to ward off unwished-for interventions. “Autonomous choice,” rather than general capacities for governance and self-management is emphasized as constitutive of human freedom. The ideal of securing respect for body-selves is undoubtedly *an* important aspect of autonomy, but in Kantian terms, the presumptive anthropology of human “choosers” represents an attempt to extricate the notion of respect for persons as ends-in-themselves from the correlative duty of persons to legislate for themselves in accordance with universalizable maxims. “Freedom” on this account bears little relation to the moral law; it obligates others, but not the patient herself.⁴⁴

Living wills were introduced in the 1970s in an attempt to circumvent the myriad difficulties that patients face in articulating and securing respect for their autonomous choices at the end of life, when they are often in the throes of medical crisis and perhaps existential disorder. Originally forged by health professionals who sought to stave off what they considered to be disproportionately aggressive medical intervention for themselves at the end of life, living wills came to be included

⁴³ Velleman, “Against the Right to Die,” 55.

⁴⁴ This observation receives fuller treatment in chapter 2.

under the heading of advance directives, which are now routinely recommended for nearly everyone.⁴⁵ Advance directives, sometimes referred to as “anticipatory documents,” are still widely presumed to hold the tantalizing prospect of securing future respect for a person’s autonomous choices by recording an individual’s considered values and desires while that person is still unambiguously competent. They have been promoted by physicians’ and lawyers’ professional groups, state and federal policies (including the Patient Self-Determination Act), as well as lay-led end-of-life-care coalitions that encourage their hearers to “consider the conversation,” and to complete one of many standardized documents in consultation with their loved ones and their family physician.

Many state and federal resources have been devoted to increasing the percentage of Americans who have completed advance directives;⁴⁶ several states have adopted The Uniform Health Care Decisions Act, which seeks to ensure that health care decisions documented in one locale will be honored across state lines—a crucial provision in our increasingly mobile society. These priorities are not particularly surprising, for when “autonomy” is spoken of in medical settings, its meaning is usually synonymous with “patient choice.” Nevertheless, much of the prioritization of living wills is derived from hopes of more pragmatic advantage: it is hoped that documentation of a patient’s wishes will reduce legal liability for physicians and hospitals, that the burdens of decision-making on family members will be eased, and that cost-savings will accrue as physicians are empowered to honor a patient’s autonomous and documented decisions to forego or discontinue intensive life-sustaining interventions. Living wills, still fervently advocated as the

⁴⁵ Veatch, *Death, Dying, and the Biological Revolution*, 148-165. Cf. Abigail Rian Evans, *Is God Still at the Bedside? The Medical, Ethical, and Pastoral Issues of Death and Dying* (Grand Rapids: Eerdmans, 2011), 208-215, 437-438.

⁴⁶ Jeremy Sugarman *et al.*, “The Cost of Ethics Legislation: A Look at the Patient Self-Determination Act,” *Kennedy Institute of Ethics Journal* Vol. 3, No. 4 (December 1993), 387-399. <https://doi.org/10.1353/ken.0.0142>.

guarantors of patient autonomy, have come under suspicion with respect to their efficacy, however.

One article in the *Hastings Center Report* declares them failed. In brief,

for a regime of living wills to function as their advocates hope...people must have living wills. Second, they must decide what treatment they would want if incompetent. Third, they must accurately and lucidly state that preference. Fourth, their living wills must be available to people making decisions for a patient. Fifth, those people must grasp and heed the living will's instructions. These conditions are unmet and largely unmeetable.⁴⁷

Fagerlin and Schneider invoke the great difficulties—psychological and philosophical—of binding oneself through time and space to decisions made when one was differently situated. As patients get sicker, for example, many come to value life under conditions of disability and incapacity more than they had predicted when healthier. Preferences are notoriously unstable, and the answers that persons supply have been found to be heavily dependent on the way that questions are asked—including whether rates of interventional failure or success are highlighted, and what sort of normatively loaded language is included in the questioning—words and phrases like “futility” and “prolonged dying” understandably skew responses.⁴⁸ While researchers work on ways to reduce the biases inherent in the questionnaires, a majority of persons seem yet unable, or at least unwilling, to contemplate the potentially medically-relevant circumstances of their deaths. Many persons defer completion of living wills despite extensive advocacy, so much so that one study has concluded that among the elderly, delayed execution of advance directives “is a deliberate, if not explicit, [strategy of] refusal to participate in the advance directives process.”⁴⁹ In two programs designed to educate and assist persons through the process of completing advance directives, over seventy percent of the

⁴⁷ Angela Fagerlin and Carl E. Schneider, “Enough: The Failure of the Living Will,” *Hastings Center Report* 34:2 (2004): 32.

⁴⁸ Laraine Winter, Susan M. Parks, and James J. Diamond, “Ask a Different Question, Get a Different Answer: Why Living Wills are Poor Guides to Care Preferences at the End of Life,” *Journal of Palliative Medicine*, Vol. 13, No. 5 (2010). DOI: 10.1089/jpm.2009.0311

⁴⁹ Dallas M. High, “Why Are Elderly People Not Using Advance Directives?” *Journal of Aging and Health* 5, no. 4 (November 1993): 497-515.

participants indicated that they preferred to delegate final resuscitation decisions to their family and physician rather than choose for themselves.⁵⁰

Beauchamp and Childress insist, “no theory of autonomy is acceptable if it presents an ideal beyond the reach of normal agents and choosers”⁵¹ but Fagerlin and Schneider remind us that “writing complex instructions for the future is crushingly difficult.”⁵² The capacity to express oneself clearly in writing is far from universal, and written directives are only as valuable as the considered conclusions they represent. Yet persons are asked to consent to propositions with respect to which they can hardly be adequately informed. In their standardized manifestations, living wills can embody an “astonishing catalog of momentous choices.”⁵³ Furthermore, the expected outcomes of interventions change continuously as medicine advances, so in practice, living wills require regular updating in addition to initial signing.

Advocates of health care reform have prized the idea of implementing shared electronic medical records. If such a system were to take hold, advance directives could be stored and made accessible to the persons making decisions for an incompetent patient, thereby mitigating one of the five obstacles that Fagerlin and Schneider enumerate as precluding living wills from becoming

⁵⁰ Fagerlin and Schneider, “Enough: The Failure of the Living Will,” 32. Christina M. Puchalski *et al.*, “Patients Who Want their Family and Physician to Make Resuscitation Decisions for Them: Observations from SUPPORT and HELP,” *Journal of the American Geriatrics Society*, vol.48, issue S1 (May 2000): S84. <https://doi.org/10.1111/j.1532-5415.2000.tb03146.x>. This delegation, through power of attorney or health care proxy, can be a recognized exercise of personal autonomy but raises issues of its own including the accuracy of substituted judgment.

⁵¹ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, sixth edition (New York: Oxford University Press, 2009), 101.

⁵² Fagerlin and Schneider, “Enough: The Failure of the Living Will,” 34. Much of this difficulty is attributable to stubborn difficulties in predicting how future selves would value life under conditions they have never encountered. While one might plainly wish to be allowed to die if he or she were to enter a persistent vegetative state, that same person might go on to develop dementia and to enjoy experiential pleasures to a degree they had not anticipated. Cf. Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (New York: Vintage Books, 1994), 224. Rebecca Dresser, “Dworkin on Dementia: Elegant Theory, Questionable Policy.” *Hastings Center Report*, vol. 25, no. 6 (November – December 1995), 36. In chapter 5, I work to account for a vision of “mature autonomy” that mediates between the goal that one’s death might consummate a coherent life of love as well as the capacity to freely receive the life that one is given.

⁵³ Fagerlin and Schneider, “Enough: The Failure of the Living Will,” 33.

effective anticipatory documents. The fifth and final obstacle may be far more recalcitrant; having others “grasp and heed the living will’s instructions” demands a feat of hermeneutics, often from intimates who are anxious, distraught, and grappling with their own desires and preferences for the patient. Determining the point at which to implement the directive requires precision in medical prognostication and discernment, as bright lines demarcating the point at which the patient becomes “incompetent,” or begins the phase of “active dying” are not always clear. Citing one 1991 study which showed that having access to a patient’s living will did not help spouses and children to make more accurate predictions about what treatments the patient would choose, Fagerlin and Schneider submit that living wills do not help families to secure a person’s autonomous choices.⁵⁴ Finally, and most critically, they find that living wills do not affect the overall level of medical care that patients receive; they conclude, “if living wills do not affect treatment, they do not work.”⁵⁵

In spite of the myriad difficulties of executing advance directives, and the limited conditions under which they might perfectly function, they may still bear considerable value. While I hold that preoccupation with legal procedures and institutional protocols can crowd out attention to the meaning of death and to the quality of one’s will, actions, and dispositions, the creation of advance directives and advance care planning more generally represents the effort to responsibly acknowledge the reality of death, and to that end, the value-clarifying conversations that surround their preparation are an important part of the quest to face one’s own death freely and responsibly within a network of obligating relationships.

⁵⁴ Fagerlin and Schneider, “Enough: The Failure of the Living Will,” 36. Linda Emanuel, “The Health Care Directive: Learning How to Draft Advance Care Documents,” *Journal of the American Geriatrics Society* vol. 39, issue 12 (December 1991): 1221-1228. <https://doi.org/10.1111/j.1532-5415.1991.tb03578.x>.

⁵⁵ Fagerlin and Schneider, “Enough: The Failure of the Living Will,” 37.

“Substituted judgment” is yet another important means of respecting a previously-competent patient’s autonomy after he or she has become incapacitated—one that has achieved canonical status among bioethicists.⁵⁶ In the absence of a preference clearly expressed in a patient’s advance directive, decision-making surrogates might help to extend their loved one’s self-determination by offering faithful answers to questions such as, “What do you think your mother would [want] if she [were] able to tell us herself?”⁵⁷ “Substituted judgment” was originally promulgated as “donning the ‘mental mantle’ of the person who could not speak for himself or herself, deciding according to the motives and considerations that the person would have had were he or she able to make the decision”⁵⁸—a feat that must be distinguished from the determination of “best interests” which stem from paternalistic duties of beneficence rather than respect for autonomy.

The coherence of substituted judgment relies on particular understandings of “precedent autonomy”—that is to say, caretakers should “act on the patient’s prior autonomous judgments.”⁵⁹ This hermeneutical task is not easy. While some families will have enjoyed extensive conversations about such eventualities, others might recall only offhand comments their loved one made, perhaps while watching a television program. It can be difficult to weigh casual remarks like “I would never want to live like that.” Should a surrogate who remembers that their loved one once indignantly exclaimed that “[hospitals] just let black people die!” translate that recollection into a “do everything” medical imperative?

⁵⁶ Daniel P. Sulmasy, “Research in Medical Ethics: Scholarship in ‘Substituted Judgment’” in *Methods in Medical Ethics*, second edition, eds. Jeremy Sugarman and Daniel P. Sulmasy (Washington, D.C.: Georgetown University Press, 2010), 296.

⁵⁷ Sulmasy, “Research in Medical Ethics: Scholarship in ‘Substituted Judgment,’” 295.

⁵⁸ Sulmasy, “Research in Medical Ethics: Scholarship in ‘Substituted Judgment,’” 296-97.

⁵⁹ Beauchamp and Childress, *Principles of Biomedical Ethics*, 228.

Philosopher and legal scholar Ronald Dworkin argued that the making of substituted judgments need not necessarily rely on the patient's past choices [nor, presumably, on discrete remarks] but rather on his or her "character and values." He argued that the most plausible point of autonomy emphasizes the *integrity* of the individual and his or her interest in expressing their distinctive sense of self—"values, commitments, convictions, and critical as well as experiential interests."⁶⁰ Surrogates might extend the now-incompetent person's autonomous self-determination by making choices on his or her behalf that are consistent with the character and values of the individual they knew.⁶¹ Dworkin demonstrates that the valuation of autonomy hinges on philosophical understandings of the (dis)/continuity of personal identity, and on what one seeks to protect, *viz.* a coherent legacy of "integrity" or the capacity of the afflicted individual to offer a fresher evaluation of the situation at hand. He defends the former as "precedent autonomy" and argues that such autonomy makes self-creation possible, encouraging and protecting "people's general capacity to lead their lives out of a distinctive sense of their own character, a sense of what is important to and for them."⁶² Contra Dworkin, Rebecca Dresser questions whether this ideal of integrity is overly constraining, and asks, "Are real-life characters such as the fiercely independent intellectual permitted to become people who appreciate simple experiential pleasures and accept their dependence on others?"⁶³ In chapter 5, I will work to account for a vision of "mature

⁶⁰ Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (New York: Vintage Books, 1994), 224.

⁶¹ See Michelle Harrington and Daniel P. Sulmasy, "Spiritual Preparation for Death" in *Dying in the Twenty-First Century: A New Ethical Framework for the Art of Dying Well*, ed. Lydia Dugdale (Cambridge, MA: The MIT Press, 2015), 102. "At the end of life, others will be forced to make medical decisions for many of us. Their judgments will be greatly enhanced, and their burdens eased, to the extent that we have become transparent to them, through explicit conversations about end-of-life care and the appropriate documentation, certainly, but especially through the way that we have lived out our values—with maximal integrity and consistency."

⁶² Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (New York: Vintage Books, 1994), 224.

⁶³ Rebecca Dresser, "Dworkin on Dementia: Elegant Theory, Questionable Policy." *Hastings Center Report*, vol. 25, no. 6 (November – December, 1995), 36. Cf. Daniel P. Sulmasy, "Holding Life and Death in Dynamic Tension" *Health*

autonomy” that mediates between these dichotomous conceptions of autonomy, both the goal that one’s death might consummate a coherent life of love as well as the capacity to freely receive a potentially discontinuous life as it is actually given.

ACCEPTABLE DEATH?

Current national health care goals appear to acknowledge disappointment with advance directives. A recent fact sheet published by the National Institutes of Health emphasizes family decision-making—perhaps a concession to the fact that most elderly persons never complete an advance directive and appear to prefer to have others make end-of-life care decisions for them. In a nod to the challenges of making accurate prognostications about the immanence of death, the NIH declares itself poised “to improve the *prediction* of end-of-life care trajectories, to *personalize* individual treatments, and to use this information to *preempt* discomfort in the patient and stress in the family at this sensitive time.”⁶⁴ This brief fact sheet articulates a programmatic model for medicalized death—for the biopsychosocial management of patients and their families. Its aims include “prepar[ing] loved ones for this delicate transition,” reducing “dissatisfaction” with end-of-life care and decreasing feelings of “uncertainty, guilt, regret, and anger” in family caregivers faced with the decision of whether to withdraw or withhold life support from a relative. Truth claims appear to be rather fungible; it is inferred that family members can be made to feel confident about their decisions, with salutary consequences for their emotional comfort, irrespective of whether their decisions are true or good. The NIH asserts, “[p]ersonalized care that incorporates cultural beliefs

Progress, vol. 98, no. 6 (November-December 2017), 32. See also Karl Rahner, “The Comfort of Time,” *Theological Investigations* 3:10.

⁶⁴ National Institutes of Health End-of-Life Fact Sheet, updated September 2006. www.nih.gov/about/researchresultsforthepublic/EndofLife.pdf

and practices will alleviate pain while maintaining awareness, address other discomforting symptoms, and help patients prepare advance directives.”⁶⁵ It appears that cultural beliefs are to be used instrumentally in order to achieve the goals of medicalization—reducing stress and discomfort and eliciting a consumerist approach to autonomous choice. This document, as representative of the ethos of mainstream end-of-life care, represents the triumph of therapeutic modes of thinking over the questions of morality and human values that have traditionally attended dying. In the next chapter, I will attend more explicitly to how this seemingly benign style of management which presumes to mediate family relationships and cultural beliefs and to steer the interior responses of the dying individual and his or her attendants represents a more profound threat to autonomy than the paternalisms of decades past.

National goals for end-of-life care trajectories include vestiges of the late twentieth century patient autonomy discourse, but are arguably more indebted to the ideology of the death acceptance movement pioneered by Elisabeth Kübler-Ross, a Swiss-American psychiatrist. Her *On Death and Dying* gained widespread popularity in the wake of its 1969 publication.⁶⁶ Kübler-Ross helped to articulate growing recognition of the enormous suffering that was being inflicted on the hospitalized terminally ill, who were routinely subjected to painful and unwanted medical interventions, social isolation, and dehumanizing objectification. She echoed the concerns of many theologians by venturing to ask, with respect to technocratic care of the dying: “Are we becoming less or more human?”⁶⁷ In highly accessible prose, *On Death and Dying* exposed the pernicious consequences of systemic death-denial by allowing terminally ill patients at the University of Chicago Billings Hospital

⁶⁵ National Institutes of Health End-of-Life Fact Sheet, updated September 2006, 2. www.nih.gov/about/researchresultsforthepublic/EndofLife.pdf

⁶⁶ Elisabeth Kübler-Ross, *On Death and Dying* (New York: Macmillan, 1969).

⁶⁷ Elisabeth Kübler-Ross, *On Death and Dying*, 10.

to tell their stories. Kübler-Ross, along with other physicians, nurses, and theology students conducted patient interviews which were found to have pedagogical value for physicians, and a therapeutic, even “curative” function for patients, à la “the talking cure.” Kübler-Ross used these patient stories to give narrative content to the five “stages” of dying for which she is renowned.⁶⁸

Given enough time and the appropriate therapeutic support, Kübler-Ross maintained that a dying individual could achieve a “dignified” death, marked by calm and equanimity if he or she would progress through the stages of denial and isolation, anger, bargaining, depression, and finally, acceptance. The fifth and final stage is characterized by *decathexis*—a detachment from the world akin to a return to infantile narcissism, predominantly devoid of feelings—and yet, inextricably connected with self-realization.⁶⁹ While Kübler-Ross’s turn to the patient represented a humanizing advance over the technological excesses employed in the medicalized war against death, its psychoanalytic presuppositions were uncritically accepted and appropriated by chaplains and pastors, who helped to reify an ethical naturalism that does not readily cohere with traditional Christian affirmations about death and sin: as Miller-McLemore observed, “For Kübler-Ross, any problems with death lie in the institutionalization of modern society, *never* in human society in its natural state.”⁷⁰

Kübler-Ross wrote out of the awareness that anxiety about death had become more acute as religious affirmations about the afterlife and about the meaning of suffering had begun to falter.⁷¹ Nevertheless, her account maintains that anxiety is psychological rather than existential. Grief, shame, and guilt are not seen to bear a relation to ontic truths about the human condition, or to

⁶⁸ Denial and isolation, anger, bargaining, depression, and acceptance.

⁶⁹ Kübler-Ross, *On Death and Dying*, 113, 119-20.

⁷⁰ Bonnie J. Miller-McLemore, *Death, Sin, and the Moral Life: Contemporary Cultural Interpretations of Death* (Atlanta: Scholars Press), 89.

⁷¹ Kübler-Ross, *On Death and Dying*, 15.

genuine moral transgressions against God or neighbor, but are construed as arising from amoral, unconscious psychic connections to one's personal death.

In simple terms, in our unconscious mind we can only be killed; it is inconceivable to die of a natural cause or of old age. Therefore death in itself is associated with a bad act, a frightening happening, something that in itself calls for retribution and punishment.⁷²

The norm of death “acceptance” is premised upon an ethical naturalism that regards the moment of death “as simply the peaceful cessation of the human body”⁷³ that happens to provoke unconscious reactions in others. The resolution of “unfinished business” and satisfaction of the dying person's remaining wishes are seen here to have replaced more traditional language about forgiveness and personal obligation.

As interventions to stave off death, or to induce its acceptance, proliferate, some ethicists and historians have observed that persons, regulated by technique, are now more helpless in the presence of death than ever before. Robert Veatch articulates this with some force:

to ask the meaning of death is, in an indirect way, to ask the meaning of life...If individuals and societies are to retain their freedom and dignity, their responsibilities, in the living of their lives, then they must do so in their last quest for responsibility.⁷⁴

In subsequent chapters, I will demonstrate how the medicalization of death enervates patient autonomy, even as it purports to safeguard it. I turn now to selected classical thinkers in Christian medical ethics who focused their attentions on the practice of medicine and the role of the patient within it, particularly those that relate to patient duties and responsibilities—an aspect of moral theory that remains undertheorized. By so doing, I will more adequately situate my own contention that Christian ethics, rightly understood, supports free, responsible, and faithful dying, and that practical theology, here understood as the critical application of Christian sacred texts and tradition,

⁷² Kübler-Ross, *On Death and Dying*, 2.

⁷³ Kübler-Ross, *On Death and Dying*, 276.

⁷⁴ Veatch, *Death, Dying, and the Biological Revolution*, x.

posits as normative an understanding of the self that progresses in freedom and moral maturity throughout the lifespan.

LITERATURE REVIEW

Paul Ramsey's bioethical corpus is notable, for in it one sees him struggle to hold in tension the responsibilities of persons vis-à-vis the medical enterprise with an appreciation for the vulnerable and unequally situated patient. For Ramsey, death is not always a disaster, particularly for those who have reached a good old age, who have their affairs in order, and who have begun the process of their own dying—and it need not be treated as such (i.e., with triage medicine) but rather integrated as a part of life.⁷⁵ The real disaster of death, Ramsey averred in his 1970 *Patient as Person*, is our failure to care for one another through it, to be faithful and present to the dying—to those who bear a human countenance and constitute a sacredness in the social, political, and biological orders: “Desertion is more choking than death, and more feared. The chief problem of dying is how not to die alone.”⁷⁶ Ramsey links the proliferation of extraordinary measures at the end of life and the normalization of concomitantly vast expenditures of money during this period to the metaphor of illness-as-enemy, but especially to the ‘sealing up of metaphysical concerns.’⁷⁷ He notes that children are nowadays sheltered from contact with the reality of death by their parents and that adults are

⁷⁵ Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics*, Second Edition (New Haven: Yale University Press, 1970, 2002), 118, 122. Cf. “moralists [in distinction from physicians] almost always understand the distinction between ordinary and extraordinary procedures to refer decisively to morally relevant, nonmedical features of a particular patient's care: his ‘domestic economy,’ his familial obligations, the neighborhood that has become a part of his human existence, the person and the common good, and whether a man's fiduciary relations with God and with his fellow man have been settled. The difference between an imperative and an elective effort to save life will vary according to evaluations of these features of a human life, and a moralist's terms for expressing this final verdict are ordinary and extraordinary. Despite his contention that death need not always be construed as a disaster, Ramsey avers that “untimely deaths are easy to describe” and wonders how even the most long-lived persons feel about applying the phrase “fullness of years” to their own lives, cf. “The Indignity of Death with Dignity,” *The Hastings Center Studies*, vol. 2, no. 2 (May 1974), 51.

⁷⁶ Ramsey, *The Patient as Person*, 134.

⁷⁷ Ramsey, *The Patient as Person*, 136.

similarly shielded from death by hospital management of it. It is notable that in this classic work in Christian medical ethics which seeks to explicate physicians' duties always to care for their patients with whom they are taken to be in covenant relationships of fidelity that Ramsey supports moving foreknown deaths out of the hospital and into the purview of families and religious communities.

Against hospital "management" of death, he wrote:

If the 'systemic change' here proposed in caring for the dying were actually brought about, ministers, priests, and rabbis would have on their hands a great many shattered families and relatives. But for once they would be shattered by confrontation with reality, by the claims of the dying not to be deserted, not to be pushed from the circle that specially owes them love and care, not to be denied human presence with them. Then God might not be as dead as lately He is supposed to be.⁷⁸

The medicalization that functions to shield dying individuals and their loved ones from the metaphysical realities of dying and death expresses in shorthand what I have intended to advance through the phrase "*modus vivendi*:" a way of getting along through liminal situations in which shared ultimate values cannot be supposed. Ramsey critiqued "a society that itself has no moral philosophy and no common assumptions as to the good or well-being of man which medicine sporadically invokes" and thought it inconceivable that the medical profession would presume to adopt a comprehensive definition of health on such a morally muddled foundation.⁷⁹ It is on these grounds, that is, on the *lack* of a shared moral philosophy and a common understanding of the good and well-being of man that Ramsey worked as a Christian deontologist to delimit the definition of 'health' and to explicate the obligations of those who would care for "patients as persons."

The Patient as Person has come to be regarded as a book with significant implications for patient autonomy and particularly informed consent.⁸⁰ Ramsey emphasized that a patient should not

⁷⁸ Ramsey, *The Patient as Person*, 135-36.

⁷⁹ Ramsey, *The Patient as Person*, 123-24.

⁸⁰ Ramsey, *The Patient as Person*, xiii.

be helped against his will or without his cooperation. Still, it is remarkable that this deontological thinker did not choose to probe the moral life of the patient or to reflect explicitly on the patient's obligations "as person."⁸¹ At least part of the reason for this lacuna is Ramsey's thoroughgoing attention to the vulnerability of the patient. He is oftentimes exquisitely sensitive to the competing interests that operate in a hospital environment as well as to the aspects of moral psychology that would exert pressure on a patient to, for example, donate her organs or participate in medical experiments. He rightly recognizes that the covenant of fidelity between physician and patient exists between two unevenly situated persons, and hence generates 'the inflexible principle that utter helplessness demands utter protection.'⁸² The physician is obliged both to honor and safeguard the will of the vulnerable patient. The question then arises: is the patient's moral life suspended or "held in trust" during periods of great vulnerability, illness, and pain? Are her actions and dispositions evaluable? Is she culpable for the choices she makes prior to and during her sickness unto death?

In his concern to explicate the duty of care in the face of obligating vulnerability, Ramsey may have been reluctant to consider the moral life of the patient for fear that societal need would

⁸¹ Ramsey is hard to pin down on these matters; in *Fabricated Man: The Ethics of Genetic Control* (New Haven: Yale University Press, 1970), 1-59, he addresses geneticists' concerns about an ostensibly deteriorating human gene pool resulting from medical advances which have arguably thwarted processes of natural selection by preserving the lives of those whose serious diseases would have, in former times, proved fatal in childhood. Ramsey attempts to "intend the world as a Christian," and to correlate individuals' responsibility to the health of future generations with the freedom and sanctity of individuals and the unitive and procreative goods of marriage. He concludes that would-be parents have the (negative) obligation to refrain from procreating if they would be likely to pass on a serious disease or genetic defect to their offspring. I cite this example because it demonstrates that Ramsey is willing to uphold a duty to sacrifice for the common good (of the human genotype), yet "patients" appear to be spared this moral scrutiny. While death may not always be a disaster for Ramsey, it is always alien, other. He was variously a proponent of autonomy, and at other times quite restrictive about whether patients should even be allowed to refuse treatment. In *Ethics at the Edges of Life: Medical and Legal Intersections* (New Haven: Yale University Press, 1978) he emphasizes that the power to choose self-existence or self-extinction is not ours; life is a gift and a trust. Persons may not prematurely sever human relationships, but only choose how to live while dying (148). In *Ethics at the Edges of Life*, Ramsey modifies a patient's right to refuse treatment, investing the physician with that prerogative—the paternalism of the so-called "medical man's burden" based ostensibly on medical indications (156-59). In Ramsey's decades of work, one sees an early example of a Christian ethicist working to correlate theological interpretations with a shifting medical landscape. In this dissertation, I carry forward his concern with the legitimate contours of Christian freedom and the goods of embodied life. See Karen Lebacqz, "Cult Books Revisited: The Legacy of Paul Ramsey's Fabricated Man," *Theology* vol. 120(6), (2017): 403-411.

⁸² Ramsey, *The Patient as Person*, 110.

overwhelm the sanctity of the individual and erode her claim to inviolability. Ramsey treats appeals to the common good within the context of medicine as deeply suspect, essentially arguing that the common good is most effectively secured through a Christian individualism that defends each individual life as “noninterchangeable, not substitutable, and not meldable with other lives.”⁸³ While Ramsey was prescient on this account—there have indeed been political pressures to, for instance, treat the dying as repositories of spare parts rather than persons who may deign to make a gift of self—it is the goal of this dissertation to inquire about the qualities of freedom and responsibility still attributable to vulnerable patient-persons, and to ask about the forms of care and justice that they might yet help to enact, even amidst debility.

In 1983, theological ethicist William F. May took up “the physician’s covenant” where Ramsey left off, and revisited the matter in 2002; he sought to examine the nature of the physician’s profession and the images that belong to it (parent, fighter, technician, and teacher).⁸⁴ With respect to attending the dying, he noted that the healer might “parentally” shield the patient from (knowledge of) death, might wage war against death as a fighter, or look to death and dying for the deepening and ennobling of the human, as the patient’s companion.⁸⁵ Each of these responses is at times an appropriate expression of the healer’s faithfulness to the patient, however, the first evidently vitiates patient autonomy or at least informed consent. The second image of the fighter, while perhaps the dominant image in medicine today, must reckon with limits; death can sometimes

⁸³ Paul Ramsey, *Ethics at the Edges of Life: Medical and Legal Intersections* (New Haven: Yale University Press, 1978), xiv.

⁸⁴ William F. May, *The Physician’s Covenant: Images of the Healer in Medical Ethics*, Second Edition (Louisville: Westminster John Knox, 1983, 2002).

⁸⁵ May, *The Physician’s Covenant*, 25-27. May avers that the place of teaching is ambiguous with respect to terminal care when compared to its apposite role in cure, prevention, and rehabilitation. He notes, “Teaching seems irrelevant to the ultimate crisis,” and chooses instead to elide the notion of “teaching” the terminal patient with a consideration of the physician’s style of truth-telling in the face of medical crisis (175-178). This strategy is ambiguous yet suggestive: is it the temporal nature of the medical crisis that makes the physician’s potential teaching “irrelevant,” i.e. there is not enough time to effectively teach anything? Is the physician simply professionally unsuited to helping one “learn to die?”

be delayed, but never denied, and an undiscerning war against disease may violate and abandon the patient, deform the physician's profession, and abuse the community's fiscal and moral resources. Lastly, one should acknowledge that the image of the covenanted healer-companion who looks to dying and death for the "deepening and ennobling of the human" rests upon a particular anthropology that must be interrogated. Here, I shall merely flag the question, to which I will later return: what, if anything, about death can or should be ennobling?

Each of May's images of the healer presumes the vulnerability, lack, and need of the patient vis-à-vis the physician. However, May insightfully suggests that patients—even the dying ones—may be abandoned by more than the failure of others to "keep company with them" as Ramsey suggested. May describes the *moral abandonment* of the patient: the institutional and social forces that conspire to push the patient from the community of moral actors. An antipaternalist focus on patient autonomy (which arguably reaches its apotheosis in campaigns for advance directives and living wills) reduces to negative liberty; the patient is ostensibly protected from the exigencies of others' wills, and perhaps from physicians' self-interest, but a positive vision of the patient's freedom is absent.⁸⁶

In the libertarian perspective, it suffices simply that patients make their own decisions. What decisions they make or what behavior they display is not of interest—beyond minimal concerns that they do not interfere with the similar liberty of others...This apparent respect for autonomy actually consigns the patient to moral oblivion. If we do not bother to judge actions, we imply that neither the act nor the actor matters.⁸⁷

In addition to neglecting the patient "as person," that is, as moral agent, May is concerned that medical antipaternalism enervates the physician's profession, yielding an overly disinterested,

⁸⁶ I write 'ostensibly' because, as May records, physicians and surgeons report that they find it easy to manipulate or circumvent the wishes of uncooperative or "difficult" patients (p. 40). Frederick Wiseman's documentary shows that physicians secure "informed consent" from the patient by carefully shaping their questions and offering a set of options that are inflected with the professional's own preferences. Furthermore, as I have indicated, contemporary "management" of patient cases may be far more insidiously controlling than paternalisms of years past.

⁸⁷ May, *The Physician's Covenant*, 46.

minimalist ethic that thwarts the truly beneficent, covenanted relationship that he believes ought to inhere between physician and patient. This minimalist ethic has been exacerbated by increased specialization and the surge in elective procedures that encourage patients to think of themselves as fee-for-service consumers, effectively prizing technical virtuosity divorced from professional judgment. According to May, technological virtuosity is all that patients “marked by liberty alone, without moral responsibility, can expect.”⁸⁸

The implications of the minimalist ethic for the practice of medicine are profound. Classically, the physician *qua* professional has been understood to be a person who *professes* something—in the physician’s case, a specialized body of knowledge *and* technical skill—as well as a vow to be faithful to someone in pursuit of something (to be faithful to the patient in pursuit of his or her health).⁸⁹ Medical specialization, a transient society, elective and cosmetic procedures, and the constraints of managed care inhibit the long-term relationships between physicians and patients that could sustain that vision of fidelity; they both reinforce and help to produce the minimalist ethic of patient choice. These externalities discourage physicians from investigating the root causes of a patient’s complaint (insomnia, for example) in favor of prescribing a pharmaceutical fix.

Absent a relationship between physician and patient marked by some measure of trust and accountability, the conception of health itself must be delimited. If the physician cannot or will not teach the patient what she knows because medical appointments are too brief, or because her relationship with the patient is so tenuous that she dare not presume to instruct him in matters that would fundamentally alter his habitus, one deals with an attenuated understanding of health that is akin to symptom management. The lack of trust and of authentic relationship implicated in this

⁸⁸ May, *The Physician’s Covenant*, 47.

⁸⁹ May, *The Physician’s Covenant*, 6, 148-54.

diminished definition of health has contributed to the practice of defensive medicine that has been widely lamented—superfluous tests and procedures strain public coffers and induce iatrogenic illness. More fundamentally, defensive medicine manifests a crisis of trust and responsibility in the medical environment. According to May,

the physician cannot successfully enact a program of preventive, rehabilitative, and chronic care without the patient’s cooperation. The reconstruction of habits requires that the patient personally must accept some responsibility for a unitary, comprehensive, and concrete governance of his or her life and health.⁹⁰

The second edition of *The Physician’s Covenant* was updated to reflect May’s interim work on the ethics of health care reform. In it, he works to revision the covenanted relationship between physician and patient by expanding it to constitute a broader covenant between health care institutions and society in the interest of the common good. He links the sustainability of health care institutions and the hope of universal access to health care with an increased emphasis on patient responsibility and to more realistic expectations with respect to the practice of medicine.

The success or failure of a system depends on the ‘habits of the heart’ of a citizenry. Patients must be active partners in their health care...The system cannot gratify all wants, tamp down all worries, or remove the mark of mortality from our frame. We need some self-control over our wants, some composure in the midst of illness, and some courage in the face of dying. No system of itself can bring these virtues to us. We need to bring them to the system so that its benefits may sustain us more fully.⁹¹

In an explicit turn to the virtues of the patient, Stanley Hauerwas and Charles Pinches critique the practice of modern medicine, along with the “ahistorical account of moral agency that so effectively disguises [its] power over us.”⁹² Hauerwas is a staunch critic of the contemporary emphasis on autonomy, particularly when decisions and choices are presumed to be that which

⁹⁰ May, *The Physician’s Covenant*, 111.

⁹¹ May, *The Physician’s Covenant*, 220.

⁹² Stanley Hauerwas with Charles Pinches, “Practicing Patience: How Christians Should be Sick” (1997) in John Berkman and Michael Cartwright, eds., *The Hauerwas Reader* (Durham, NC: Duke University Press, 2001), 350.

makes life meaningful.⁹³ In several of his works, patient choice and its overemphasis are construed as part of a larger conspiracy, in which the practice of medicine functions to save liberalism.⁹⁴ He asserts that the Hobbesian fear of death is all that we have in common; it is the one common denominator of our implacably pluralistic culture, which nonetheless belies the observation that our understandings of death are not held in common.⁹⁵ Hauerwas portrays medicine as a charged nexus that promises to deny, or at least delay death, but in any case, gives us “a sense that none of us will have to come to terms with the reality of our death.”⁹⁶

Hauerwas’s alternative to the liberal death-avoidant social order lies in the virtuous formation of individuals within a sectarian community that acknowledges the reality of suffering and death, but also the existence of God who took these into himself and overcame them. Against pagan philosophical pretensions to self-sufficient happiness, Hauerwas argues that Christianity offers “a way to go on,” that is, a community that is capable of absorbing suffering. Its members can abide the reality of illness and death without recourse to misplaced faith in medicine’s ability to tame them.

Like May, who articulated medicine’s inability to form persons in virtuous habits, Hauerwas emphasizes the role of the Christian community in forming individuals in the theological virtues. With respect to medicine, he and Pinches maintain that the practices of faith, hope, and love give rise to *patience*, the preeminent virtue of *patients*. Tracing the understanding of “patience” to the Patristics as well as to St. Thomas Aquinas, they argue that this virtue (which must be practiced by members of the community before illness strikes) characterizes those who endure the stings of illness and death without hastening the end of life or relying on frenetic diversions from the inherent

⁹³ Hauerwas and Pinches, “Practicing Patience,” 351.

⁹⁴ Stanley Hauerwas, *Naming the Silences: God, Medicine, and the Problem of Suffering* (Grand Rapids: Eerdmans, 1990); Stanley Hauerwas and Charles Pinches, *Christians Among the Virtues: Theological Conversations with Ancient and Modern Ethics* (South Bend: University of Notre Dame Press, 1997); Hauerwas and Pinches, “Practicing Patience.”

⁹⁵ Stanley Hauerwas, *Naming the Silences: God, Medicine, and the Problem of Suffering* (Grand Rapids: Eerdmans, 1990), 123.

⁹⁶ Hauerwas and Pinches, “Practicing Patience,” 353.

sorrowfulness of the human condition. With Thomas, Hauerwas insists that patience is not the same as passivity: “Patience...is the radiant embodiment of ultimate integrity;” “Through patience man possesses his soul.”⁹⁷ On their account, the virtue of patience seems primarily to entail the exercise of fortitude and endurance.

Hauerwas and Pinches have provided a brief, but compelling account of virtuous habituation within a Christian community that culminates in witness to one’s co-religionists and perhaps to the wider world. Nevertheless, in Hauerwas’s haste to castigate the arbitrary freedom that undergirds contemporary biomedical understandings of autonomy, the true nature of Christian freedom is left unexamined. He portrays death as that which comes from without—that which must be endured rather than enacted. Yet, in approving the suggestion that the patient person “possesses his soul,” another alternative comes into view—the possibility of a more profound autonomy.

LEGITIMATE AUTONOMY IN THE CHRISTIAN LIFE

This chapter has endeavored to establish that twenty-first century individuals have largely given over the care of the dying to the medical establishment, and that we anticipate our own deaths with undue reference to this medicalization in light of the observation that Christianity is a religion formed around death and resurrection. Christian practices celebrate the death of one who self-consciously laid down his life for us—although as the Gospels tell us, not without trepidation, fear, and trembling. Christians enact this death in their initiatory rite of baptism and commemorate it, sometimes daily, in the Eucharist. Notwithstanding participation in this ritual formation, which could be understood as “learning how to die,” that is, both how to receive our lives from God as

⁹⁷ Hauerwas and Pinches, “Practicing Patience,” n. 24. Hauerwas quotes Josef Piper, approvingly. *The Four Cardinal Virtues* (South Bend: University of Notre Dame Press, 1966), 129.

gift, and to offer them back to God in freedom, I will continue to contend that contemporary practices are dominated by an enervated vision of a peculiarly medicalized understanding of “autonomy.” I will argue that Christian practical theology and moral philosophy can illuminate the moral significance of death as well as how one can prepare to face his or her death with integrity. While Christians do not celebrate the notion of autonomy unreservedly, I will argue that Christian practical theology exhorts moral and spiritual maturity and points to an appropriate inhabiting of genuine freedom along with self-mastery. I wish to explore the contours of this freedom and to reflect and elaborate on the practices of personal and communal formation that might inform the visional and obligational aspects of medical decision-making and self-disposition.

I will advance the thesis that authentic moral and spiritual autonomy depend on engaging life and death with clear eyes and an open heart, and to argue that a fully “informed consent” requires that Christians give some consideration to what they can expect from medical resources in contrast to what must be drawn from personal and communal resources of faith. To that end, I will engage thinkers that offer a counterbalance to medical positivism and that help to situate death more adequately within the Christian life.

CHAPTER 2:

COMPARING THE ERSATZ LITURGIES

‘Autonomy’ is a disputed term that is currently invoked nowhere more frequently than in the contexts of U.S. medicine and medical ethics. There, it is most often construed as “respect for patient autonomy” which in practice primarily entails respect for patient choice, i.e., health care providers’ commitment to honoring patient preferences, although conceptions of liberty, dignity, integrity, individuality, independence, responsibility and self-knowledge, self-assertion, the absence of external compulsion, and knowledge of one’s own interests inform this construal.¹ Notions of “privacy, voluntariness, self-mastery, choosing freely, choosing one’s own moral position, and accepting responsibility for one’s own choices” are also implicated.² Philosopher Gerald Dworkin contends that in light of these broad conceptual variations, “[t]he only features that are held constant from one author to another are that autonomy is a feature of persons and that [it] is a desirable quality to have.”³ Other philosophers cannot assent to even this—Onora O’Neill points out that autonomy was in antiquity a property of polities or city-states rather than persons, designating those that made laws for themselves (*autos* – “self,” *nomos* – “law”).⁴ She, along with many care ethicists, maternal feminists, and theologians, disputes the idea that personal autonomy is universally desirable; while some, citing human interdependence deny that individual autonomy is even possible, other critics disparage the excessive individualism and arbitrary self-assertion that a cultural emphasis on personal autonomy appears to reinforce. Respect for autonomy nonetheless

¹ Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988), 6.

² Ruth R. Faden and Tom L. Beauchamp, *The History and Theory of Informed Consent* (New York: Oxford University Press, 1986), 7.

³ Dworkin, *The Theory and Practice of Autonomy*, 6.

⁴ Onora O’Neill, “Autonomy: The Emperor’s New Clothes,” *Proceedings of the Aristotelian Society*, Supplementary Volume 77, issue 1 (2003), 3.

remains the key principle of contemporary biomedical ethics; efforts to secure this elusive concept are most concentrated on end-of-life care, where it is hoped that instruments like advance directives will secure patient “autonomy” even beyond the threshold of competent decision making.

I regard the medical autonomy movement with deep approbation and acknowledge that proponents of medical autonomy recognized the unique personal values that patients seek to realize in the course of their medical treatment, as well as the ways in which their bodies, spirits, and life-plans can be violated by paternalistic medical practices. I will nevertheless argue that growing processes of medicalization, particularly as they pertain to medicalized death, left patients and their families more “managed” than ever, and actually enervated many of the psychological and spiritual aspects of autonomy that are, I will argue, essential for a comprehensive understanding of the “mature autonomy” I will put forward in the final chapter, even as they purported to uphold individual freedom and choice. In what follows, I will contend that it is necessary to distinguish among diverse and often interlocking understandings of autonomy and to clarify the relationship of respect for autonomy in biomedical ethics to the “moral” and “spiritual” autonomy I will characterize in subsequent chapters. I will argue that autonomy, understood from the perspective of theological ethics, is not mere arbitrary self-assertion, but rather a morally normative ideal, and furthermore, one that is consonant with an ecumenical Christian anthropology; it holds together the deep freedom and responsibility to which Christians are summoned. In the latter part of this chapter, I will compare the contemporary “ersatz liturgies” of medicalized death (a phrase I borrow from a 2008 journal article by Jeffrey P. Bishop, Philipp W. Rosemann, and Frederick W. Schmidt that describes the totalizing and artificial nature of the “biopsychosociospiritual” ministrations

employed in the course of palliative care on patients and their families)⁵ with the (admittedly anachronistic) *Ars moriendi*, “art of dying” literature in order to suggest that the fifteenth century communal practice envisioned a more morally and spiritually autonomous mode of dying than that found in widespread practices of contemporary medicalized dying.

Respect for the personal autonomy of others springs readily from the fundamental political commitments of the United States, and importantly, from the nature of the medical encounter itself; my account will be limited to North America, and primarily the U.S. While I will elucidate the philosophical and theoretical foundations of biomedical autonomy, I will work to support the claim that at the end of life, autonomy is better construed as an achievement worth pursuing than a property or right ascribed to persons. As Alasdair MacIntyre has written, autonomy “is an achievement and a social achievement, as is rationality itself. It is in and through our network of relationships that we achieve or fail to achieve rational control of our lives.”⁶ By shifting attention from the duties of health care professionals to the moral life of the dying patient-person,⁷ I will attend to a neglected constituency; with few exceptions, not much scholarly attention has been paid to the moral life of the patient.⁸ Furthermore, it is important to attend to the ways in which the biomedical enterprise purports to safeguard patient autonomy but arguably undermines the moral and spiritual autonomy of patient-persons and their communities.

⁵ Jeffrey P. Bishop, Philipp W. Rosemann, and Frederick W. Schmidt, “*Fides Ancilla Medicinae*: On the Ersatz Liturgy of Biopsychosociospiritual Medicine,” *Heythrop Journal* XLIX (2008), 20-43.

⁶ Alasdair MacIntyre, “Medicine Aimed at the Care of Persons Rather than What...?” *Changing Values in Medicine*, eds. Eric J. Cassell and Mark Siegler (Frederick, MD: University Publications of America, 1985), 95.

⁷ I specify ‘patient-person’ in many places throughout this chapter in order to signal that my concern is with the moral agency of the person occupying, in part, the role of the patient vis-à-vis the health care team. In addition, I want to question the conditions under which dying persons are properly construed as patients, i.e., to contrast the sick-role with the dying-role.

⁸ Exceptions include: Stanley Hauerwas with Charles Pinches, “Practicing Patience: How Christians Should be Sick” (1997) in John Berkman and Michael Cartwright, eds., *The Hauerwas Reader* (Durham, NC: Duke University Press, 2001). Alastair V. Campbell and Teresa Swift, “What Does it Mean to be a Virtuous Patient? Virtue from the Patient’s Perspective,” *Scottish Journal of Healthcare Chaplaincy*, vol. 5, no. 1 (2002), 29-35. John Hardwig *et al.*, *Is There a Duty to Die? And Other Essays in Medical Ethics* (New York: Routledge, 2000).

CONTEXTUALIZING BIOMEDICAL AUTONOMY

In the United States, the principle of respect for patient autonomy came to the fore in the mid-1960s, amid a more general restructuring of social authority. The principle was formulated in response to medical paternalism as a rejection of the presumption that the physician qua professional had a special claim to authority in nonmedical matters, a rejection that paralleled contemporaneous movements for human, civil, students', and women's rights. Each of these movements represented a new popular self-consciousness and suspicion of traditional forms of authority.

The 1964 Declaration of Helsinki, produced by the World Medical Association, codified the principles for ethical research and the protection of human subjects that had emerged in the 1947 Nuremberg Code. Those principles were formulated in response to the “Doctor’s Trial”—one of twelve Subsequent Nuremberg Trials that revealed Nazi doctors’ roles in mass murder, as well as the leading role that some German physicians had played in devising and implementing atrocious medical “experiments” on concentration camp prisoners. Closer to home, an elite American physician named Henry Beecher had shaken the confidence of his compatriots by publishing synopses of twenty-two instances of domestic medical research that he deemed highly unethical—experiments that contravened the patient protections articulated in the wake of World War II.⁹ Ethical violations in medical research highlighted the tension within the physician’s dual roles of scientist and healer, undermined perceptions of benign paternalism, and sparked preoccupation with informed consent.

⁹ Henry K. Beecher, “Ethics and Clinical Research,” *New England Journal of Medicine* 274 (1966): 1354-1360. doi: 10.1056/NEJM196606162742405.

Prior to the mid-1960s, physicians enjoyed broad latitude of professional discretion, including whether and how to treat and what information to disclose and to withhold from the patient and his or her family, particularly in the face of critical illness. Under the auspices of beneficence, so-called “therapeutic privilege” gave physicians license to withhold dire prognoses if they thought their patients would be adversely affected psychologically. Most did—citing the desire to prevent anxiety, stave off death, prevent suicide (a seemingly unsubstantiated fear), or maintain the patient’s hope, the vast majority of physicians opted not to disclose serious diagnoses like cancer; meanwhile, studies show that upwards of eighty percent of contemporaneous patients wanted to be told.¹⁰ It took until the mid-1970s for physician disclosure of terminal prognoses to become normative. Efforts to secure respect for patient autonomy were thus endeavors to secure respect for persons and their idiosyncratic values in the face of an imbalance of knowledge, power, and skill between the physician and the patient. In addition to the practice of obtaining informed consent for medical interventions and research, patient autonomy originally bore special reference to truth-telling and to the right to be informed about one’s condition, particularly at the end of life; those who were kept in the dark about their true prognosis, ostensibly for their own psychological benefit, were routinely deprived of the opportunity to prepare for their deaths and to put their spiritual and material affairs in order.

The medical profession has long recognized that much more is at stake in the medical encounter than medical issues alone. Physicians gaze upon their patients’ nakedness, palpate intimate areas of the body, and as of the nineteenth and twentieth centuries, attend the most liminal events of human life—birth and death. Biomedical understandings of autonomy have sought to recognize that

¹⁰ Robert M. Veatch, *Death, Dying, and the Biological Revolution: Our Last Quest for Responsibility* (New Haven: Yale University Press, 1989), 169, 183.

the patient is vulnerable by virtue of her illness and unequally situated vis-à-vis the physician. That patients are needful of privacy has been recognized since the time of the Hippocratic oath, as physicians vowed:

Things I may see or hear in the course of the treatment or even outside of treatment regarding the life of human beings, things which one should never divulge outside, I will keep to myself holding such things unutterable [or “shameful to be spoken”].¹¹

From the Hippocratic Oath to contemporary HIPAA¹² regulations, health care professionals acknowledge that what is revealed in the medical encounter may have far-reaching implications for the patient-person within his or her community; physicians hold that information in trust, both for the good of their patients and for the reputation of their profession. Similarly, the patient must authorize clinical touching and invasive medical interventions, lest the professional open him or herself to a charge of battery. Biomedical autonomy is intended to safeguard the patient’s personal integrity.

While medical privacy and authorized touching are rather straightforward instantiations of respect for patient autonomy, the twentieth century has seen the scope of medicine expand in ways that pose new challenges to this principle. Unprecedented health advances have yielded longer life spans, largely owed to gains in public health, including widened access to public toilets, clean water, and improved nutrition. Advances in medical science and technological achievements have also produced dramatically new expectations about the length and quality of the lifespan: for those with access to them, immunizations, innovative drugs, anesthesia, advanced surgeries, joint replacements, dialysis, and ventilators have effected a new relationship of persons to their mortality. Mark Siegler has dubbed organ transplantation “a Promethean achievement,” nodding to the immense power

¹¹ As quoted in Leon R. Kass, *Toward a More Natural Science: Biology and Human Affairs* (New York: The Free Press, 1985), 229.

¹² The Health Insurance Portability and Accountability Act of 1996, Pub.L.104-191.

over life and death that technology, and the physicians who wield it, have wrought.¹³ Deaths from acute infections have given way to deaths from chronic conditions, with important implications for patient autonomy: extant lifesaving and life-extending technologies demand difficult choices from patients and their surrogates—whether to start, forgo, continue, or withdraw—and more Americans than ever spend years if not decades of their lives under “medical management” for one or more chronic conditions.

Medical “management” is a common term applied to diseases that can be partially controlled, but not cured, as well as to physiological processes that are unpredictable or painful. “Management” in this sense involves some combination of close monitoring and standardized interventions.¹⁴ A patient with diabetes might undergo regular blood sugar checks, adjusting his diet or administering insulin according to his physician’s recommendations in order to keep his blood sugar within a standardized range. Contemporary medically managed childbirth provides another illustrative example, as it typically involves a standardized protocol: individual hospitals set

¹³ Mark Siegler, “Clinical Ethics and the Physician-Patient Relationship” lecture, *The MacLean Center for Clinical Medical Ethics*, Chicago, Illinois, July 2, 2012.

¹⁴ Medical management has sometimes been taken to be even more intrusive than the examples offered here. One professor of medicine at Johns Hopkins taught: “management means that the physician comprehends and is sensitive to the total effects of an illness on the total person, the spiritual effects as well as the physical, and the social as well as the economic.” Regarding a hypothetical female patient complaining of headaches, a stiff and sore neck, fatigability, loose stools, and weight loss, he advised prescribing, in addition to Valium and Metamucil, advice regarding: “the relation between her symptoms and factors in her personality and home situation; a review of all the elements in her circumstances that might be creating stress; some constructive advice about children’s behavior and discipline, and about being a young wife; insistence on an hour’s rest period every day after lunch, free of the children; the writing down of a well organized weekly work schedule to bring some order out of household chaos, and insistence upon adherence to it; the suggestion that she employ a day worker every week or two to help with the heavy housecleaning; a conference with the husband to ensure that he understands how to support his wife’s position (inquiries about sex adjustment would be apropos at this juncture); efforts to interest the patient in hobbies and activities affording some respite from daily unending household routines; and an admonition to go light on relaxing cocktails and nightcaps during this stressful period, lest dependencies develop.” This commendation of paternalism is rather striking in a publication dating to 1970—the height of patient autonomy discourse; it is, nonetheless, in keeping with the spirit of biopsychosocial and biopsychosociospiritual models of medical care that inform contemporary palliative care philosophy. Philip A. Tumulty, “What is a Clinician and What Does He Do?” *The New England Journal of Medicine*, 283 (July 1970), 20-21, republished in Philip A. Tumulty, *The Effective Clinician: His Methods and Approach to Diagnosis and Care* (Philadelphia, PA: W. B. Saunders, 1973), 1-3.

timetables for labor and delivery in consultation with the recommendations of professional obstetric organizations. Laboring women are usually forbidden from eating or drinking to mitigate the risk of aspiration in the event of an emergency caesarian section. Most women endure an IV throughout their labor, undergo routinized cervical exams, continuous electronic fetal monitoring, and submit to increasing doses of contraction-intensifying Pitocin if they fail to “progress” according to the hospital’s timetable. Critics of medicalized childbirth argue that these routine interventions limit a woman’s range of movement during labor and make epidural anesthesia nearly a foregone conclusion, further restricting the position in which a woman gives birth, necessitating her being “coached” to deliver, or pressured to consent to a C-section.

I cite this example because birth, like death, is one of the liminal human situations routinely managed by physicians.¹⁵ Laboring women do not in law or principle have their autonomy revoked,¹⁶ but in practice may find it difficult or impossible to refuse these interventions, or even to imagine that their refusal might be honored. While both patient and physician presumably seek to preserve the life and health of both the woman and her neonate, the hospital values the efficient use of resources and personnel, and seeks to avoid birth-related lawsuits, while the pregnant woman may value avoiding major surgery and embarking on parenthood with a sense of accomplishment and competence in hand—values may conflict. Preoccupation with medical indications and interventions thus frame the event of childbirth as a primarily medical one, obscuring the personal significance and profundity of the life-giving event that establishes new human relationships and roles. Medical

¹⁵ Janet Harvey has analyzed the social management of birth and death, and argues that technologies of surveillance play a crucial role in shaping the trajectories of labor and what she calls the “work” of dying to accord with cultural expectations about how each should proceed. Janet Harvey, “The Technological Regulation of Death: With Reference to the Technological Regulation of Birth,” *Sociology* 31 (1997), 713-735. doi: 10.1177/0038038597031004005.

¹⁶ Mary Briody Mahowald, *Bioethics and Women: Across the Lifespan* (Oxford: Oxford University Press, 2006), 113.

management is inevitably a moral issue that raises crucial questions about human freedom and the justifications for restricting it, as well as the moral agency of the persons involved.

Medical management is not a new phenomenon; as cited in chapter one, Plato probed the (inverse) relationship between medical management and personal and political freedom through Socrates' character in *Republic*.¹⁷ While the ancient physician's armamentarium consisted primarily of dietetic advice and exercise regimens, the "patient" who agrees to follow the regime assents to use his time to exercise in accordance with the physician's vision of health, and ascribes at least a partially medicinal meaning to food; in so doing, he may sacrifice other time-intensive pursuits, along with some of eating's cultural and convivial pleasures. The patient invites the physician to reform his *habitus* at some cost to his personal freedom, and perhaps even his political role. For Plato, an individual's chronic overreliance on medical management indicated a troubling relinquishment of self-government and personal judgment, as well as diminished personal competence—the ability to assess and deal with a situation oneself.¹⁸ He suggested that medical management always introduces a measure of heteronomy into an individual's life and concluded that a free man should set limits to medical management and to other external forms of control.

The contemporary (and canonical) bioethicists Tom L. Beauchamp and James F. Childress hold that the two essential conditions for autonomy are *liberty*—"independence from controlling influences" and *agency*—"capacity for intentional action."¹⁹ As the forgoing examples suggest, the nature of the medical encounter often tends, of its own accord, to militate against these conditions. Those who engage health care systems typically do so because their lives have become disordered by

¹⁷ Plato, *Republic III* 403d-410e in *Plato: Complete Works*, ed. John M. Cooper (Indianapolis, IN: Hackett Publishing, 1997).

¹⁸ Plato, *Republic III*, 405a-b.

¹⁹ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, seventh edition (New York: Oxford University Press, 2013), 102.

illness; they perceive themselves to have need of a physician's knowledge, skill, care, or prerogative, and thus engage the health system from a position of relative dependence. Requirements for informed consent have been the primary mode of safeguarding the conditions for autonomy. Patients should, ideally, have all pertinent information about their condition disclosed to them, along with the risks and benefits of a proposed treatment and its alternatives before being given the opportunity to voluntarily authorize or refuse interventions and procedures. As Beauchamp and Childress observe, the trend in recent medical ethics has been to emphasize not merely the disclosure, but rather the patient's *understanding* of information pertinent to diagnosis, prognosis, and treatment.²⁰ Nevertheless, as the nature of medicine has become more comprehensive, the opportunity to reject discrete interventions is invariably compromised.

One need only think of Freud and to the rise of psychiatry as a medical subspecialty to reflect on some of these changes. The psychiatrist's claim to superior knowledge lies not only in the areas of physiology and pharmaceuticals, but also in an ostensibly fuller understanding of the psyche itself. The psychiatrist lays claim to a normative understanding of psychosexual development and analyzes her patient according to a professionally sanctioned school of thought, replete with therapeutic norms and remissive prescriptions—a role that has been compared to that of a secular priesthood.²¹ In the twentieth century, sexual frigidity and religious ideation alike were assessed and addressed via “medical” models. While psychiatrists reach deeply into the private lives of their patients and seek to intervene in the most intimate aspects of human life, they have often been able to excuse a lack of transparency on therapeutic grounds—the therapist's observations might be withheld from the patient so as to allow the patient time to arrive at her own insight, for example. Insofar as psychiatry

²⁰ Beauchamp Childress, *Principles of Biomedical Ethics*, 131-34.

²¹ See Philip Rieff, *The Triumph of the Therapeutic: Uses of Faith after Freud* (Chicago: University of Chicago Press, 1966, 1987).

constitutes a crucial component of palliative care medicine and end of life care, it is important to attend to the ways in which psychiatric assessments and interventions may thwart patient autonomy; I will return to this matter later in the chapter.

For the moment, it is important to note the gatekeeping function that psychiatrists play with respect to autonomy; while only a court can declare someone legally incompetent, health professionals—usually psychiatrists—are called upon to assess patient capacity.²² Health professionals are not obligated to respect the preferences and decisions of one who is judged to lack capacity; functionally, the incapacitated person is considered nonautonomous.²³

While the principle of respect for autonomy seeks to safeguard the physical integrity of the individual, to allow that person to live in a consistent way with his or her values, and to protect meaning-making in a pluralistic society, the practice of medicine has its own values, some prosaic, others arguably political and metaphysical.²⁴ Medicine has been invested with the tremendous power to diagnose, to label as deviant, and to manage the human condition, as social theorists and critics of medicalization have worked to disclose.²⁵ I will go on to substantiate the claim that palliative care, in aspiring to the total care of patients at the end of life, threatens to become totalizing in a way that is particularly subversive of autonomy. Medicalized aspirations of “biopsychosociospiritual” care manage patient-persons in ways both intimate and comprehensive. These ministrations, as I will

²² Beauchamp and Childress, *Principles of Biomedical Ethics*, 114-15.

²³ Physicians acknowledge that capacity assessments tend to be triggered by patients who reject their medical recommendations.

²⁴ Jeffrey Bishop has argued that modern medicine eschews the metaphysics of final and formal causation—modern medicine is agnostic with respect to human ends—but embraces the metaphysics of material and efficient causation, premised on keeping animated matter in motion. Through a Foucauldian analysis, Bishop argues that the contemporary practice of medicine helps to control the body politic while sustaining an illusion of self-sovereignty, i.e., “patient choice.” See Jeffrey P. Bishop, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (Notre Dame, IN: University of Notre Dame Press, 2011).

²⁵ See José Luis Peset and Diego Gracia, *The Ethics of Diagnosis* (Dordrecht: Kluwer Academic, 1992). Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper & Row, 1974); *The Manufacture of Madness* (London: Routledge & Kegan Paul, 1971).

argue, are nevertheless cut off from communities of practical wisdom that could effectively reinforce persons' autonomous integrity.

In the forgoing, I have worked to substantiate the premise that medicalization and medical management are inescapably moral issues when they affect the ethos and self-understanding of persons. I turn now to the philosophical underpinnings of the principle of respect for patient autonomy in order to examine more closely the nature of autonomy ascribed to individuals in order to focus attention on the moral life of the patient.

THEORIZING AUTONOMY

While the principle of respect for autonomy is widely assumed to have its roots in Kantian morality, contemporary biomedical discourse and practice has only selectively appropriated Kant's philosophy; the principle of "respect for patient autonomy" that invites patient-persons to "choose their choice" without reference to duty, obligation, or universalizability owes much more to John Stuart Mill's theory of liberty than to deontological moral theory. This amalgamation of theoretical underpinnings offers important protections to patients against the kinds of infringements detailed in the previous section, but suggests a certain dismissiveness toward the obligations *of* the patient. As I suggested at the conclusion of chapter one, this minimalist ethic functions in biomedical ethics to ground the obligations of others to patient-persons, but may in fact consign the patient herself to moral abandonment and oblivion,²⁶ an ironic outcome when one considers that the concept of autonomy inherently affirms the moral agency of individual persons.

²⁶ See my chapter 1, p. 41ff. Cf. "In the libertarian perspective, it suffices simply that patients make their own decisions. What decisions they make or what behavior they display is not of interest—beyond minimal concerns that they do not interfere with the similar liberty of others...This apparent respect for autonomy actually consigns the patient to moral oblivion. If we do not bother to judge actions, we imply that neither the act nor the actor matters." In William F. May, *The Physician's Covenant: Images of the Healer in Medical Ethics*, second edition (Louisville, KY: Westminster John Knox, 1983, 2002), 46.

In the biomedical setting, autonomy is often invoked as either a supreme limiting principle—that which keeps a health care professional from running roughshod over the patient—or as a property of the patient that yields the inchoate duty of the professional to promote the patient’s interests, or even her happiness. Each of these ideas finds some theoretical grounding in the philosophies of both Immanuel Kant and John Stuart Mill. In these moral theories, autonomy is central “both as a model of the moral person—the feature of the person by virtue of which she is morally obligated—and as the aspect of persons which ground others’ obligations to them.”²⁷ These theories affirm that the patient-person is a moral agent, replete with obligations that include self-development.²⁸ However, Kantian autonomy, with its insistence that reason is the proper governor of the will, and not inclination or instinct, is a far more rigorous idea than Mill’s conception of autonomy as personal liberty. Additionally, for Kant, this idea of morality is far more central to our humanity than it is for Mill. Under the Kantian conception there is, in principle, no “moral holiday” for the autonomous individual who wills in accordance with the moral law. No sickness, even unto death, would permit a rational being to except herself from the strictures of the categorical imperative.

In spite of its moral rigor, Kant “invented” the concept of autonomy in order to liberate and dignify ordinary individuals. J.B. Schneewind traced the philosophical forerunners to Kant’s formulation in order to demonstrate that the supposition of prima facie equal moral competence was, after the seventeenth century, a fairly coveted conclusion in search of a metaphysical backing. Kant, like many of his predecessors, wanted out from under the cloak of clerical authority and

²⁷ John Christman, “Autonomy in Moral and Political Philosophy,” *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta (Spring 2011). <http://plato.stanford.edu/archives/spr2011/entries/autonomy-moral>.

²⁸ On the harmonization of duties and the duty to develop oneself, compare Immanuel Kant, *Fundamental Principles of the Metaphysics of Morals*, trans. Thomas K. Abbott (Upper Saddle River, NJ: Prentice Hall, 1949), 40 (Ak 447) with J.S. Mill, *On Liberty*, ed. Gertrude Himmelfarb (London: Penguin, 1974), 127, 180-81.

chafed at the thought of the dependence “of one rational being on the commands and desires of another.”²⁹ By positing that rational beings have the capacity to comprehend the moral law and to impose it on themselves, Kant was able to ground a new self-understanding that included the possibility of feeling self-wrought respect, along with a novel foundation for social intercourse:

The conception of morality as self-governance provides a conceptual framework for a social space in which we may each rightly claim to direct our own actions without interference from the state, the church, the neighbors, or those claiming to be better or wiser than we.³⁰

One might add physicians to this list. Self-governance, made possible by the autonomy of the will, grounded ascriptions of dignity, inviolability, and incomparable worth to human beings and gave rational beings reasons for abjuring every form of paternalism.

Contra Mill, however, Kant’s idea of autonomy—the autonomy of the will—is hardly synonymous with personal spontaneity, or the freedom “to pursue [one’s] own good in [one’s] own way.”³¹ The principle of morality that would revolutionize modern moral theory holds, rather, “that a free will and a will subject to moral laws are one and the same.”³² Kant held this formula to be equivalent to other formulations of the categorical imperative.³³ It is the capacity to be obligated by the moral law and to formulate one’s maxims in accordance with duty that constitutes rational freedom.

While Kant’s is a formal theory that partially secures the freedom of rational beings precisely by refusing to dictate the content of their maxims (their subjective principles of volition), one can

²⁹ J.B. Schneewind, *The Invention of Autonomy: A History of Modern Moral Philosophy* (Cambridge: Cambridge University Press, 1998), 511.

³⁰ Schneewind, *The Invention of Autonomy*, 4.

³¹ J.S. Mill, *On Liberty*, 72.

³² Immanuel Kant, *Fundamental Principles of the Metaphysics of Morals*, trans. Thomas K. Abbott (Upper Saddle River, NJ: Prentice Hall, 1949), 63-64.

³³ Compare “act only on that maxim whereby thou canst at the same will that it should become a universal law,” with the second formulation of the categorical imperative, the so-called “practical imperative;” “So act as to treat humanity, whether in thine own person or in that of any other, in every case as an end withal, never as means only.” Kant, *Fundamental Principles*, 38, 46.

conceive of maxims formulated by patient-persons that would fall short of what Kantian morality requires. Just as one may feel compelled, when in dire straits, to borrow money with the promise to pay it back when one knows that he will not be able to,³⁴ the exigencies of serious illness pose varied opportunities that may necessitate the thwarting of self-love. Those who “formulate a maxim” to devise a way to jump the organ transplant waiting list could hardly will that others to do likewise.

PSYCHOLOGICAL AUTONOMY

Thus far, I have endeavored to demonstrate that the philosophical theories that ground respect for patient autonomy in the biomedical setting are equally significant for their use in interrogating the moral life of the patient-person herself. Kant and Mill advance distinctive moral theories of autonomy that have, to an extent, been selectively harmonized in the biomedical literature, but cannot be conflated. Near the outset of this chapter, I indicated that I would support the claim that with respect to the end of life, autonomy is better construed as an achievement worth pursuing than a property or right ascribed to persons. While the philosophical theories already addressed provide an essential normative lens for comprehending the autonomy of patient-persons, I concur with Jurrit Bergsma and David Thomasma that in the health care setting, autonomy is an even more complex phenomenon than philosophical theories suggest: “Autonomy is a fundamental building block of an individual’s identity and mechanisms for dealing with illness, disease, and incapacity.”³⁵ Bergsma and Thomasma attend to both philosophical and *psychological* dimensions of autonomy within the clinical medical context, and contend:

Autonomy, from the perspective of psychology, is not a static principle, but a dynamic one that describes the self-determination of individuals and their relationships within the context

³⁴ Kant, *Fundamental Principles*, 39.

³⁵ Jurrit Bergsma and David C. Thomasma, *Autonomy and Clinical Medicine: Renewing the Health Professional Relationship with the Patient* (Dordrecht: Kluwer Academic Publishers, 2000), xi.

of their life...the essence of autonomy is that it becomes visible within the living context of a person.”³⁶

In this sense, autonomy is a quality of personal identity, closely related to the capacity for problem solving that may be elicited by the crises and setbacks that arise in the context of life cycle events, including health problems and even terminal illness.

Although they seek to bridge and integrate descriptive (psychological) and normative (ethical) dimensions of autonomy, Bergsma and Thomasma are reluctant to consider psychological autonomy a moral norm—they wisely decline to conflate a descriptive *is* with a normative *ought*.³⁷ Many persons exhibit a basic pattern of non-autonomy; such persons fall under what they term the “No Future-Unanticipated” basic autonomy pattern. These persons are characterized as lacking a life “script,” and tend to exhibit a dearth of problem-solving capacity when unexpected events intervene in their lives; from a descriptive standpoint, such persons are characterized by subsistence adaptation and life organization “around external, controlled powers,” including “the divine will, human authority figures, or authoritative life structures.”³⁸

The autonomy pattern is a heuristic tool for describing typologies of persons. One cannot leap from a description of those who do not exhibit much autonomy in their lives and insist that they simply become more autonomous, or suggest that they have failed morally in some way.

Drawing on Erik Erikson’s theories of ego development,³⁹ Bergsma and Thomasma accept that

³⁶ Bergsma and Thomasma, *Autonomy and Clinical Medicine*, 22.

³⁷ Bergsma and Thomasma, *Autonomy and Clinical Medicine*, 17.

³⁸ Bergsma and Thomasma, *Autonomy and Clinical Medicine*, 20.

³⁹ For Erik Erikson, ‘autonomy’ is, in the strict sense, one component in the stages of ego development. Schematically, the developmental “crisis” of “autonomy versus shame or doubt” is associated with a child’s mastery of toilet training in early childhood. A child’s healthy ego is, in part, consolidated when a she successfully gains a sense of self-control without loss of self-esteem by negotiating respect for her burgeoning autonomous will as she demonstrates increasing skill and self-direction with respect to “holding on” and “letting go.” Healthy ego development is diminished to the extent that shame and doubt preponderate over the burgeoning autonomous will, an outcome that Erikson attributes to overbearing parents who undermine their child’s emerging self-reliance. Each stage of ego development is epigenetic, so that while the crisis of autonomy initially emerges in early childhood, an individual’s autonomous functioning is challenged to undergo recapitulation at each stage of ego development. When Bergsma and Thomasma use the word

personal identity is shaped by one's upbringing, by the values and commitments of one's community and social milieu, and by one's personal responses to developmental crises. Personal identity, although a dynamic process, is to some extent simply a fact in the world. Bergsma and Thomasma are careful to remark that respect for persons should not be predicated on the degree of autonomy they (do not) exhibit.

Yet, despite the partial "givenness" of personal identity, Bergsma and Thomasma cannot but help affirm that autonomy matters; they observe that "autonomy and individual patient reactions [to illness and disease] are strongly related," and imply that self-determination is desirable and perhaps, even ideal.⁴⁰ Identity is dynamic, and subject to revision in response to life crises, depending on how and whether the individual is able to meet and "solve" the presenting "problem." In the context of health care,

[a]n individual's autonomy may become vulnerable if she got the wrong medication, or her mental ability to act decreased or became paralyzed. But, especially in cases of physical impairment, patients are often able to overcome bodily restraints or impediments and 'come through' the experience as very autonomous people. Thus disease itself may not challenge autonomy.⁴¹

Health crises test an individual's ego flexibility and problem-solving capacities, and confront the individual with the challenge of psychosocial reintegration in response to physical diminishment whether illness is temporary or progressive and ongoing. The occasion of illness provides an opportunity for ego integrity to be manifested. One can imagine an individual whose serious illness

'autonomy,' they seem to be invoking Erikson's more comprehensive idea of 'integrity,' which describes the healthy ego functioning ideally attained during mature adulthood. The individual characterized by integrity has successfully navigated the tasks of development with a preponderance of healthy functioning, having successfully integrated a sense of basic trust with autonomy, initiative, industry, identity, intimacy, and generativity. The individual marked by integrity demonstrates ownership of, and responsibility for, his or her life. Cf. Erik H. Erikson, *Identity and the Life Cycle* (New York: W. W. Norton and Company, 1980), 53, 71ff. I will address Erikson's theory more comprehensively in chapter 3 which engages the work of Don S. Browning.

⁴⁰ Bergsma and Thomasma, *Autonomy and Clinical Medicine*, 8.

⁴¹ Bergsma and Thomasma, *Autonomy and Clinical Medicine*, 11.

spurred her to solidarity with, and action on behalf of, similarly-situated others, perhaps culminating in advocacy work or in the establishment of a charity to promote research on the afflicting disease. Less dramatically, an elderly widower might, upon discharge from the hospital, enlist help to modify his home so that he can continue to practice his woodworking, and thereby continue to live in a way that is consistent with his life plan. These are examples of the kind of problem solving that actualizes psychological autonomy. The alternative must be acknowledged, too: a medical crisis might occasion a spiral of dependency and a marked disintegration of ego identity in the life of an individual; one might continue to inhabit the sick-role long after the physiological crisis has passed.

Bergsma and Thomsma are unwilling to cast autonomy as a moral norm, but they do view the self-determination of individuals and their relationships as a hallmark of human flourishing; autonomy would seem to be, on their account, at least a moral—and social—ideal. The one who derives (perhaps unconscious) gratification from persisting in the sick-role claims exemptions from social obligations and expectations, and consequently demands more of others.⁴² The sick-role can become a strategy of passive manipulation that compromises the autonomous strategies of one's intimates—in this sense, autonomy is relational—strength gives rise to strength, and vice versa.⁴³

⁴² Talcott Parsons famously analyzed the sick role in terms of social deviance. Cf. "The Sick Role and the Role of the Physician Reconsidered," *The Milbank Memorial Fund Quarterly*. Health and Society, vol. 53. no. 3 (Summer, 1975), 257-278.

⁴³ Heather Curtis offers an historic example of how an individual's refusal of the sick role can also disrupt social norms and practices. She relates that during the Victorian era, many bourgeois women endured protracted stints of invalidism that were sanctioned by highly gendered understandings of Christian holiness allied to the ideal of passive resignation as the proper response to pain and suffering. Many of these women became attracted to divine healing movements, convinced that Christian holiness demanded their more active service to God; their efforts to embrace a more self-directive mode of living were met with resistance as attacks on the reigning masculine-activity/feminine-passivity paradigm and its socioeconomic supports. Heather D. Curtis, *Faith in the Great Physician: Suffering and Divine Healing in American Culture, 1860-1900* (Baltimore, MD: John Hopkins University Press, 2007).

Bergsma and Thomasma worry that the contemporary medical context poses novel hazards to autonomy; an abundance of technological innovations offer unprecedented opportunities for patients to assume a medically managed identity. For example,

lifelong [immunosuppressive] medication for [organ] transplant patients [may induce] learned dependency on medical checkups. *If the patient tends to give up to these events, and transforms active strategies into a coping style characterized by learned dependency, the patient's humanity will suffer...* Some challenges and responses may alter personal character in such a way that the patient becomes unable to survive as a person, even if the body does.⁴⁴

Meanwhile, they aver that the contemporary context of medical care constitutes “an assault” on the patient’s life and values, as it is delivered in a context where physicians and patients meet as strangers who cannot presume to share common traditions or a common culture.⁴⁵ While the language of “assault” may appear hyperbolic, Bergsma and Thomasma are presumably relying on the Eriksonian insight that ego development is decisively impacted by the historical era in which a cohort develops; Erikson assumed that “men who share an ethnic area, a historical era, or an economic pursuit are guided by common images of good and evil.”⁴⁶ Bergsma and Thomasma avow that a greater degree of moral pluralism than Erikson imagined may inhere in the contemporary hospital room; they judge that a presumptive lack of shared values in the medical encounter makes it more difficult for the patient to elicit her autonomous problem solving capacity in response to her health problems—and that her “humanity” is thereby diminished. Autonomy, they argue, is a psycho-social and behavioral aspect of personhood, “part of a whole-istic view of human life;” they observe that the “the relationship of autonomy and disease is very intimate.”⁴⁷ One’s sense of identity and integrity can be interrupted in a medical encounter, particularly when one is vulnerable,

⁴⁴ Bergsma and Thomasma, *Autonomy and Clinical Medicine*, 12, emphasis mine.

⁴⁵ Bergsma and Thomasma, *Autonomy and Clinical Medicine*, xv.

⁴⁶ Erik H. Erikson, *Identity and the Life Cycle* (New York: W. W. Norton and Company, 1980), 17.

⁴⁷ Beauchamp and Childress, *Autonomy and Clinical Medicine*, 13.

very sick, and removed from one's community. Not everyone is able to maintain their life's momentum through the wake of such events.

With sketches of moral, personal, and psychological autonomy in hand, I turn now to compare the “ersatz liturgies” of end-of-life care with particular attention to the construal of the dying person and his or her intimates (the majority of Americans die within healthcare institutions, so the dying person is simultaneously the “patient-person” more than sixty percent of the time). Contemporary practices of medicalized death are increasingly recognized as forms of ritual that, as such, are imbued with symbolic, social, cultural—and moral meanings.⁴⁸ I will compare several modern “liturgies” of medicalized dying to the *Ars moriendi* “art of dying” practice that began in the fifteenth century. By examining the ways that rituals shape, recognize, and order the end of life, I will have occasion to attend to the roles, responsibilities, and construal of the patient-person and his or her attendants. I intend to support the thesis that the *Ars* supported a more morally, personally, and psychologically autonomous mode of dying than do most contemporary practices.

ERSATZ LITURGIES: CONTEMPORARY RITES

*“At the level of practice, few actually advocate beating the elderly to death...”*⁴⁹

Advance directives have long been occupied with the so-called question of “extraordinary means.” Many of the earliest directives were written to deflect unwanted interventions that carry a low likelihood of success so that individuals could, by their own lights, “die with dignity.” Today, seriously ill patients can request that their physician write an order to “make them DNR, or

⁴⁸ Shan Mohammed and Elizabeth Peter, “Rituals, Death and the Moral Practice of Medical Futility,” *Nursing Ethics* 16(3), (2009), 295. doi: 10.1177/0969733009102691.

⁴⁹ John Tercier, “The Lips of the Dead and the ‘Kiss of Life’: The Contemporary Deathbed and the Aesthetic of CPR,” *Journal of Historical Sociology*, vol. 15, no. 3 (September 2002), 314.

depending on jurisdiction, DNAR—“Do Not *Attempt* Resuscitation.” Without such a legal order in their medical record, any hospitalized patient who suffers cardiopulmonary arrest—for any reason—triggers a full code, whereupon a medical team will descend to provide cardiopulmonary resuscitation (CPR), cardiac compressions, intubation of the airway and artificial respiration, along with defibrillation (cardiac shock) and often the administration of medications through a central line. CPR is a violent procedure that can leave broken ribs and punctured organs in its wake; media depictions, including popular hospital dramas, tend to vastly overestimate its efficacy: “Peberdy *et al.* reported that only 1-6% of hospital inpatients survive CPR, and only 17% of the patients who survived were discharged alive.”⁵⁰

These statistics are rather grim. Recent debates in medical ethics have swirled around the question of whether and under what circumstances CPR should be considered medically futile, and thus non-obligatory. Many ethicists emphasize that truly informed consent requires that patients be made to understand CPR’s low likelihood of success. Still, a 2003 study showed that palliative care patients requested CPR at similar rates to those receiving curative treatment;⁵¹ advance directives, originally constructed to reject unwanted medical interventions are as easily used to request that “everything be done.” The public does not seem ready to relinquish the full code. Several scholars have recently argued that while usually *physiologically* futile, the routine practice of CPR is a ritual that functions morally, aesthetically, and culturally to navigate and negotiate the existential anxiety and uncertainty of the dying process.

⁵⁰ M. Peberdy, W. Kaye, J. Ornato et al. “Cardiopulmonary Resuscitation of Adults in the Hospital: A Report of 14,720 Cardiac Arrests from the National Registry of Cardiopulmonary Resuscitation,” *Resuscitation* 58 (2003), 297-308. As quoted in Shan Mohammed and Elizabeth Peter, “Rituals, Death and the Moral Practice of Medical Futility,” *Nursing Ethics* 16 (2009), 294.

⁵¹ M. Cantor *et al.*, “Do-Not-Resuscitate Orders and Medical Futility,” *Archives of Internal Medicine* vol. 163(22), (December 2003), 2689-94.

Shan Mohammed and Elizabeth Peter concede that CPR may meet the statistical threshold for “physiological futility,” but contend that it may not be “qualitatively futile”—in other words, CPR has qualitative *utility* insofar as it “facilitates the process of dying and death” for “patients, families, and health care providers.”⁵² They contend that CPR is a moral practice insofar as it “mediates important social meanings in the dying process” and makes “individuals accountable to each other in a social network.”⁵³ On their account, “social meaning” remains undefined; it seems plausible to infer that the health team’s strenuous exertions ascribe value to the perishing individual. “Social accountability” is mediated through a complex pattern: the family yields responsibility for the active rite to the health care team, whose plurality allow them to diffuse responsibility for the resuscitative drama among themselves; the denouement of unsuccessful CPR allows them to attribute the patient’s death to the underlying cause of his disease—they thereby carefully extricate themselves from the causal chain of dying in order to deflect responsibility away from themselves.

John Tercier argues that the practice of CPR meets “the enduring needs of the psyche at the deathbed.”⁵⁴ Holding no illusions that CPR is done for the benefit of the (terminal) patient, Tercier contends that a sudden death is perceived as a violent assault on propriety and order: “How could you leave me?” shriek the survivors, perhaps while shaking or pounding the corpse. CPR allows the symbolic violence of sudden death (even well-anticipated deaths may be perceived as abrupt) to be met with both symbolic and actual violence.⁵⁵ The pummeled body exorcises the dark emotions of collective loss.

⁵² Mohammed and Peter, “Rituals, Death and the Moral Practice of Medical Futility,” 293.

⁵³ Mohammed and Peter, “Rituals, Death and the Moral Practice of Medical Futility,” 296.

⁵⁴ Tercier, “The Lips of the Dead and the ‘Kiss of Life,’” 284.

⁵⁵ Tercier, “The Lips of the Dead and the ‘Kiss of Life,’” 299.

Since the Harvard *ad hoc* committee published criteria for “permanent coma” or brain death in 1968, laypersons have been less able to rely on their own judgments about whether death has occurred. The “foggy mirror” test, or checking for faint signs of respiration on a piece of glass, no longer suffices; most people have come to rely on clinical judgment and the prerogative of a physician to “pronounce” death. In this sense, CPR fulfills “a triple role: it might restore life, it helps diagnose death and, failing all else, it insures it.”⁵⁶ The patient who “fails” CPR is immediately pronounced dead, and an island of certainty is established in the midst of clinical and existential ambiguity. The time of death has been “called” and all present can begin to adjust to the reality of personal and professional loss.

The alleged ritual function of CPR has become particularly persuasive in the last two decades, as nurses have begun to invite families in from the hallway to be present for the resuscitative attempt. “The admittance of the family onto the stage” clinches the ritual significance of the performance by inviting the congregants to participate in the ritual, either by stroking their loved one’s head or by whispering words of support or goodbye. Having seen for themselves that no effort was spared, families are able to confirm the finality of death with their own eyes, and to begin the work of mourning. Tercier thus avers that “the ER functions as the contemporary deathbed, and that CPR and other resuscitative protocols are the last rites of the postmodern.”⁵⁷

In practice, there are many liturgies in the contemporary repertoire of medicalized death. According to Stefan Timmermans,

it is virtually impossible to die or be dead without encountering some medical involvement. Most people die surrounded by medical professionals; even when dying occurs at home, hospice staff or visiting nurses mediate the dying process.⁵⁸

⁵⁶ Tercier, “The Lips of the Dead and the ‘Kiss of Life,’” 299.

⁵⁷ Tercier, “The Lips of the Dead and the ‘Kiss of Life,’” 316-317.

⁵⁸ Stefan Timmermans, “Death Brokering: Constructing Culturally Appropriate Deaths,” *Sociology of Health & Illness* vol. 27, issue 7 (November 2005), 1005. doi: 10.1111/j.1467-9566.2005.00467.x.

In the past several decades, the hospice and right-to-die movements have sought to wrest control over the dying process away from health care professionals, but have themselves become subsumed under the auspices of medical professionals' considerable cultural authority. Thus, hospice has become an extension of most health care systems,⁵⁹ and proponents of suicide seek the legitimation of physicians' assistance. While "ways of dying" have proliferated since the 1960s, the intervening decades have seen no loss of medical power. According to Timmermans, medical staff characteristically "broker" deaths through medical activities in order to render deaths "culturally appropriate" and meaningful.⁶⁰ In addition to the resuscitated death already addressed, he identifies "the natural death," "the good death," and "the dignified death"⁶¹ as common ideals brokered according to the patient's location, perceived characteristics, involvement with relatives, and disease trajectory.⁶²

The ICU is, ironically enough, the site of "the natural death." There, patients are usually comatose or minimally conscious, so death is primarily orchestrated for the sake of the patient's intimates. Medical professionals broker natural death by parceling interventions and the release of information to accord with a trajectory of dying that is neither too long nor too short. Death may be delayed by supportive interventions to allow relatives time to gather and to come to terms with their loved one's deteriorating condition. Death can also be effected by the gradual removal of supports, such as reducing supplemental oxygen and drugs to sustain adequate blood pressure, or, more

⁵⁹ Beverly McNamara *et al.*, "The Institutionalization of the Good Death," *Social Science and Medicine* vol. 39, no. 11 (1994), 1502.

⁶⁰ Timmermans, "Death Brokering," 993.

⁶¹ Timmermans takes "dignified death" to involve legal physician-assisted suicide. The legitimacy of aid-in-dying is assumed to rest on physicians' careful assessment of a patient's prognosis along with their certifications that the patient is not suffering from depression; "dignified death" is thus professionally orchestrated, scripted—and effectively brokered. Thus far, physician-assisted suicide is only legal in two states, and I do not treat it here. Timmermans, "Death Brokering," 999.

⁶² Timmermans, "Death Brokering," 997.

dramatically, by turning off the ventilator. The medically managed death is thus made to mimic popular ideas about natural dying. The patient's family members are managed with equal intentionality:

The staff's 'orchestration' (Seymour 2001: 128) of the death as an inevitable transitory process with a measured balance of action and non-action involves matching their interventions with the expectations of relatives, including actively shaping those expectations when relatives are 'unrealistic,' showering them with technical information, presenting ready-made decisions, relieving guilt feelings, and 'psychologising' them when they resist staff (Anspach 1993).⁶³

The incremental staging of information and prognostication functions as a mechanism of interpersonal control. Health care professionals work to titrate relatives' continued hope with realistic expectations about their loved one's recovery, but this delicate strategy sometimes backfires and leads relatives to distrust the medical team. When the patient's surrogate cannot be made to share the values or epistemology of the medical staff and will not assent to the trajectory laid out for their loved one, a hospital ethics consult may be invoked to mediate between the parties.

Timmermans paints "good death" as the ideal trajectory for dying persons who are neither immanently dying nor acutely dependent on advanced technologies. He places hospice deaths in this category. I will treat deaths that occur under the palliative care medical subspecialty in this category, too, as the philosophies of hospice and palliative care are sufficiently similar and strong;⁶⁴ their practices tend to overlap, and palliative care professionals frequently work within hospices.

⁶³ Timmermans, "Death Brokering," 997-998. Jane E. Seymour, *Critical Moments: Death and Dying in Intensive Care* (Buckingham: Open University Press, 2001). Renee R. Anspach, *Deciding Who Lives: Fateful Choices in the Intensive Care Nursery* (Berkeley: University of California Press, 1993).

⁶⁴ "Hospices" date from the middle ages; the practice of contemporary palliative care originated with Dame Cicely Saunders' development of St. Christopher's hospice in the 1960s. During the 1980s, hospices began to reintegrate with mainstream medicine. Randall and Downie observe that hospice has its roots in the medieval religious orders that were concerned with the care of the dying. "These orders had a conception of a 'good death', which involved an acceptance of human mortality and a recognition that human weakness and sin could be forgiven, and that death itself could be seen as the signature of a meaningful life." Fiona Randall and R.S. Downie, *The Philosophy of Palliative Care: Critique and Reconstruction* (Oxford: Oxford University Press, 2006), 5-6.

The modern hospice movement was originally founded as an autonomy-promoting alternative to hospitalized dying in an era when medicine flatly denied death through a focus on an all-out war against disease. The title of Dame Cicely Saunders' article, "Watch with Me,"⁶⁵ offers some indication of the philosophy of companionship and nonintervention that characterized her practice. Saunders, motivated by her Christian faith, became a physician to promote adequate pain control among terminally ill persons and worked to foster a communal home, and later, in-home care, such that residents could be cared for as individuals, and care for one another, in an atmosphere that openly acknowledged their mutual mortality. Her nonsectarian philosophy lent itself to hospice's proliferation, and then its increasing institutionalization. Hospice care is now part of the Medicare benefit, and is at least partially aimed at cost-savings, as it is expected that those who enter hospice will forego further curative treatments and emergency room visits.

As hospice has reintegrated with allopathic medicine, becoming a part of, rather than an alternative to it, signs of standardization have appeared. Timmermans contends that hospice workers now broker a routinized "good death" marked by "powerfully prescribed and normalized behaviors and choices."⁶⁶ They hold out the acceptance of impending death as a normative goal, and patients are expected to assent to the hospice philosophy by contenting themselves with the provision of symptom management while eschewing suicide or hastened death. Hospice workers manage the last stage of "active dying,"—the so-called "death watch"—by shepherding relatives to say their goodbyes in an order that they deem optimal.

Palliative care was originally intended for "hard cases"—terminal cancer patients with intractable pain, for example. Like hospice, it was intended to provide de-medicalized, holistic care

⁶⁵ Cicely Saunders, "Watch with Me," *Nursing Times*, vol. 61, no. 48 (November 1965), 1615-17.

⁶⁶ Bethne Hart *et al.*, "Whose Dying? A Sociological Critique of the 'Good Death,'" *Mortality*, vol. 3, no.1 (March 1998), 65-77, as quoted in Stefan Timmermans, "Death Brokering," 998.

to patients. A recent philosophy statement of the World Health Organization demonstrates that its guiding principles have grown quite expansive; the statement indicates that palliative care need not be limited to those who have relinquished life-prolonging therapies, but should be offered to anyone threatened with terminal illness *as well as their family members*.⁶⁷ The palliative care philosophy is concerned with relieving suffering in its biological, psychological, social, and spiritual dimensions as well as enhancing the quality of life for the ill individual and his or her relatives. While palliative care philosophies claim to incorporate respect for autonomy with stated commitments to honoring advance directives and patient wishes (including how much the patient would like disclosed to her family about her prognosis), the trend toward comprehensive, or perhaps “totalizing” *management* of patients and their families raises important questions about the meaning of autonomy for individuals, families, and religious communities—as well as important questions about the meaning of life that this medical regime posits as morally normative.

Jeffrey Bishop, Philipp Rosemann and Frederick Schmidt have christened the comprehensive practice of palliative care “biopsychosociospiritual medicine” and argued that it constitutes “an ersatz liturgy of death:”

What most consider a genuine movement away from the medicalization of death – namely, palliative care – is really the extreme extension of the medical gaze into the realm of spirit. Death, while returning to the community, is now presided over by a series of experts, whose

⁶⁷ WHO Statement on Palliative Care (2002): “Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual...Palliative care provides relief from pain and other distressing symptoms, affirms life and regards dying as a normal process, and intends neither to hasten nor to prolong death. Palliative care integrates the psychological and spiritual aspects of patient care and offers a support system to help patients live as actively as possible until death. It also offers a support system to help the family cope during the patient’s illness and in their own bereavement. Using a team approach, palliative care addresses the needs of patients and their families, including bereavement counseling if necessary. It enhances quality of life, and may positively influence the course of the illness. It is applicable early in the course of the illness with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.” As quoted in Fiona Randall and R. S. Downie, *The Philosophy of Palliative Care: Critique and Reconstruction* (Oxford: Oxford University Press, 2006), 4.

discourses fix the place of death in the body politic – a place where all goods are defined scientifically and the gaze extends beyond the grave to the grieving family.⁶⁸

Fiona Randall and R. S. Downie corroborate this critique at the level of practice, arguing that palliative care has grown “too elaborate, too intrusive, [and] too precious.”⁶⁹ They question the legitimacy of including members of the dying person’s family as co-patients, as the desire to support the dying person does not constitute consent to “treatment.” They also accuse palliative care of unsustainable overreach: the resources required to promote global “quality of life,” are, in principle, limitless, and the concept itself is nearly impossible to define.

“Quality of life” is a contested idea that relies on idiosyncratic appraisals of human capacities and purposes—linked to disparate metaphysical schemes. It is an inherently evaluative concept which some have tried to capture with econometric instruments (so-called “Quality Adjusted Life Years”, or QALYs); despite attempts to develop standardized assessments, quality of life remains, for the most part, subjective. One person might consider himself to have a high quality of life so long as he could hold his loved one’s hand and pray, while another would prefer to succumb to the complications of diabetes rather than to live with an amputated toe or foot. In the absence of societal consensus, biopsychosociospiritual medicine will promote “quality of life” according to the statistical analysis of patient self-reports or according to uncritical notions of happiness and well-being. With respect to the latter, Randall and Downie observe that as part of a strategy to enhance “quality of life,” palliative care professionals might encourage dying patients to plan a family vacation or to make alternative career plans.⁷⁰ In the absence of enduring relationship, such expansive pretensions border on the inappropriate and intrusive; the efforts of medical professionals

⁶⁸ Bishop *et al.*, “*Fides Ancilla Medicinae*: On the Ersatz Liturgy of Biopsychosociospiritual Medicine,” 20-43.

⁶⁹ Randall and Downie, *The Philosophy of Palliative Care*, 5.

⁷⁰ Randall and Downie, *The Philosophy of Palliative Care*, 86-87.

to promote “quality of life” through non-medical means exceed the bounds of medical expertise and constitute new forms of paternalism, as they attempt to influence the intimate economic and familial affairs of persons whom one has, in all likelihood, only recently met.

An emphasis on promoting quality of life through relieving distress in all its forms tends to functionalize the ultimate concerns of patients and their families. As part of medical practice, palliative care relies on an evidence base accrued through standardized assessments. Randall and Downie protest that psychological, social, and religious assessments are themselves interventions that patients and their families may not feel at liberty to refuse. Bishop observes that assessments give rise to further interventions that aim to regulate the patient into a “good death” marked by an absence of distress and the survivors’ efficient social functioning. To those ends, the palliative care specialist’s toolkit includes assessments that measure religious “coping” and religious “need,” as well as grief.⁷¹ Trans-denominational chaplains, trained counselors, and social workers can be mobilized to intervene with patients and their families when assessments indicate a negative “style” of religious coping or suggest a “complicated” grief.

THE MORALITY OF “DEATH BROKERING”

It is probably not too much to claim that human death has always been “brokered.” Liminal life events call forth fitting rituals that socialize the generations into how to behave, to think, and to feel in the presence of ambiguity, existential anxiety, and moral guilt. It is worth reflecting that the twentieth century hospice and right-to-die movements sought to reclaim this liminal territory for themselves under the banner of autonomy. Yet, the proliferation of “ersatz liturgies” would suggest that self-governance was short-lived. As we already observed, the decades since the 1960s have seen

⁷¹ Randall and Downie, *The Philosophy of Palliative Care*, 154.

no loss of medical power, and alternative ways of facing death have been thoroughly re-institutionalized under medical auspices. What does this mean for the moral, personal, and psychological autonomy of patient-persons and their families?

Dying persons are thoroughly managed under each of the “liturgies” recently described; death appears unmanageable in the absence of medical mediation. Experts are needed, not only to control pain or other physiological symptoms, but also to compensate for the absence of personal, social, and religious resources that individuals bring to the event. From the perspective of Eriksonian psychological autonomy, the liturgies portray death, for the dying and his or her attendants alike, as a problem that individuals lack the ego integrity to solve for themselves, within their traditions.

The diffusion of responsibility and the violence demonstrated during medically futile attempts at resuscitation raise troubling questions from the perspective of moral autonomy. According to Kant, rational beings have the capacity to know what morality requires. If one were not able to act according to her own good will with respect to performing CPR on a person who is almost certainly dying, if not already dead, sharing responsibility with other medical professionals does not then make the act moral. The effort to justify the practice of physiologically futile CPR as “not qualitatively futile” because of how the intervention functions to mediate death for those in attendance exemplifies treating the dying person as a means, and not as an end in him or herself. Insofar as medical “heroics” accord with advance directives that request medical professionals “do everything,” moral autonomy requires that one examine one’s maxims in light of the categorical imperative to determine whether one’s intended acts are consistent with shared or scarce resources and to refrain from attempting to secure exceptions for oneself out of inordinate self-love.

Medicalized “liturgies” that promise to ascribe “meaning” to death, and reflexively, life, appear only capable of ascribing meaning that is sufficiently vague to be pluralistic; they are, of necessity, homogenizing. While demonstrative heroics serve to buttress the value of human life, personal autonomy, mediated through Mill, lauds the human faculties of perception, judgment, and moral preference. It is simply paternalistic—and hubristic—for healthcare professionals to ascribe meaning to the life of a relative stranger.

The withholding of bad prognoses and diagnoses during the mid-twentieth century undoubtedly undermined patient autonomy in each of its moral, personal, and psychological manifestations. It is not evident that the orchestration of “natural death” promotes any more autonomy. The calculated management of patients and their families effected through staged releases of prognostic information serves to maintain an uneven playing field, on which those most personally affected lack the relevant information to be self-determining. For the sake of autonomy, persons who are conscious in the ICU should have the opportunity to confront their mortality and to inhabit the more socially and spiritually self-directive dying role if the health care team is convinced they are dying.

AUTONOMY AND THE *ARS MORIENDI*

The *Ars moriendi*, or “art of dying” originated in the Middle Ages as conduct books that enjoyed maximal circulation between the years of 1470 and 1520. Many of the texts were crafted from wood-block prints aimed at the semi-literate, while other versions featured a more comprehensive manuscript. All purported to prepare the reader to “die well,” just as other conduct books might teach one to properly hold a knife. While authorship remains speculative, Mary Catherine O’Connor believes that the work can likely be attributed to a Dominican or a Franciscan,

and that it was probably assembled at the Council of Constance (1414-1418) in southern Germany. The tradition of the *Ars moriendi* arose amid the specter of mass deaths from virulent outbreaks of plague and was intended to laicize individual preparation for death when the ranks of priests had grown too thin to attend the dying. The Council recommended the work as part of a strategy of reform—an aid to more devout Christian living.⁷² Religious leaders were dismayed that, between outbreaks of plague, Christians tended to grow “callous” toward death—or in more contemporary parlance, “death denying.”

The *Ars moriendi* was distinct from an *Ars viviendi*; it was intended to offer a consummately practical craft and method for dying, yet it managed to reinforce the conceptual connection between wisdom and awareness of, and preparedness for, death. The sources of the *Ars* included Scripture, patristic writings from authors such as Saints Augustine, Gregory and Jerome, ecclesiastical writers including Jean Charlier de Gerson and Duns Scotus. Versions of the *Ars* appear in several European languages. The tradition extends into mid-nineteenth century “Holy Dying” literature,⁷³ but as one might expect, post-Reformation literature is sometimes marked by polemic, and tends to reflect the ecclesiastical and political controversies of its day. Later texts and editions are marked by deviation from the original CP and QS texts, and include omissions, interpolations, substitutions, rearrangements, and shifts of emphasis. I focus my attention on the commonalities of the texts in the *Ars moriendi* tradition in order to examine how the dying individual—“*Moriens*?”—is construed. In what follows, I will offer brief a synopsis of some morally relevant aspects of the tradition, analyze

⁷² Mary Catharine O’Connor, *The Art of Dying Well: The Development of the Ars moriendi* (New York: Columbia University Press, 1942), 54.

⁷³ Drew Gilpin Faust has authored a fascinating account of how Civil War Americans, following the texts and traditions of Holy Dying, prepared to do the “work of death.” As the war went on, the art of dying became less coherent as a result of soldiers’ increasing social dislocation and the difficulty of securing personal identities in the midst of mass casualties. Drew Gilpin Faust, *This Republic of Suffering: Death and the American Civil War* (New York: Vintage Books, 2008).

these in light of contemporary medical understandings of “autonomy,” and then contrast these with the philosophic commitments of contemporary palliative care.

The *Ars Moriendi* is marked by practicality, and seems to have been born of necessity. O’Connor avers, “With epidemics recurring as they did, Christians [had to] be given a method of directing their own passing to a happy eternity.”⁷⁴ The *Ars* offered its readers arresting woodcuts—pictures that were themselves instructive, and for those who could read the text, “complete directions for meeting the greatest crisis of their lives.”⁷⁵ Even before the Council of Constance, Franciscans and Dominicans used feast days to preach about the last moments of a Christian on earth.⁷⁶ By the seventeenth century, the holy dying texts considered the art of dying “the art of all arts” (allegedly superior to each of the seven liberal arts)⁷⁷ and “the craft of all crafts.”⁷⁸ Diverse authors, including Martin Luther, stressed the significance of the moment of death as a gauge of the worth of an individual life, and George Strode (*The Anatomie of Mortalitie*, 1618) maintained that “the conclusion of our life is the touchstone of all the actions of our life.”⁷⁹

With the exception of John Kettlewell’s *Death Made Comfortable* (1695), the texts that stand in the *Ars* tradition emphasize not a “good death” per se, but rather *dying well* and *knowing* well to die—and in most cases, knowing how to help a friend to die. The two main late medieval texts treat death as a serious task; they do not stress hell, but aim to instruct and prepare the individual for a momentous struggle filled with great temptation.

⁷⁴ O’Connor, *The Art of Dying Well*, 6-7, n. 40, 41.

⁷⁵ O’Connor, *The Art of Dying Well*, 115.

⁷⁶ O’Connor, *The Art of Dying Well*, 56 n. 286.

⁷⁷ Christopher Sutton, *Disce mori: Learne to Die*, third ed. (London: The Society for Promoting Christian Knowledge, 1600), 4. “What is it by arithmetical account, to divide the least fractions and with the man of God never to think of numbering the days we have yet to live? What is it by geometry to take the longitude of the most spacious prospects, and not to measure what the prophet calleth only a span?”

⁷⁸ Jeremy Taylor, *The Rules and Exercises of Holy Dying: In Which Are Described the Means and Instruments of Preparing Our Selves and Others Respectively, for a Blessed Death* (London: William Ballard, 1651).

⁷⁹ O’Connor, *The Art of Dying Well*, 205.

The longer (and, O'Connor thinks, original) of the two principle versions of the *Ars* is divided into six parts, including: Part One: The "Commendacyon of dethe and cunnyng to die wel" (The Commendation of Death and Cunning to Die Well") which gathers together unrelated utterances of the ecclesiastical writers on the subject of death and turns them to the uses of a conduct book on the art of dying. *Moriens* is coached into giving up his soul "gladlye and wilfully" (gladly and willfully). Part Two takes up the method of meeting the five temptations—unbelief, despair, impatience, vainglory, and attachment—with which, one after another, the devil will put *Moriens* to the test. Part Three consists of questions ("interrogations") which, answered rightly, will insure the salvation of *Moriens*. Part Four contains rules of conduct that will help *Moriens* to pattern his dying upon that of Christ on the cross; Christ prayed, cried, wept, and committed his soul to his Father, willfully giving up the ghost. *Moriens* is instructed to do likewise, and the section concludes with short prayers that he should learn to say himself. In Part Five, the emphasis shifts from the conduct of the dying man to the duties of the friends who stand by his bed; presumably, the dying person is at this point too enfeebled to act for himself. Part Five consists of prayers to be said by the bystanders for *Moriens'* safe departure.

In the throes of suffering, *Moriens* was expected to thread a narrow path between despair of salvation and complacency with respect to his personal righteousness (the woodcuts portray lurking demons and encouraging angels encircling the deathbed.) The series of questions in part three of the (CP) text "askings and demands" induced *Moriens* to undergo a series of interrogations administered by a trusted friend. If he was yet capable of reasoning and speech, *Moriens* was asked to profess his faith by acknowledging his sins of commission and omission, to take personal responsibility for the life he had lived, to seek God's grace and to offer forgiveness in what were understood as speech

acts of faith, hope, and charity.⁸⁰ *Moriens* is portrayed as surrounded by a trusted friend as well as praying onlookers, a heavenly host, and sometimes pastoral animals, but he is the center of the spiritual and moral drama, and the answers are his alone: “the dispositions of the dying man are more important than his friend’s help.”⁸¹ *Moriens* is responsible for the tenor of his will, for striving to die “willingly,” and for preparing his heart and soul to be ready ‘up to Godward.’⁸²

When compared to twenty-first century depictions of death, these interrogations seem decidedly untherapeutic. Those attending the deathbed are warned not to mislead *Moriens* about the direness of his condition, nor to dissemble by inappropriately calling for the physician, or by offering idle distractions or false consolations.⁸³ The *Arts* acknowledges that death is “Grievous to the Body and Soul,”⁸⁴ and does not pretend that there is nothing left to suffer. The vulnerable individual is not construed as only a recipient of ministrations (human and divine), but as one who has obligations to God and to his community to the very last.

Strict Kantians will object that “autonomy” does not consist in following a manual, or in imitation—even of Christ.⁸⁵ Nevertheless, the *Arts* demonstrates a concern with the quality of the will that is highly individuating when compared to contemporary palliative care literature that

⁸⁰ O’Connor, *The Art of Dying Well*, 32.

⁸¹ O’Connor, *The Art of Dying Well*, 165.

⁸² O’Connor, *The Art of Dying Well*, 187 n. 108.

⁸³ In the Middle Ages, there was a widely-circulated warning against giving bodily rather than spiritual aid for a sick man (O’Connor, *The Art of Dying Well*, pp. 38-39). Later Protestant texts record a shifting relationship toward greater embrace of the physician’s ministrations—the (sometimes lamented) image is one of the doctor entering in and putting the priest outside the sickroom door.

⁸⁴ O’Connor, *The Art of Dying Well*, 197 n. 191.

⁸⁵ “Even the Holy One of the Gospels must first be compared with our ideal of moral perfection before we can recognize Him as such; and so He says of Himself, ‘Why call ye Me [whom you see] good; none is good [the model of good] but God only [whom ye do not see]?’ But whence we have the conception of God as the supreme good? Simply from the idea of moral perfection, which reason frames a priori and connects inseparably with the notion of a free will. Imitation finds no place at all in morality, and examples serve only for encouragement, that is, they put beyond doubt the feasibility of what the law commands, they make visible that which the practical rule expresses more generally, but they can never authorize us to set aside the true original which lies in reason, and to guide ourselves by example.” Immanuel Kant, *Fundamental Principles of the Metaphysics of Morals*, translated by Thomas K. Abbott (Upper Saddle River, NJ: Prentice Hall, 1949), 26.

construes “peace” in terms of physiological and psychological tranquility (notwithstanding whether these are induced by drugs or by therapeutic remissions from a counselor) and posits “comfort” as the fulfilling of wishes and inclinations. The *Ars* construes *Moriens* as a rational practical creature who can self-legislate while being bombarded with inclinations and disordered by suffering. While not an *Ars vivendi*, the *Ars moriendi* tradition stresses the foolishness of deferred repentance (particularly in the texts contributed by the Reformers)⁸⁶ and thus implicitly spurs its readers to perpetual moral self-scrutiny and sanctification. One is enjoined to use his life-time well, and to learn the art while in good health.

Apart from a Kantian understanding of moral self-governance, the *Ars moriendi* tradition illuminates other aspects of autonomy. The *Ars*’ emphasis on learning to die and helping others to die well exemplifies the psychological idea of autonomy as the capacity and confidence to face the problems of the life cycle with integrity and to nurture a strong group ego. The *Ars* emphasizes that one must do one’s own dying, albeit in a communal context of faithful and skilled friends who themselves know the art.

While contemporary bioethics has given a great deal of attention to securing personal liberty and integrity in the medical setting through its emphasis on patient choice, I believe I have demonstrated that medical “management” of death contradicts authentic personal liberty and integrity. Palliative care philosophy purports to enhance “quality of life,” autonomy, dignity, patient-centeredness, and family relationships through assessment and intervention (including invasive measurement scales and counseling in intimate matters). As compared to the *Ars moriendi* tradition, these assessments and interventions may be judged especially heteronomous; they aim to orchestrate a peaceful and “meaningful” death irrespective of moral reality or the truth about an individual’s

⁸⁶ O’Connor, *The Art of Dying Well*, 39 n. 183.

life,⁸⁷ and introduce abstracted relationships (which is to say that the modern-day “*Moriens*” is “managed” through the liminality of suffering and death by strangers who do not know his life history and do not necessarily share his religio-moral commitments).

It has been my contention that palliative care can undermine the autonomy of patient-persons when it uses religion and culture instrumentally in order to move the “patient” toward tranquil “acceptance” of death. In general, palliative care philosophy often seems to lack adequate critical reflection on its own normative principles or on the subtle forms of violence that may be inflicted on patients who stand in a tradition that affirms the significance of the end of life as the consummation a morally responsible individual before God. In what follows, I will work toward a conception of mature autonomy that includes psychological and spiritual forms of autonomy that are sufficiently robust to counter the trends I have elucidated in the foregoing pages, and to consider the communities and practices that can sustain maturely autonomous persons through the liminal situations just described.

⁸⁷ Cf. Bishop, *The Anticipatory Corpse*; Randall and Downie, *The Philosophy of Palliative Care*.

CHAPTER 3:
DON BROWNING: PSYCHOLOGICAL AUTONOMY
AND GENERATIVE INTEGRITY

In previous chapters I worked to uncover how popular understandings of biomedical autonomy bear an inconsistent relationship to the strictures of philosophical autonomy from which they purportedly hail. (Recall that while medical autonomy functions to safeguard vulnerable patients from various intrusions, patients are not seriously expected to make their medical decisions in light of universal maxims, à la Kant.) I also examined the ersatz end-of-life rituals that have preponderated in the wake of medicalized dying. Despite medical and legal efforts to safeguard the autonomy of dying persons, I suggested that the terminally ill and their families find themselves more managed than ever, while the *Ars moriendi* of the Christian tradition represented a collective way of preparing for death that was comparatively autonomy-promoting.

In this chapter, I move to lift up the psychological and moral aspects of autonomy that are crucial to navigating the challenges of the life cycle, including the clinical medical context.¹ In particular, I will capitalize on a psychological insight briefly mentioned in the foregoing chapter: individual autonomy is relationally activated. Social fragmentation and dislocation weaken ego integrity, personal identity, and thus the cycle of the generations. Each of these aspects, I maintain, bears on our capacities for the deep freedom and responsibility which I hold to be constitutive of autonomy; I maintain that freedom and responsibility are interrelated, and capable of increasing over the lifespan. Here, I will attend to the developmental psychological schema conceptualized by Erik

¹ Cf. Jurrit Bergsma and David C. Thomasma, *Autonomy and Clinical Medicine: Renewing the Health Professional Relationship with the Patient* (Dordrecht: Kluwer Academic Publishers, 2000), xi, 22.

Erikson, and through the work of Don Browning who drew heavily on Erikson's work, begin to consider the role of the church in cultivating both psychologically and morally autonomous persons.

Browning was a practical theologian whose works ranged over religious thought and modern psychology, the ethics of the life cycle, pastoral care, Christian humanism, marriage and globalization, and family law.² Browning's practical theology is notable for its attention to the conditions of modernity.³ His "fundamental practical theology" is oriented to establishing and maintaining churches as communities of moral discourse and action amidst the contemporary multiplicity of voices that extend innumerable moral visions and life plans. While incorporating the insights of ego and social psychologies, his early work posited a normative anthropology—a psychoanalytic description of the good person—that stands as a corrective to many of the culturally influential remissive, adjustment-oriented, and romantically harmonistic psychologies of the twentieth century. The theme of generativity, defined as "the concern in establishing and guiding the

² While "practical theology" was traditionally understood to encompass the church disciplines of preaching, worship, pastoral care, and religious education, Browning held that "all theology is practical" and that "the Christian message is primarily practical in nature" (Don S. Browning, *A Fundamental Practical Theology: Descriptive and Strategic Proposals* (Minneapolis, Fortress Press, 1991), 67. Browning worked to expand traditional understandings of practical theology in both fundamental and critical directions; his work endorses David Tracy's "revised correlational approach" of correlating both a hermeneutically sophisticated interpretation of one's situation with the interpretation of what one's best understanding of the Christian witness demands in order to effect practical action" (*A Fundamental Practical Theology*, ix, 67). While he developed an expanded *practical* theology, advocating a critical and revised correlational approach that "begins with the intuitions of faith, but ends, when needed, with reasons and justifications for the practical actions it proposes" (*A Fundamental Practical Theology*, 3), Browning was not a systematic theologian who forwarded or defended novel understandings of God, Christology, pneumatology, eschatology, etc.; he understood his personal theology to be "a synthesis of neoorthodoxy and [Protestant] liberalism" and acknowledges being influenced by process theologians Alfred North Whitehead, Charles Hartshorne, and William James (63-64). His Protestant liberalism incorporated neoorthodox anthropologies from Reinhold and H. Richard Niebuhr and Paul Tillich. Browning's fundamental practical theology exhorted a communitarian approach in which he expected that congregations would enact their own critical correlations according to their preferred sources of authority, use of the "Christian classics," and ordering of traditional theological sources, including Scripture, reason, and experience. As we shall see in the next chapter, Karl Rahner was a very different kind of theologian, who took a much stronger view of the human capacity to receive God's self-communication.

³ Browning equates modernity with "the social impact of that conglomeration of forces associated with industrialization, technology, structural differentiation of basic social institutions, occupational specialization, and urbanization." Don S. Browning, *Generative Man: Psychoanalytic Perspectives* (Philadelphia: Westminster Press, 1973), 11.

next generation”⁴ threads through his works, as does the hermeneutical analysis of horizons, including the implicit assumptions and normative images that govern human action. An investigation into the concept of generativity is an attempt to answer an essential question: ‘What makes humans strong?’

Browning was attentive to the concept of “health,” especially in its psychoanalytic and moral dimensions.⁵ According to Browning, “[H]ealth’ is a term which takes on meaning only when placed in the context of broader concepts about the meaning of the good in ethical terms.” He observed that the disciplines of care—religious, medical, and psychological—had become divorced from their religio-ethical contexts; he was concerned about the impact of the subsequent moral pluralism on one’s relation to herself, to the social world, to time, and to the other.⁶ One imagines he would have had much to say about the implicit assumptions and normative images guiding the end-of-life medical ritualization described in the previous chapter.⁷ His works examine the potential for human strength while reckoning with the difficulty of achieving a coherent identity amidst the unprecedented multiplicity of instinctual and cultural pluralisms that individuals now face.

In advanced, highly complex societies, it is difficult to find a meaningful scale of values by which to live. This is due to the great plethora of patterns held out for us to emulate. As modern societies grow more complex, various subgroups become more autonomous from any single dominating system of symbols which might define who they are. In such societies, it is difficult for individuals to select the images and symbols which should be uppermost in their lives.⁸

⁴ Don Browning, “An Ethical Analysis of Erikson’s Concept of Generativity,” in Ed de St. Aubin, Dan P. McAdams and Tae Chang Kim, eds. *The Generative Society: Caring for Future Generations* (Washington, DC: American Psychological Association, 2004), 295. See also Erik H. Erikson, *Childhood and Society* (New York: Norton, 1964), 267.

⁵ Don S. Browning, *Pluralism and Personality: William James and Some Contemporary Cultures of Psychology* (Lewisburg, PA: Bucknell University Press, 1980), 27.

⁶ These categories come from Browning’s chapter on “The Empirics of Generative Man,” *Generative Man*, 179-217.

⁷ “When inattentively borrowing from secular disciplines such as medicine or psychology, we now recognize that we appropriate... ‘not only scientific information and therapeutic techniques but various normative visions of human fulfillment which are often neither philosophically sound nor theologically defensible.” Don S. Browning, “Pastoral Theology in a Pluralistic Age.” In D.S. Browning, ed., *Practical Theology* (San Francisco: Harper and Row, 1983), 188, quoted in Bonnie J. Miller-McLemore, “Thinking Theologically about Modern Medicine,” *Journal of Religion and Health*, vol. 30, no. 4 (Winter 1991), 294.

⁸ Don S. Browning, *Pluralism and Personality*, 19.

To Browning, the “ersatz liturgies” I described in the last chapter would surely exemplify one more way that contemporary individuals “live on scraps” (of meaning).⁹ His decades-long consideration of the ideal-type “generative man”—later, the “generative human”—and his subsequent effort to integrate this psychoanalytic ethical ideal with Christian theology¹⁰ constitutes the endeavor to proffer a “master scrap” by which persons might meaningfully and faithfully organize their lives.¹¹

Browning’s ideal-type “generative human” is derived from the psychology of Erik Erikson, and it gains strength from the psychology—and ethics—of William James. In the hands of Browning the Christian ethicist, generativity offers a vision of human fulfillment which indicates that life has a normative direction marked by widening care and responsibility for what one has generated, including persons, ideas, and institutions, and potentially culminates in the psychosocial stage of integrity—a stage that has real implications for the consideration of a “maturely autonomous” *consummation* of life, as I will demonstrate in chapter five. In this chapter, I will exploit the psychological understanding of autonomy that inheres in the Eriksonian life-cycle—a socially-activated autonomy that is successively, and progressively, reiterated in later stages of the life cycle, including generativity and integrity. I will also argue that Browning’s later *A Fundamental Practical Theology* (1991) posits a methodology for relating the care of individuals with the ethical demands of the Christian tradition—an enterprise that has the potential to promote moral autonomy within congregations through the employment of critical correlation, rational planning, and the retrenchment and shaping of the institutions that shape our lives.

⁹ Don S. Browning and Terry D. Cooper, *Religious Thought and the Modern Psychologies* (Minneapolis, MN: Fortress Press, 2004), 1, 19.

¹⁰ Browning and Cooper, *Religious Thought and the Modern Psychologies*, 182ff.

¹¹ Browning and Cooper, *Religious Thought and the Modern Psychologies*, 1.

Browning defended the concept of generativity as an ethical one;¹² I take it as my task to explicate how the ideal-type “generative human” is an ethical response to human finitude—one that informs and enriches practical theology by highlighting human tendencies and needs, and also articulates the goal of moral maturity that can and ought to be fostered in religious communities, which become important sites for the promotion of both psychological and moral autonomy in relation to death, particularly amidst the fragmentation and pluralism characteristic of contemporary life.

While Browning was undoubtedly concerned with the elements of moral autonomy received through Kant and expounded in Lawrence Kohlberg’s stages of moral development, I aver that the agential and psychosocial aspects of autonomy posited by Erikson and analyzed by Browning are uniquely illuminating for the present situation. These include the know-how and being-able-to-do that I referenced in the previous chapter (there, dying well or helping a friend to die). While this conception of autonomy is practical, it is also transcendent and revelatory of the self; Browning avers that “[t]he meaning of life is to be found in the end of life, in the purpose of life as it expresses itself in maturity and generativity.”¹³ And yet, according to this psychosocial schema, there is also the possibility that despair will preponderate in the final stage of life. Whether the medicalized liturgies are a hallmark of widespread despair (I am speaking psychosocially here, but perhaps theologically as well) and admission of a lack of inner, communal, and theological resources in the face of death or simply the reigning rituals of the zeitgeist will depend upon an analysis of horizons.

For the moment, I wish to point out two things: 1) I am here offering, via Browning and Erikson, a psychosocial account of autonomy. This account takes seriously the embodied and

¹² Browning, “An Ethical Analysis of Erikson’s Concept of Generativity,” 241-255.

¹³ Don S. Browning, *Generative Man*, 181.

historical conditions under which individuals navigate the developmental crises of their lives. 2) I use the phrase life cycle rather than lifespan (or its equivalent) intentionally; according to this account, the possibility of autonomy and generativity depend upon the interplay between an individual and significant others; while a person must navigate the developmental crises of his or her own life, Browning and Erikson do not allow us to discount the critical importance of mutual activation and confirmation. According to this psychosocial theory, the human is the teaching animal. Young and old are activated, confirmed, and vitalized in their ritualized role interactions with one another. According to Erikson, ritualistic decomposition is indicative of social pathology¹⁴—in the context of this work, a lack of viable end-of-life ritualization and the vague social role of twenty-first century elders signals the widespread sapping of human strength.

GENERATIVITY AND MEDICALIZATION

Don Browning's *Generative Man* (1973) may be read as both an extension of and response to Philip Rieff's *The Triumph of the Therapeutic* (1966). Rieff, a sociologist and cultural critic, contended that "psychological man" had become the dominant symbolic by which persons had come to understand themselves.¹⁵ Replacing "political man," "religious man," and "economic man" of yore, psychological man coped with the modern world by way of therapeutic remissions granted by psychotherapists who had become, functionally, a secular priesthood for culture bearers. Freudian analysis was designed to facilitate insight, and hence, dispassionate liberation from the moralism of an overbearing superego. Psychological man's commitment to his own private sense of

¹⁴ Erik H. Erikson and Joan M. Erikson, *The Life Cycle Completed* (New York: W.W. Norton, 1997), 81.

¹⁵ "[T]he premise that justifies taking psychoanalysis and its moral implications so seriously is nothing less than the claim, put forth by many, that psychoanalysis has become the dominant symbolic in the Western world for the organization of the character of modern man." Browning, *Generative Man*, 13.

well-being precluded communal loyalties, including those to religious institutions and faith traditions. The resulting analytic attitude enjoined a circumspect shepherding of personal energies until *thanatos* finally defeated *eros* to return a life to organic homeostasis—death. The significance of the therapeutic attitude to widespread conceptions of autonomy should by no means be overlooked: by asserting that man has a right to be himself, liberated from traditional structures of authority, the therapeutic attitude provided an authoritative psychological gloss to J. S. Mill’s philosophical conception of autonomy as personal liberty and furthered Kant’s anticlericalism—recall that Kant was, according to Schneewind, motivated to invent a moral theory that would abjure every form of dependence on priestly authority.¹⁶

After Freud, more positive psychologies sprang up; typically harmonistic, they proposed the heights of self-actualization to which humans could aspire if more basic needs were met, or, more romantically, if human nature were simply allowed to remain in touch with its intrinsic dynamisms, unfettered by the repressions of civilization. Browning’s *Generative Man* took itself to address the moral significance of these emerging psychoanalytic traditions and to explore the nature of “the good man” in the works of select ethically-oriented psychologists; he also aimed to investigate “the particular organization of human energy that psychoanalysis, in its later forms, seems to envision as normative or good.”¹⁷ While Browning appreciated the important contributions that the human psychologies made to religious self-understanding and practice, including pastoral care,¹⁸ he nevertheless recognized that many psychoanalytic traditions furthered the forces of social fragmentation and exacerbated moral pluralisms. Many of Browning’s subsequent works

¹⁶ J.B. Schneewind, *The Invention of Autonomy: A History of Modern Moral Philosophy* (Cambridge: Cambridge University Press, 1998), 511.

¹⁷ Browning, *Generative Man*, 11-12.

¹⁸ See Don S. Browning, *Atonement and Psychotherapy* (Philadelphia: Westminster Press, 1966).

discouraged the uncritical appropriation of psychoanalytic theories within pastoral care, where zeal for the imprimatur of the social sciences had caused many pastors to ignore fundamental incompatibilities with the basic moral commitments of Christian faith.

Of the psychoanalytic thinkers Browning examined in *Generative Man*, he concluded that Erikson offered the most comprehensive, compelling, and even ethical characterology of “the good man.” Throughout his career, using Erikson’s work as a touchstone, Browning forwarded developmental psychology’s preoccupation with identity, especially the reciprocal identities that persons confirm in relationship with one another, and which evolve over a lifetime. While granting the significance of early childhood deprivations and traumas to the development of a firm sense of identity, Browning maintained, with Erikson, that the meaning of life is to be found in its end—a rather Aristotelian conviction that he believed was consonant with the best insights of the Christian tradition.¹⁹

It is an implicit premise of this work that “the medicalized person” now rivals “psychological man” as a prevailing symbolic. In a pluralistic age, persons still share a common physiology and the frailties to which the flesh is heir; any shared horizon of ultimate meaning is therapeutic²⁰—that which works to restore the individual to a sense of well-being. I have already indicated that medical authority was consolidated in the later part of the twentieth century, and that with respect to death and dying, medicine incorporated the varied self-understandings of psychoanalysis via popular authors such as Kübler-Ross. As a medical specialty, psychiatry has taken psychological anthropologies into the heart of medical practice, with important consequences for palliative care services that routinely include psychiatric consultations. With respect to the normative organization of personal energies that interested Browning, I observe that the ‘ersatz liturgies’ of medicalized

¹⁹ Browning, *Generative Man*, 181.

²⁰ I use “therapeutic” in Rieff’s sense here, cf. “Not the good life, but better living is the therapeutic standard.” *The Triumph of the Therapeutic: Uses of Faith After Freud* (Chicago: The University of Chicago Press, 1966, 1987), 58, 60-61.

death indicate that dying belongs primarily to the body and should be conceived in terms of winding down and as cessation—as opposed to consummation. Palliative care strategies are decidedly therapeutic in the sense that they focus on making individuals “feel better” through their comprehensive biopsychosociospiritual ministrations. I wish to extend to the analysis of medicalized death Browning’s reflections that such efforts

become nihilistic, i.e., function to disconnect people from the cultural accomplishments of earlier generations and undermine the very socialization process itself. Or, in the name of objectivity, they will become unwitting conspirators with and reinforcements of the dominant social and cultural ethos of our age, i.e., the rational-choice processes of the market and the individualistic and consumerist ethic that it encourages.²¹

In the dominant cultures of North America, the social, religious, and cultural contributions of the elderly are assumed to lie in the past tense. In name and practice, palliative care cloaks the moral demands of dying by focusing on pain relief and “symptom management” such that the elderly do not feel obligated to reveal maturity, generativity, or purpose in their dying.²² I do not wish to denigrate symptom management, but rather to argue that moving death and dying back into religious congregations and communities would be highly significant for the ecological ethics of the life-cycle that could nurture maturely-autonomous persons.

According to the testimony of Stephen Jenkinson, who managed the counseling services of a large palliative care program in Toronto, “managed, muted expiration...has become the norm.”²³ In the course of his work, Jenkinson observed that despite well-controlled pain, the vast majority of the individuals in his care found living with the news of their own (respective) deaths to be intolerable. He reports that requests for terminal sedation for existential suffering and terror (rather than

²¹ Browning Cooper, *Religious Thought and the Modern Psychologies*, 9.

²² I acknowledge that symptom management, including pharmaceutical preparations, can obliterate consciousness or give the mind “greater freedom and strength in facing reality.” Cf. Cicely Saunders, *Watch with Me: Inspiration for a Life in Hospice Care* (Lancaster: Observatory Publications, 2005), 24.

²³ Stephen Jenkinson, *Die Wise: A Manifesto for Sanity and Soul* (Berkeley, CA: North Atlantic Books, 2015), 13.

unremitting physical pain) were commonplace and avers that “antidepressants and sedation were the rule and not the exception.”²⁴ Under the banner of medical autonomy, many patients demand that medicine help them to deny death to the greatest extent possible by offering a sequence of nearly limitless treatments, and then ask that physicians terminally sedate them or assist their suicides so that they do not have to ‘die.’ According to Jenkinson, the implications for intergenerational relationships are stark:

If you can begin to see how dying badly poisons the social, political, professional, and personal discourse about the purpose and meaning of health care and social welfare and being born and dying, if you get a glimpse of how the concentric circles of mayhem and spell casting attending a bad death do not end with that death but actually accelerate and deepen and turn into best practice manuals and family mythologies that have generations of unintended consequences, then you can know each death properly as another chance to die well and to learn the adult mystery of deep living in the face of what often seems to rob life of its depth. Dying well must become an obligation that living people and dying people owe to each other and to those to come.

This extended excerpt is drawn from Jenkinson’s self-titled “manifesto,” but I quote it here at length because it aptly illustrates what is at stake when the large themes of Browning’s works are turned to illuminate the moral context of dying in contemporary North America. The medicalization of death imposes its own ersatz rituals in order to compensate for an uninitiated and de-skilled society in which individuals do not know how to prepare to face their deaths or the deaths of those they love. While acknowledging that there are many frightful ways to die, a norm of “managed, muted expiration” indicates that autonomy—in any deep sense—is hardly widespread. Browning appreciated that an individual’s successful synthesis of his or her developmental crises—including aging and death—“leave[s] certain deposits for the future which constitute adaptive strengths not only for the individual but for the larger evolutionary cycle of which the individual is a part.”²⁵ The

²⁴ Stephen Jenkinson, *Die Wise*, 10.

²⁵ Browning, *Generative Man*, 161.

converse, as Jenkinson observes, is also true. Browning's works situate the rigorous demands made of the individual who would have the strength of integrity preponderate at the end of his or her life; his works demonstrate that one must attend to the complex ecology of an increasingly globalized world, and to the moral horizons that pertain in a given era.

“Autonomy” construed as “choosing one's choice”—an individualistic, atomistic, and consumeristic exercise—owes much to the frontier mentality of North American culture where bonds to persons, place, and tradition were severed by a trans-Atlantic journey and by subsequent Western expansion. Browning held that rapid social change and the erosion of inherited tradition have given way to a pervasive sense of uprootedness.²⁶ He makes much of Erikson's observation that Americans are marked by a unique space-time identity; in contrast to “hemmed in” Europeans, they retain a sense of freedom that is intertwined with their experience of ample, open land and, failing that, the expectation of economic mobility. This sense of limitlessness, however, manifests as tentativeness and ardently retained autonomous choice:

The individual must be able to feel that ‘the next step is up to him’ and that whether he is ‘staying or going,’ settling down or moving on, he is not being told to do either and that the options are basically up to him.²⁷

This strategy was illustrated in Wiseman's *Near Death* documentary; recall the pervasive theme of patients and physicians conspiring for “more time” in which to make end of life decisions, coupled with physicians' reassurances to their enfeebled patients: “you're the boss.” The deliberate strategy of elderly persons delaying the completion of advance directives corroborates this idea; this sort of autonomous choosing incorporates a deep reluctance to ‘prematurely’ commit oneself to any course of action. In practice, of course, the choice is often not to choose.

²⁶ Browning, *Generative Man*, 151.

²⁷ Browning, *Generative Man*, 174. For Erikson's elaboration of this space-time identity thesis and its relation to American “tentativeness,” see Erik H. Erikson, *Childhood and Society*, second edition (New York: Norton, 1963), 114-186, 286.

In *Generative Man*, Browning maintained that the basic sources funding modern self-understanding are personal, individual, and privatized.²⁸ Consequently, the modern person has few resources for meeting the tumult of ‘future shock,’ “the disintegrating effects to our spiritual and psychological integrity of living in a world of endless and unpredictable change.”²⁹ Insofar as efforts to increase autonomy at the end of life represent “an overdetermined drive for totalistic control, domination, and tightfisted mastery,” they may indicate the ego has been thwarted in its drive to coordinate a meaningful wholeness out of the variety of life’s experiences.³⁰ In forwarding the characterology of the generative person, Browning extends a hopeful alternative: the possibility of a self-confirming autonomy that is contextualized within a particular history and sociality. A person is not constituted *ex nihilo*, and does not live in a vacuum. Popular understandings of autonomy associated with freedom from constraints do not cohere with moral reality, which is beset by human finitude, material limits and genuine occasions for sacrifice. While granting the finite conditions and limitations of human life, Browning holds forth the goal of increasing the human capacity for active, conscious, and responsible activity—including the retrenchment and control of industrial and technological society—and he notably includes health services under this heading.³¹

The World Health Organization’s statement on palliative care represents an expansive goal for health services that is ripe for retrenchment and control—the statement professes totalizing aspirations to treat dying persons and their families, to assess and treat grief, pain, suboptimal coping styles, and psychospiritual “problems” on a global scale such that one might wonder whether the organization does not simply intend to relieve mortals the world over of the human condition.³² To

²⁸ Browning, *Generative Man*, 13.

²⁹ Browning, *Pluralism and Personality*, 29.

³⁰ Browning, *Generative Man*, 157.

³¹ Don S. Browning, *Generative Man*, 8.

³² World Health Organization, *National Cancer Control Programmes: Policies and Managerial Guidelines*, 2nd ed. (Geneva, WHO: 2002).

be sure, the crafters of that statement are responding to observed needs; the question, in the context of this argument, is what such extensive interventions do to the human capacity for active, conscious, and responsible activity. Do they facilitate “managed, muted expiration,” or free and responsible deaths? Do such interventions respect the integrity of the particular ecological niches in which an individual’s autonomy may be activated and exercised?

If palliative care philosophies have grown overly intrusive, extending “the medical gaze into the realm of spirit,” as Jeffrey Bishop attests,³³ one should also reckon with evidence that suggests that Americans are attempting to palliate their own spiritual malaise at record levels. A recent economics paper is now being heralded as a startling harbinger of premature mortality in America’s heartland—a quiet epidemic of bad deaths. Princeton economists Anne Case and Angus Deaton found that all-cause mortality for white Americans ages 45-54 in the period between 1999 and 2013 exceeded projections based on previous declines in mortality rates by up to a half million deaths.³⁴ Deaths attributed to drug and alcohol poisoning, suicide, chronic liver disease, and cirrhosis largely account for the increase, which is most marked among the least educated. The paper indicates that “[c]oncurrent declines in self-reported health, mental health, and ability to work, increased reports of pain, and deteriorating measures of liver function all point to increasing midlife distress.”³⁵ The paper has sparked much speculation about the causes of these unexpected deaths; mortality rates for black and Hispanic Americans fell during the same period.³⁶ Health demonstrably intersects with the

³³ Bishop, *et al.*, “*Fides Ancilla Medicinae*: On the Ersatz Liturgy of Biopsychosociospiritual Medicine,” 20-43.

³⁴ Anne Case and Angus Deaton, “Rising mortality and morbidity among white non-Hispanic Americans in the twenty-first century,” *Proceedings of the National Academy of the Sciences of the United States of America* 112(49), (December 8, 2015). DOI: <http://dx.doi.org/10.1073/pnas.1518393112>

³⁵ Case and Deaton, “Rising Mortality.”

³⁶ A 2001 study found that African American adults scored slightly higher on some measures of generativity compared to their white counterparts; researchers report “their accounts of especially generative experiences were more likely to contain references to religious activities and intergenerational family events.” The study suggests that racially and socioeconomically marginalized groups have nevertheless managed to preserve a comparatively greater sense of cohesiveness and strength through viable rituals of recognition that are seemingly protective of “health.” Holly M. Hart,

political and economic milieu, but not in a straightforward way; many have conjectured about a widespread despair resulting from conditions that did not match the expectations that these white Americans had for their lives. The extensive use and abuse of prescribed opioids, self-administered drugs and alcohol echoes the self-destructiveness of many Russians after the fall of communism; Deaton, a Nobel laureate for his work on poverty and consumption, suggests that “middle aged whites have ‘lost the narrative of their lives.’”³⁷

Browning would concur that “an average expectable environment”³⁸ eluded these individuals; amid the changing conditions and the political and economic realities of their lives, these persons were unsuccessful in their attempts to regulate, and be regulated by, their historical milieu. This early invalidism, while tragic, is unsurprising in the context of Erikson’s thought.³⁹ As the psychoanalytic schema in the next section will make clear, despair seems to have come early to these middle-aged Americans; the Eriksonian life cycle posits that adults in that age group would ideally be caring for succeeding generations in a relatively non-conflictual way. Instead, their heirs must reckon with the models of “stagnation” and “despair” that they have witnessed as they themselves come to maturity.

Even in 1973, Browning found little evidence that “generative man” was emerging “as a dominant character type in the Western world.”⁴⁰ Yet, this spate of bad deaths, and the norm of “managed, muted expiration” suggests that renewed attention to Erikson’s norm of generativity—which Browning judged, contains an implicit mixed ethic⁴¹ which combines a theory of virtue, a principle of obligation, and narrative ethics—along with attention to human tendencies and needs—

et al., “Generativity and Social Involvement among African Americans and White Adults,” *Journal of Research in Personality*, 35 (2001), 208-230.

³⁷ Paul Krugman, “Despair, American Style” *The New York Times*, November 9, 2015.

³⁸ A phrase Browning borrowed from ego psychologist Heinz Hartmann, *Ego Psychology and the Problem of Adaptation* (New York: International Universities Press, 1958).

³⁹ Browning, *Generative Man*, 163.

⁴⁰ Browning, *Generative Man*, 217.

⁴¹ Browning, “An Ethical Analysis of Erikson’s Concept of Generativity,” 241.

may be sufficiently creative and comprehensive to address the moral significance of our contemporary situation.⁴²

Browning's *Generative Man* kicked off a decades-long dialogue between psychoanalysis and religion. In what follows, I will explore the psychoanalytical premises of autonomy and integrity, along with the societal contexts that promote or hinder these potential virtues (strengths). I will then turn to Browning's practical theology in order to construct ways in which "listeners to the Christian message"⁴³ might prepare to live and die with generativity as an organizing "master scrap" that elicits more autonomy and integrity than the dominant medicalized paradigms.

EPIGENESIS AND COGWHEELING

Astute readers and devotees of developmental psychology might wonder what autonomy has to do with the end of life in a developmental psychological schema—after all, autonomy belongs to early childhood. Indeed, among Erikson's eight stages, the developmental crisis of "autonomy versus shame and doubt" is only the second, characteristic of toddlers who are toilet learning and experimenting with the assertion of their independent wills.⁴⁴ Furthermore, I noted that it is 'generativity' rather than 'autonomy' that is central to Browning's thought; one might wonder whether I intend to use 'autonomy' in such an elastic sense that it loses all meaningfulness. Is

⁴² "[T]he world suggested in the imagery of universal technology and apt to be dramatized by the media can turn into a vision of a totally fabricated order to be planned according to strictly logical and technological principles—a vision dangerously oblivious of what we are emphasizing in these pages, namely the dystonic and antipathic trends endangering the organismic existence and the communal order on which the ecology of psychic life depends. An art and science of the human mind, however, must be informed by a developmental, or shall we say life-historical, orientation, as well as by a special historical self-awareness." Erik H. Erikson with Joan M. Erikson, *The Life Cycle Completed* (New York: Norton, 1997), 96.

⁴³ Browning admits he is a "listener to the Christian message," but like most modern persons, "listen[s] to a variety of messages." *Generative Man*, 16. He left the task of "determining what the psychoanalytic symbolic finally means... for the Christian symbolic" to his later works; compare *Christian Ethics and the Moral Psychologies* (2006).

⁴⁴ Erik H. Erikson, *Childhood and Society* (New York: Norton, 1963), 251-54.

autonomy finally, as Gerald Dworkin mused, simply “a feature of persons” and “a desirable quality to have?”⁴⁵

I maintain that in its genuine manifestations, ‘autonomy’ incorporates both freedom and responsibility, and that this quality may increase over the lifespan. In the thought worlds of Erikson and Browning, this possibility depends heavily on the significance of epigenesis and the cogwheeling of the generations. Erikson borrowed the concept of ‘epigenesis’ from embryology and applied it to ego development—“the various aspects of the ego grow from ‘a ground plan, and...out of this ground plan the parts arise, each part having its time of special ascendancy, until all parts have arisen to form a functioning whole.’”⁴⁶ The concept of ‘cogwheeling’ borrows a metaphor from mechanics. It highlights the deeply social nature of Erikson’s psychology and supports an ethic of recognition, insisting that the human “needs to be needed.” Like intermeshing gears that propel one another forward, old and young confirm, activate, and vitalize one another. I wrote that Erikson dubbed humans ‘the teaching animal’ but the reflexivity of this statement should be appreciated; he equally believed that a baby “brings up a family,” calling forth ascendant subjectivities and capacities for care in parents and siblings alike and readying in them what is ripe for release: “dependency and maturity are reciprocal...and maturity is guided by the nature of that which must be cared for.”⁴⁷ The concept of cogwheeling also entails that while the strengths of the life cycle have their initial time of ascendancy, they are revisited and elaborated at each subsequent stage; they also anticipate the strengths to come.

In the context of this argument it is important to note that the strengths of generativity and integrity recapitulate and synthesize autonomy at their respective higher levels, so that autonomy is

⁴⁵ Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988), 6.

⁴⁶ Browning, *Generative Man*, 157-58.

⁴⁷ Browning, *Generative Man*, 163.

never a stage that is abandoned or moved past, but rather deepened, enriched, and made evident in the life of one who faces his or her own death. The stage of integrity is indeed an integration, unifying the strengths that have been developed (albeit unevenly) over the life span. Autonomy's first appearance in early life makes it, along with basic trust, particularly foundational, part of the "ground floor" of personal identity. An exposition of Erikson's eight "stages of man" will help to clarify the relationship of autonomy to generativity, and finally, integrity.

According to Erikson's theory, which he developed out of his clinical experience with children and adults, human life is delineated by a series of stages, each of which contains a native psychosocial crisis corresponding to a psychosexual mode keyed to the significant relationships of each particular stage. Each stage also has its own "principles of social order," "ritualizations" and "ritualisms." The crisis itself is comprised of opposed syntonic and dystonic attitudes that are synthesized by the developing ego to yield basic strengths (sometimes called virtues) as well as antipathies.⁴⁸ In the healthy personality, the antipathies are not defeated so much as incorporated. Outcomes of the crises should be conceived in terms of synthesis—which attitude preponderates in its wake? What strengths are laid down for the future (and for others)?

In the case of stage one—infancy—the psychosocial crisis is one of basic trust versus basic mistrust. In relation with the mother or maternal person, the infant must learn to incorporate, primarily with her mouth, but also with her eyes, hands, and body, that which is offered. While the "binding ritualization" of this stage is "numinous," the rituals themselves are intensely physical and

⁴⁸ Erikson elsewhere describes attitudes as "a sense of." Despite the seeming imprecision of this language, he specifies: "In describing the growth and the crises of the human person as a series of alternative basic attitudes such as trust vs. mistrust, we take recourse to the term a 'sense of,' although, like a 'sense of health,' or a 'sense of being unwell,' such 'senses' pervade surface and depth, consciousness and the unconscious. They are, then, at the same time, ways of experiencing accessible to introspection; ways of behaving, observable by others; and unconscious inner states determinable by test and analysis. It is important to keep these three dimensions in mind, as we proceed." Erik H. Erikson, *Childhood and Society* (New York: Norton, 1963), 251.

ordinary: mother and infant greet one another in an idiosyncratic, yet universally recognizable way; the infant roots and the maternal person offers her breast or a bottle; the duo develops an increasingly coordinated pattern of giving and receiving against the background of their particular culture. What must and must not happen in order to keep the infant alive and relatively undamaged is rather straightforward, as the outer bounds of neglect and abuse that would cause a basic sense of mistrust to preponderate are well documented, but “different cultures make extensive use of their prerogative to decide what they consider workable and insist upon calling necessary”⁴⁹ and what may happen is more nebulous. Is the baby spanked at birth and rushed to the nursery or placed on her mother’s chest? Is the infant routinely swaddled or encouraged to feel herself stretch and kick? Made to cry for nourishment or comfort in the guise of “exercising one’s lungs” or quickly attended to?

Erikson writes:

There is some intrinsic wisdom, some unconscious planning and much superstition in the seemingly arbitrary varieties of child training: what is ‘good for the child,’ what may happen to him, depends on what he is supposed to become and where.⁵⁰

Whatever the unconscious goals of any particular culture, the successful synthesis of basic trust over basic mistrust in infancy forms the cornerstone of a healthy personality. The fund of basic trust and hope founded on the confirmation bestowed by a mother’s smiling face will, if subsequently supported by one’s environment and the recognition of significant others, be elaborated at each subsequent stage of development including the last, in which one has ideally become a trustworthy and numinous model for subsequent generations.⁵¹ Deep trust is required to face the prospect of dying; the “active passivity” of infancy will have to be reiterated in old age, as we shall see.

⁴⁹ Erik H. Erikson, *Identity and the Life Cycle* (New York: Norton, 1980), 59.

⁵⁰ Erikson, *Identity and the Life Cycle*, 60.

⁵¹ Erikson, *Identity and the Life Cycle*, 58.

The second stage, as I have presaged, includes the crisis of a sense of autonomy versus shame and doubt. This stage coincides with the developing musculature of the young child who is gaining the physical capacity to hold on to or expel and release his bodily waste and the desire to begin to “do for himself.”⁵² Toilet training appears a fraught enterprise in much of the psychosexual literature following Freud as it was feared that a fixation at this stage would produce either an overly controlling or dissolute personality. One can appreciate the high stakes represented in the toilet learning process: it involves both one’s literal and metaphorical “backside,” the emerging experience of intermittent episodes of the loss of control of one’s body, the potential for soiling oneself and the resulting shame in being seen to have done so, and the experience of conflicting demands—one wishes to continue to play, but the “prudent restraints of an institutionalized legal order”⁵³ assert that the toddler take a bathroom break. Despite the potential for turmoil, Erikson maintains that the second stage builds on the basic trust consolidated in the first. It is properly a psychosocial stage; when successful, the toddler learns “that when he exercises his own powers, the world will not respond in such a way as to humiliate and shame him, rendering him doubtful about his capacity to successfully order crucial aspects of his own life.”⁵⁴ As Browning observes, this is an autonomy grounded in a prior receptivity: “[the toddler] has learned to trust his own powers partially because he has first learned to experience the basic reciprocity between his powers and the powers of the external world.”⁵⁵ A successful synthesis of this stage yields the virtue of will, which incorporates a

⁵² “[O]ne may well ask how it is that we find the epigenetic principle so practical in depicting the overall configuration of psychosocial phenomena; does this not mean to give a somatic process exclusive organizing power over a social one? The answer must be that the stages of life remain throughout ‘linked’ to somatic processes, even as they remain dependent on the psychic processes of personality development and on the ethical power of the social process” Erikson, *The Life Cycle Completed*, 59. “The ego,” as Browning maintains, “is very much a body ego.” *Generative Man*, 159.

⁵³ Browning, *Generative Man*, 183.

⁵⁴ Browning, *Generative Man*, 183.

⁵⁵ Browning, *Generative Man*, 183. Erikson strove to understand “the way in which social organization codetermines the structure of the family.” Erikson, *Identity and the Life Cycle*, 20. He observed that the burgeoning autonomy of the toddler was supported in proportion to the dignity her parents derived in their own lives, at their places of work and within their

burgeoning “freedom to do” (as opposed to a merely negative “freedom from”); this ‘freedom to do’ anticipates the initiative characteristic of the play age.

The notion of autonomy as ‘being a law unto oneself’ is relevant here, as one grows in awareness of various legal orders imposed from the outside and becomes conscious of the desires and purposes of others and how they may conflict with one’s own. The ego is charged with developing sufficient strength and flexibility to accommodate the limitation and loss encountered by the maturing human. Despite the child’s temptation to regress to diapers, and to relinquish the responsibility for her bodily functions to another—a regression often accompanied by the pleasure of the experience of being cared for—she must learn to stand on her own two feet and to take responsibility for her own bodily functions, an experience that has its compensatory satisfactions, but may certainly be experienced as a loss. The anticipated recapitulation of autonomy in old age is projected, too, as elderly persons experience many varieties of loss, including the death of loved ones, physical diminishment and incapacity, and a lack of time in which to redress their regrets; the dystonic elements in life may begin to outweigh the syntonic. Late in life, the ego may need to be sufficiently autonomous to accept the forms of care that the toddler had to leave behind (i.e., help with toileting activities) which have now become necessary, and to do so without “unmanageable shame and doubt.”⁵⁶ Jenkinson’s experience with the dying corroborates how closely a sense of autonomy is tied to toileting activities:

here the toilet is ubiquitous, and so for us the symbolic project that carries so much the nuance of autonomy, control, and mastery is absorbed into how we manage the vision of the void beneath us. When our last weeks are lived partly according to the dilemma of who wipes whom, the sense of regression, the loss of basic dignity, and a feeling [of] being utterly without competence are acute, implacable, and enduring.⁵⁷

social milieu; the concept of cogwheeling suggests that socioeconomically or racially marginalized adults and micromanaged workers are not likely to activate a strong sense of autonomy in their children.

⁵⁶ Browning, *Generative Man*, 183.

⁵⁷ Jenkinson, *Die Wise*, 147.

Many people in Jenkinson's care expressed a desire to die before they lost competence in navigating the bathroom. Despite the dystonic realities of aging, Erikson nevertheless posits an "existential core"—the possibility of an ego that is strong enough to withstand the dystonic elements of aging and death while manifesting integrity and mature care. Browning reminds us that maturity, or "full generativity," ergo, mature autonomy,

is born out of a series of confrontations with mistrust, doubt, limitation, powerlessness, and confusion...Generative man is one who recognizes and includes within his higher affirmations the deeper, untrustworthy, humiliating, limiting, inferiority-producing, and fragmenting dimensions of life.⁵⁸

In relation to others, the generative person will ultimately be able to "accept the limitations of his will without losing confidence in the right to exercise it" and to "assert limitations on the will of others without undue fear of destroying the other."⁵⁹ While broadly applicable, we can signal here that these capacities are relevant to engaging medicalized contexts; the mature expression of autonomy will enable an individual to ward off unwished-for interventions and to trustingly secure his or her own needs with the help of others while seeking a coordination between the needs and desires of the self and the actuality of a given situation. The maturely autonomous individual has learned to "hold on" and to "let go" in ways that do not compromise her existential identity.⁶⁰

The next two stages (play age and school age) remain pre-ethical.⁶¹ Under the epigenetic model, the ego does not develop the capacity for ethics until adolescence; the properly ethical strengths of generativity and wisdom continue to mature in middle and later adulthood.⁶²

⁵⁸ Browning, *Generative Man*, 180.

⁵⁹ Browning, *Generative Man*, 183.

⁶⁰ Erikson defines existential identity as "the 'I' in the totality of life;" it includes a person's system of values, beliefs, and his or her identifying characteristics. Erik H. Erikson, Joan M. Erikson, and Helen Q. Kivnick, *Vital Involvement in Old Age* (New York: Norton, 1986), 130, 140.

⁶¹ In Erikson, ethics "is that specific kind of thinking and acting which keeps in mind the generational integrity of man as a whole—the total species." Browning, *Generative Man*, 169.

⁶² Browning, *Generative Man*, 157.

Nevertheless, the childhood psychosocial crises of “initiative versus guilt” and “industry versus inferiority” help to found the capacity for higher generativity. Activated by the love, care, and wisdom of adults, growing children, who are now more “at home” in their bodies, having mastered walking and developed greater fine-motor skills direct their wills to make and to do, and are ideally confirmed by an increasing social radius of important persons, beginning with the family and widening to the school and neighborhood. They gain the respective basic strengths of purpose and competence as they focus their natural spontaneities onto the acquisition of culturally valued skills, gain facility with the technologies of their historical milieu, and prepare to contribute to the larger corporate good.⁶³ The Eriksons’ extensive longitudinal study suggests that older adults who, as children, found that their curiosity got them into trouble with authority figures or who recalled acting only in order to conform to adult demands found it difficult “in the absence of external structures and demands” (i.e., retirement) “to initiate satisfying activity on their own.”⁶⁴ Likewise, the strength of competence and sense of industry developed during the school years corresponded to how well elderly respondents continued to develop and apply their capabilities to new circumstances.⁶⁵

Adolescence portends the crisis of “identity versus identity confusion.” Identity confusion was an urgent preoccupation for Erikson, who observed a crisis of youth coming of age in industrialized society and the totalizing ideologies to which they were prone. We may appreciate the identity crisis as the great task of youth while interrogating it for the potential strength it lends to generativity and to the prospects for mature autonomy, all the while recognizing that viable models

⁶³ Browning, *Generative Man*, 190-92.

⁶⁴ Erikson *et al.*, *Vital Involvement in Old Age*, 174.

⁶⁵ Erikson *et al.*, *Vital Involvement in Old Age*, 148.

of intergenerational contact remain limited in our culture, and continue to lend peer groups an outsized influence.

Physically, the advent of puberty and genital maturation, along with cognitive gains in abstract thinking and higher-order reasoning, precipitate the identity crisis. The adolescent ego is challenged to integrate—and reintegrate—“constitutional givens, idiosyncratic libidinal needs, favored capacities, significant identifications, effective defenses, successful sublimations, and consistent roles” into a workable configuration that is consistent without being overly rigid.⁶⁶ As in the other crises, the confirming recognition of intergenerational cogwheeling is critical: the adolescent, anticipating a career role and permanent adult relationships, must be assured that his or her style of mastering experience “is a successful variant of a group identity and is in accord with its space-time and life plan.”⁶⁷ A successful ego synthesis at this stage yields the strength of fidelity. The adolescent has worked out “who she is” and “whom she can trust.” When this fidelity is resynthesized at later stages of life, she will be able to be faithful to what is trustworthy in herself and in life, and be able to present herself to succeeding generations “as a tangible identity from whom they can learn and against whom they can test their own emerging self-definitions”—a trustworthy model for others.⁶⁸

The young adult crisis of intimacy versus isolation must build on a reasonably successful synthesis of the foregoing stage. Erikson asserted that (for men at least)⁶⁹ it is only after a workable sense of identity has been established that real intimacy—sexual or psychological—becomes possible.⁷⁰ Erikson suggests that a consolidated and workable identity is the rightful

⁶⁶ Browning, *Generative Man*, 192-93.

⁶⁷ Browning, *Generative Man*, 166.

⁶⁸ Browning, *Generative Man*, 193.

⁶⁹ Cf. 109 ff. and associated footnotes in this work.

⁷⁰ Intimacy means “the capacity for two people to develop a shared commitment without the loss of a sense of individual identity.” Browning, *Generative Man*, 194.

precursor of an intimate, dialogical relationship with the self.⁷¹ While the intimacy attained in this stage has important implications for friendship with the self and with others, we are reminded that the ego in question is a bodily ego, and that the psychosexual stage corresponding to this crisis is “genitality,” normatively expressed within the life patterns of marital commitment. Much is made by both Erikson and Browning of the capacity for mutual orgasmic potency between partners. The capacity to share one’s self with, and to let go in the intimate embrace of, the other without fearing irretrievable self-loss is a nodal point taken to signify the presence of a coherent and flexible self who is capable of “enter[ing] into ‘the mutual regulation of complicated patterns’ both in genital sexuality and in wider daily activities.”⁷²

Love is the virtue and strength that results from a successful synthesis of this developmental crisis: precisely that behavior, in genital sexuality and beyond it, which weaves individual personalities and divided functions into larger commitments while granting a portion of respect and uniqueness to the specific personalities involved.⁷³

Erikson confessed that some individuals, owing to special gifts or circumstances, would choose not to marry or raise children and would exercise their talents on behalf of humanity in other ways. Nevertheless, he insists that the husband-wife relationship, like the mother-child, is among the most ethical, as it has to do with profound forms of recognition and confirmation that potentially contribute most to human strength. All humans at this stage, however, are challenged to overcome temptations to self-absorption and to become capable of risking the self in relationships of “spontaneity, warmth, and real exchange of fellowship,”⁷⁴ with spouse, friend, or stranger without needing to repudiate “the other.”

⁷¹ Erikson, *Identity and the Life Cycle*, 101.

⁷² Browning, *Generative Man*, 194.

⁷³ Browning, *Generative Man*, 195.

⁷⁴ Erikson, *Identity and the Life Cycle*, 101.

It is tempting to gloss the relation of sex to death inherent in Erikson's schema and to dismiss its heteronormative assumptions along with its psychoanalytic preoccupation with orgasm. However, I trust that practical theology has much to gain by thinking profoundly about the relations between body and spirit, and submit that it is the enduring insight of Erikson to keep in humans the high and low, the archaic and teleologic, the muscular and the self-transcendent, together in dialogical relationship. Erikson contributes to an ethics of finitude by reinterpreting Freud's Oedipal complex; where Freud diagnosed guilt related to sexual economics, Erikson interpreted an existential dilemma: "the generational complex" deriving "from the fact that man experiences life and death—and past and future—as a matter of the turnover of the generations."⁷⁵ Erikson's existential dilemma is, nevertheless, emphatically based in bodily modes, and Browning notes that James was highly influential on this account. Browning observed, "The ego seems to have the inner need to turn the passivities of life into experiences which, if not actively chosen, are at least actively affirmed."⁷⁶ James insisted that the spiritual self is "felt in the body," indicating that these affirmations have a corporeal component:

Acts of "attending, assenting, negating, making an effort, are felt as movements of something in the head." The experiences of "consenting and negating" are experienced primarily as the "opening and closing of the glottis. The feeling of "effort of any sort" seems largely to be "contractions of the jaw muscles and those of respiration."⁷⁷

Death is a primary passivity *par excellence*. In the context of medicalization, wherein dying bodies are sedated while egos are artificially bolstered and families therapeutically managed, it behooves the

⁷⁵ Browning, *Generative Man*, 147.

⁷⁶ Browning, *Generative Man*, 157.

⁷⁷ Browning, *Pluralism and Personality*, 93.

moral imagination to envisage the individual so supremely integrated—so maturely autonomous—that he commends his spirit as he breathes his last.⁷⁸

There is more than a touch of the mystical in this idea—the mystical being the counterpart to James’ strenuous (ethical) life.⁷⁹ A fortunate congruence of “internal equipment” and “external environment”⁸⁰ is also required; the widespread incidence of advanced dementia in older Americans poses a standing challenge to this ideal of a self-confirming, self-transcending death.⁸¹ Nevertheless, the recovery of a shared understanding of death as an integrated bodily, spiritual, existential, and moral event—an event with important implications for the strength of the life cycle and for the self-confirmation of an individual within it—is an important locus for thinking about the contours of human autonomy and the intergenerational cogwheeling that supports it. “Without a ritual fabric to life,” Browning writes, “community becomes conformity and individuality becomes normless privatism and destructive egoism.”⁸²

⁷⁸ “For Erikson, the child and the animal in man make a positive contribution to the ordering and the renewal of life at the level of the adult historical ego. The adult ‘I’ simultaneously opens itself to and yet directs the deeper activities of the more involuntary dimensions of life.” Browning, *Generative Man*, 180.

⁷⁹ “It is possible to read James in light of a central theme which pervades his psychology, philosophy, ethics, informal essays, and letters. This was his concern to develop an image of the kind of human needed to live in the modern world. This optimal image of the human James called the ‘strenuous life’ or the ‘strenuous mood’...these harsh sounds are mitigated when we realize that James saw his image of the strenuous life as the upper level of an ideal whose lower depths entailed an almost romantic appreciation for the passional and instinctual foundations of human life. Furthermore, although the idea of the strenuous life conveys distinctively ethical and self-sacrificial overtones, James had a nearly equal appreciation for the mystical and passional depths of life. The person living in the strenuous mood was for James an individual who was simultaneously mystical, ethical, and heroic.” Browning, *Pluralism and Personality*, 28. I will revisit the theme of mystical integration in the following chapter on Rahner.

⁸⁰ Browning, *Generative Man*, 183.

⁸¹ The widespread incidence of dementia may add power to Erikson’s theory and corroborate just how much humans “need to be needed.” Scientists have found that loneliness, or “perceived social isolation” is associated with chronic inflammation in the body that is linked with an increased risk of neurodegenerative diseases as well as cancer and viral infections. It is not yet clear whether the subjective experience of loneliness is causing dementia or is simply an early sign of neuro-degeneration, but affected individuals do seem to be caught in negative feedback loops that cyclically depress both physical and social health. See, for example, Steven W. Cole *et al.*, “Myeloid differentiation architecture of leukocyte transcriptome dynamics in perceived social isolation,” *PNAS* vol. 113 no. 2 (2016), 15142-15147. doi:10.1073/pnas.1514249112.

⁸² Browning, *Generative Man*, 202.

I will turn to Erikson's seventh stage in a moment, but I would be remiss if I failed to comment on the gendered nature of the "intimacy versus isolation" stage and its implications for mature autonomy at the end of life. As we move toward consideration of the final stage of Erikson's theory, "integrity versus despair," I want to reaffirm Browning's insistence that it is a bodily ego that we have in mind; integrity is a matter of personal integration involving the whole human being. However, the developmental psychologists upon whom Browning relied so heavily—Lawrence Kohlberg and Erik Erikson—theorized about moral maturity in highly gendered ways that took male experiences as normative. When judged according to Kohlberg's famous model of moral development, girls and women tend to offer (hypothetical) responses to moral dilemmas that paint them as morally deficient or comparatively immature, with many topping out at his third stage of moral reasoning which emphasizes "interpersonal accord and conformity" and few advancing to the Kantian-inflected stage six of a justice-oriented reasoning with respect to "universal ethical principles."⁸³ Erikson, for his part, observed differences in development between adolescent women and men, but declined to alter his life-cycle schema to reflect them. Carol Gilligan (who worked with both Kohlberg and Erikson) observes that in Erikson's "stages of man"

identity precedes intimacy and generativity in the optimal cycle of human separation and attachment, [while] for women these tasks seem instead to be fused. Intimacy goes along with identity, as the female comes to know herself as she is known, through her relationships with others.⁸⁴

⁸³ Carol Gilligan writes "herein lies a paradox, for the very traits that traditionally have defined the "goodness" of women, their care for and sensitivity to the needs of others, are those that mark them as deficient in moral development." *In a Different Voice: Psychological Theory and Women's Development* (Cambridge, MA: Harvard University Press, 1982, 1993), 18. Cf. Lawrence Kohlberg, "The Development of Modes of Thinking and Choices in Years 10 to 16." Ph.D. Diss., University of Chicago, 1958. Lawrence Kohlberg, *The Philosophy of Moral Development* (San Francisco: Harper and Row, 1981).

⁸⁴ Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge, MA: Harvard University Press, 1982, 1993), 12. See also Bonnie Miller-McLemore, who observed that women's generativity issues occur earlier in the life cycle than Erikson's schema depicts. "Generativity, Self-Sacrifice, and the Ethics of Family Life," in James Witte, Jr., et al., eds., *The Equal Regard Family and Its Friendly Critics* (Grand Rapids, MI: Eerdmans, 2007), 17-41.

Gilligan famously challenged these prevailing, masculinist theories of developmental psychology with her 1982 *In a Different Voice: Psychological Theory and Women's Development*. In it, she situates women's and girls' patterns of moral reasoning within their social, historical, and economic situations, namely patriarchal societies in which women are overwhelmingly responsible for early child care. In her own research with girls and adolescent women, Gilligan discerned complex and highly contextual patterns of moral reasoning concerned with relationships, responsibilities, and capacities for care—hardly amoral considerations. Relatedly, she also observed that her adolescent female research subjects who had been forthright as girls became prone to self-censorship, inner divisions, psychic splitting, and dissociation from their own speech.

We began to hear girls at the edge of adolescence describe impossible situations—psychological dilemmas in which they felt that if they said what they were feeling and thinking no one would want to be with them, and if they didn't say what they were thinking and feeling they would be all alone, no one would know what was happening to them...we began to witness girls edging toward relinquishing what they know and what they have held fast to, as they come face to face with a social construction of reality that is at odds with their experience, so that some kind of dissociation becomes inevitable. Girls' initiation or passage into adulthood in a world psychologically rooted and historically anchored in the experiences of powerful men marks the beginning of self-doubt and the dawning of the realization, no matter how fleeting, that womanhood will require a dissociative split between experience and what is generally taken to be reality.⁸⁵

According to Erikson's own epigenetic principle, these patterns of dissociation bode ill for the more mature recapitulations of autonomy within women's subsequent life cycle stages, as well as for women's capacities to achieve self-integration and consummation at the end of their lives—I would welcome more empirical research into how the dystonic elements of these developmental crises (namely, diffusion of identity and isolation) impact the manner in which women face their deaths. For now, it is important to acknowledge that Gilligan's concern with the ways in which

⁸⁵ Gilligan, *In a Different Voice*, xx.

psychological theory becomes prescriptive is not misplaced;⁸⁶ women's splitting of consciousness emanates, in part, from their awareness that the emphasis on caring for and not harming others that characteristically informs their moral reasoning, and for which they have traditionally received widespread social approbation, is simultaneously idealized and devalued. Women are compelled to affirm a discourse that reifies a male model of individuation and industriousness—a sort of “hero's journey”—while conscious that their own self-assertion and success might call into question their dedication to caring for others, and thus threaten the relationships that they value and upon which they depend.

⁸⁶ Gilligan, *In a Different Voice*, xv. Take, for example, Erikson's sixth stage of man, “intimacy versus isolation” and the mutual orgasmic potency taken to signify the presence of an identity achieved in the fifth (“identity versus identity confusion”) that is sufficiently strong and flexible enough to be risked in the loving and intimate embrace of the opposite sex life partner—a capacity that Browning upheld as indicative of the intimacy that affirms the unique identity of each partner while weaving these distinct identities into larger commitments (*Generative Man*, 194-95). Erikson would appear to undercut his own argument when he acknowledges that women's firm sense of identity does not precede intimacy at all. Gilligan notes that in Erikson's theory (she is drawing from his 1968 *Identity: Youth and Crisis* (New York: W. W. Norton) “[the female child] holds her identity in abeyance as she prepares to attract the man by whose name she will be known, by whose status she will be defined, the man who will rescue her from her emptiness and loneliness by filling ‘the inner space.’” (*A Different Voice*, 12). I do not deny that sexuality is an important component of human integration and integrity, but to reify the capacity for mutual orgasm in heterosexual intercourse as indicative of a sufficiently strong and flexible ego is, *prima facie*, to disadvantage women by privileging male physiology and experience. It is a holdover from Freudian theory, as it was Freud who proclaimed that mature women who were well-adjusted to their gender roles would relinquish “clitoral” orgasms which he considered immature and masturbatory for “vaginal” orgasms achieved during heterosexual intercourse. Freud deemed women who could not or would not “frigid,” “immature,” and needful of psychiatric assistance, by which he intended assistance in achieving a rational resignation to their status as secondary to men and a relinquishing of aspirations for success and achievement outside of their supporting role. With respect to the ways in which psychological theories can become prescriptive, and even medicalized, consider that at the behest of Princess Marie Bonaparte, Professor Josef von Halban of Vienna (1870-1933), an Austrian obstetrician and gynecologist, worked out a surgical technique for women who wished to conform themselves to the Freudian ideal of female sexuality that involved severing the suspensory ligament of the clitoris, and thus endeavored to alter female anatomy in order to preserve Freudian theoretical assumptions. Cf. Princess Marie Bonaparte, *Female Sexuality* trans. John Rodker (New York: International Universities Press, 1953), 148. It is possible that both Erikson and Browning were drawing on Wilhelm Reich's theory of orgasmic potency rather than Freud's, which, while still equating this capacity with the ability to love, also repudiated patriarchal societies for their tendency to produce neurotic individuals through forms of repression that he thought rendered many if not most men and women incapable of genuine mutuality. (William Reich appears five times in the index of *Generative Man*, but no specific reference to his work is made in the bibliography. Cf. *The Function of the Orgasm: Sex-Economic Problems of Biological Energy*, trans. Vincent R. Carfagno (New York: Farrar, Straus and Giroux, 1973). Given the purported fusion of women's identity and intimacy crises, along with developmental schemas that take the experience of advantaged men as normative, Browning's concept of identity, norm of mutuality, and the rule-role dimension of fundamental practical theology require ongoing critical scrutiny with respect to gender.

In her 1993 Letter to Readers, Gilligan discussed a tantalizing body of work that deepened her own appreciation for the “different”—by which she meant relational—voice that she had written about in 1982. Kristin Linklater, a leading teacher of voice for the theater, gave Gilligan “a physics for [her] psychology—a way of understanding how the voice works in the body, in language, and also psychologically.”⁸⁷

Linklater speaks of ‘freeing the natural voice,’...and what she means is that you can hear the difference between a voice that is an open channel—connected physically with breath and sound, psychologically with feelings and thoughts, and culturally with a rich resource of language—and a voice that is impeded or blocked.⁸⁸

From Normi Noel, who also worked in theater, Gilligan learned

to pick up relational resonances and follow the changes in people’s voices that occur when they speak in places where their voices are resonant with or resounded by others, and when their voices fall into a space where there is no resonance, or where the reverberations are frightening, where they begin to sound dead or flat.⁸⁹

Voice, for Gilligan, is closely connected with having something to say, a point-of-view, and is something much like the core of the self, and therefore highly relevant to the exercise of autonomy. As in stage two, one can lose confidence in one’s ability to exercise one’s will outside of a supportive, “resonant” environment, or to suppress oneself for fear of “destroying the other.” Voice links identity and intimacy, allowing one to externalize and share one’s inner world, to give expression to the self—or to conceal or disavow it. Voice is, as Gilligan came to understand, a matter of profound integration, uniting complicated patterns of physiology, psychology, breath, and culture. Like Erikson’s other virtues, it, too, is socially-activated—one must be heard into speech. As we continue through progressive reiterations of psychological autonomy in subsequent life-cycle

⁸⁷ Gilligan, *In a Different Voice*, xv. Kristin Linklater, *Freeing the Natural Voice: Imagery and Art in the Practice of Voice and Language* (Hollywood: Drama Publishers, 2006).

⁸⁸ Gilligan, *In a Different Voice*, xvi.

⁸⁹ Gilligan, *In a Different Voice*, xvi.

stages, it will be important to keep the significance of voice at hand, to consider the conditions that make it possible for voices to find resonance with one another, as well as the forms of cultural and congregational retrenchment and control that may be needed in order for women and other marginalized persons to posit themselves in responsibility, but also in freedom. I will return to this matter in chapter five.

According to Erikson, generative persons, schematically lodged between young and old, are the consummate ritualizers of the life cycle. His seventh stage—and the locus of Browning’s psychoanalytical ethics—is centered on the crisis of “generativity versus stagnation,” which deals primarily with the establishment and maintenance of subsequent generations. Despite the gendered distortions and omissions in previous stages, Browning centers the significance of Erikson’s work in this stage, whose virtue is care. As a norm, “generativity” presupposes an ethics of care; when taken on these terms, the contributions of women to the strength of the life cycle need not appear deficient, but can instead be centered.

Generativity may express itself physically in the procreation of children and culturally in ideas and institutions—the concept of generativity rightly evokes the continuity between genes and works.⁹⁰ One may become stagnated if he cannot find a mutually strengthening way of contributing to subsequent generations. “Stagnation” invokes a sense of stasis that resists the flow of the cycle of generations as well as an inordinate turning in on the self that is suggestive of many Christian descriptions of sin. Erikson observed that individuals “who do not develop generativity often begin to indulge themselves as if they were their own one and only child”—a condition linked to many

⁹⁰ Daniel Sulmasy and I argued that St. Francis of Assisi remains a pinnacle of generativity in spite of vowed celibacy owing, in large part, to his founding of the Franciscan religious orders. See “Spiritual Preparation for Death” in Lydia Dugdale, ed., *Dying in the Twenty-First Century: Toward a New Ethical Framework for the Art of Dying Well* (Cambridge, MA: The MIT Press, 2015), 99-101.

pathologies, including the early invalidism cited above.⁹¹ Biological parenthood, however, is no guarantor of generativity, nor invention, industry, or creativity. Crucially, the generative person will care for and maintain what she generates. Children who are born, but who are unevenly cared for and haphazardly educated, buildings constructed to last thirty years or less, unchecked pollution, non-recycled waste, and “societies so specialized and differentiated as virtually to segregate all children and young people from adult life” are hallmarks of a nongenerative mentality.⁹² Norman O. Brown postulated that unrestrained expansionism results from modern man’s fear of death; Browning reservedly concurred, but U.S. medical priorities, at least, seem to bear this out: hospitals herald technologically advanced (and concomitantly expensive) interventions like organ donation while doing comparatively little to prevent the chronic diseases that lead to organ failure. Physicians insert feeding tubes to ostensibly preserve the lives of elderly persons when hand feeding could offer a more humane opportunity for face-to-face recognition and sensitive personal exchange. The practice of excluding children from the ICU during flu season bespeaks a prioritization of limiting the transmission of disease, but is nongenerative insofar as it has prevented children from interacting with their dying grandparents or from witnessing their parents attend the death of their own parents.⁹³

In the modern situation we are witnessing a distortion of natural activities and potentials that are in themselves human and natural. But this distortion is in itself enough to corrupt the integrity of the evolutionary pilgrimage, the cycle of the generations, the strength of the young, and the very life of us all.⁹⁴

⁹¹ This is said not to blame such individuals for their own illness or early deaths—the synthesis is a matter of historic, economic, and political factors as well as egoic strength, which depends on strong relationships and fortuitous convergences.

⁹² Browning, *Generative Man*, 165.

⁹³ Many popular forums discourage parents from including their children during hospital visits or at funerals on (pseudo) psychological grounds. Browning’s dialogical study intended to tease out “the ultimate commitments (the really important values) behind a particular system...or socialization.” Browning, *Generative Man*, 15.

⁹⁴ Browning, *Generative Man*, 165.

Erikson’s “nuclear” or psychosocial crisis of generativity versus stagnation posits the challenge of coordinating “low,” “archaic,” and innate biological instincts to procreate with the “high” cultural products of imagination and reason.⁹⁵ Generativity and its corresponding virtue, care, constitute a grand synthesis of all the “preceding modalities, capacities, and virtues of the previous stages.”⁹⁶ Modalities of trust and hope, autonomy and will, initiative and purpose, along with complex capacities like industry and competence, identity and fidelity, intimacy and love, must come together in a work of art—the idiosyncratic life of an individual.

Browning notably spins Erikson’s seventh crisis into a characterology, projecting the ethical and universal aspects of his thought into an ideal-type. Because generativity gains its power from the instinctive forms of care that parents give to their children, which sometimes include the willingness to sacrifice themselves for their offspring, he cautions against extrapolating too far afield from these biosocial realities. Such care, nevertheless, may and must be analogized and extended when united to the complex capacities enumerated above. While “the true saints” may be those

who transfer the state of householdership to the house of God, becoming father and mother, brother and sister, son and daughter, to all of creation rather than to their own issue⁹⁷

the generative person includes her care for her children and extends this care more universally: “Care is the widening concern for what has been generated by love, necessity, or accident; it overcomes the ambivalence adhering to irreversible obligation.”⁹⁸ Browning argued that Erikson stood in a line of teleologic thinkers including Aristotle and Aquinas. The concept of generativity echoes the Thomistic insight that grace does not destroy nature but completes it, therefore the

⁹⁵ Browning, *Generative Man*, 145-146.

⁹⁶ Browning, *Generative Man*, 195-196.

⁹⁷ Erik H. Erikson, *Gandhi’s Truth: On the Origins of Militant Non-Violence* (New York: W. W. Norton & Company, 1969), 399.

⁹⁸ Browning, *Generative Man*, 163, emphasis mine.

preferential love one has for kith and kin should be extended to all who are made in God's image,⁹⁹ and elaborated according to actual social conditions as well as historical projections that rational imagination makes possible. Mature instinctual needs to teach and to be mutually activated, strengthened, and affirmed by members of subsequent generations necessitate close attention to institutions, particularly religious institutions, whose native ritualizations inherently mark the life cycle and potentially unite the generations in ways that are otherwise foreign to age-stratified societies.

Browning suggests that generativity is an arbiter of societies—a norm by which to judge them with respect to human strength and soundness. The concept is, nevertheless, a rather conservative one. In order for humans to effectively maintain and enhance what they generate, Browning suggests that they should do and produce less, slow down, and “shrink” the world—preferably to child-sized proportions.¹⁰⁰ Careers “pursued at breakneck speed” and the capitalist structures and philosophies of perpetual growth that demand them are perhaps the biggest obstacles to mutually-strengthening ritualizations and care for children and elders alike.¹⁰¹ M. Therese Lysaught observes that the socioeconomic changes of the Industrial Revolution wrought radical changes in familial and communal infrastructure and that the geography, architecture, and structures

⁹⁹ Browning, “An Ethical Analysis of Erikson's Concept of Generativity,” 249.

¹⁰⁰ Browning, *Generative Man*, 26, 205-6.

¹⁰¹ While acknowledging the highly gendered nature of child care to date, Browning advocated the “equal-regard family” and the 60-hour work week for married couples with young children—an arrangement intended to grant both partners the opportunities and responsibilities of caregiving and participation in the paid workforce; it was envisioned that the couple might choose to share the working hours in a 40-20 or 30-30 arrangement. Such an arrangement seems practically utopian given the state of the U.S. economy with respect to family leave, job-sharing, and the status of part-time work, but as a policy proposal this is highly reflective of the widening patterns of care of the generative person who seeks to regulate his environment in ways that make it ecologically supportive of human health. Don S. Browning, *Equality and the Family: A Fundamental, Practical Theology of Children, Mothers, and Fathers in Modern Societies* (Grand Rapids, MI: William B. Eerdmans, 2007), 232. See also Don Browning, Bonnie Miller-McLemore, Pamela Couture, Bernie Lyon, and Robert Franklin, *From Culture Wars to Common Ground: Religion and the American Family Debate* (Louisville, KY: Westminster John Knox, 1997, 2000), 316-18. Bonnie J. Miller-McLemore, “Generativity and Gender: The Politics of Care” in Ed de St. Aubin, Dan P. McAdams and Tae-Chang Kim, *The Generative Society: Caring for Future Generations* (Washington, DC: American Psychological Association, 2004).

of communities precipitated by this urbanization bear a direct relation to the medicalization of death.¹⁰² When families began to reside in densely populated apartments and both parents were compelled to work for long hours outside the home, mid-life adults could not afford the space or time to care for aging elders or ailing individuals, who were directed to hospitals or nursing homes. Social dislocation and economic structures that limited intergenerational contact also weakened the everyday ritualization of life—for example, in his later work on the fundamental practical theology of the family, Browning proposed that home rituals around meals and bedtime, as well as family meetings, can and should reinforce the liturgies of church and synagogue.¹⁰³

To my knowledge, Browning never explicitly wrote about extending this mutually-reinforcing ritualization to the care of the dying, but the projection of this concern is a natural extension of the practical theological thinking he advocated in the face of technological rationalization.¹⁰⁴ I will turn to these ideas in the next section; for the moment it is important to iterate that the resiliency of the generative person stems from “ecologically viable rituals of recognition.”

The man [sic] with the well-established identity is the one who has organized it ‘around basic values which cultures have in common.’ In other words, the man with the truly resilient identity is the man whose identity is built around universal principles, which are so clearly perceived and so firmly held that few experiences can seriously threaten them. His own self-consistency with these principles gives him an inner sense of abiding recognition by a face of universal proportions, be it the face of God or the generalized face of man idealized and projected into a more perfect future. But such a man, who is in fact the ‘generative character’ himself, is the man of maturity—the product of a reasonably favorable environment, many years of struggle, and perhaps a bit of genius.¹⁰⁵

¹⁰² M. Therese Lysaught, “Ritual and Practice,” in Lydia Dugdale, ed., *Dying in the Twenty-First Century* (Cambridge, MA: The MIT Press, 2015), 74-75.

¹⁰³ Don Browning, “The Task of Religious Institutions in Strengthening Families” in *Equality and the Family* (Grand Rapids, MI: Eerdmans, 2007), 226.

¹⁰⁴ Cf. Don S. Browning, “Toward a Practical Theology of Care,” *Union Seminary Quarterly Review*, vol. xxxvi, nos. 2 & 3 (Winter/Spring 1981), 159.

¹⁰⁵ Browning, *Generative Man*, 171.

Browning's generative person is in possession of an identity formed around a master-scrap; her religious narratives give content and direction to widening forms of care that redound to her self-confirmation, through the faces of others. Far from normless privatism, the mature expression of autonomy may be seen as an existential consonance and attunement of one's inner capacities to the reality of the present moment—not simply choice, but an authentic way of being, a self-affirmation derived from one's own being-for-others that simultaneously realizes one's ownmost possibility.¹⁰⁶

Browning observed that the generative person has a discernable experience of time: "The center of his time perspective is in the present, but it is a present that grows out of the past and actively leans toward the future."¹⁰⁷ Yet the crises of 'generativity versus stagnation' and 'integrity versus despair' could span more than half a century in the life of an individual, with no bright line dividing them. Disparities in what sociologists call "social timing" also contribute to contemporary pluralisms that have shifted the ecology of intergenerational life; different social groups levy diverse cultural demands on their members, in turn shaping individuals' self-understanding of their place in the life cycle.¹⁰⁸ A long period of latency after the establishment of fertility might help to ensure that prospective parents can cultivate the education, skills, and relationships that will enhance their ability to be generative people, equipped to establish and care for succeeding generations, but the deferral of parenthood puts more distance between the generations, yielding older grandparents who may themselves require care while their grandchildren are still young. When life expectancies hovered around five decades, a woman may well have experienced menopause as an unambiguous sign that

¹⁰⁶ This Heideggerian inflection is intentional; I will address spiritual autonomy with respect to Karl Rahner's Christian existentialism in the next chapter. Browning wrote that Erikson gives a developmental order to the human person's being-in-the-world (*Generative Man*, 159).

¹⁰⁷ Browning, *Generative Man*, 197.

¹⁰⁸ This phenomenon is known as social timing among sociologists. See G.H. Elder, Jr., "The Life Course Paradigm: Social Change and Individual Development." In P. Moen, G.H. Elder, Jr., and K. Luscher, eds., *Examining lives in context: Perspectives on the Ecology of Human Development* (Washington, DC: American Psychological Association, 1995), 101-139.

her generativity crisis was coming to a close, and the challenge to integrity dawning, but longer lives, later parenthood, and extended adolescence may now find a woman in her early fifties still intensely responsible for the care of children and in the midst of a productive career while other women her age are well-established grandmothers; still others may be seeking a first or second partner, or trying to reinvent an overly narrow identity. Men, having fewer well-anticipated biological cues, may rely more on their career trajectories or on health or relational crises to discern “where they are in life.” Additionally, insofar as medicalization blunts the signs of aging, it can make it more difficult to know where one is in his or her life. Hormone replacement, for example, may yield bodies that feel and look younger than their chronological ages. And yet, one cannot dismiss Heidegger too easily—one lives toward one’s own death as a genuine limit. The last chapter of life must be discerned and planned “if old people are somehow to crown the whole sequence of experience in the preceding life stages” with existential integrity,¹⁰⁹ but this planning of the chapters of one’s life now requires greater individual discernment given the diversity of life plans within any particular age cohort.

The final crisis of “integrity versus despair and disgust” is rather anomalous when compared to the preceding stages. Writing together, Joan and Erik Erikson suggest that this “old age” stage begins when the balance of dystonic elements in life are experienced as “more convincing” than the syntonic—one comes presumptively to distrust one’s capabilities, experience shame and doubt with respect to one’s body and life choices, and to suffer identity confusion amidst the dearth of viable roles for elderly persons (including, perhaps, a compelled relocation to a new community).¹¹⁰ Amid the loss of organizing linkages in “Soma,” “Psyche,” and “Ethos,” one is nevertheless challenged to

¹⁰⁹ Erikson *et al.*, *Vital Involvement in Old Age*, 14.

¹¹⁰ Erik H. Erikson and Joan M. Erikson, *The Life Cycle Completed* (New York: Norton, 1997), 61, 107-111.

synthesize a sense of coherence and wholeness that characterize the trait of integrity.¹¹¹ Life review may give way to despair (and existential panic) once one senses that “the time is short, too short for the attempt to start another life and to try out alternate roads to integrity.”¹¹² As in the other stages, generativity is not abandoned, but the ego is charged with reiterating it into a “grand-generativity” of widening, and yet, “detached concern with life itself in the face of death itself,” a challenge that yields the strength of wisdom for the successful ego.¹¹³ There is also a corresponding antipathic trend: disdain. In old age, there may be (a perhaps continued) unwillingness to include specified persons or groups in one’s generative concern; “one does not care to care for them,”¹¹⁴ Erikson writes. Such an attitude would indicate a failure in grand-generativity, for it is in the nature of generativity to expand.

Ultimately, one must come to terms with what he or she has become, a move that Erikson judged to contain elements of resignation and acceptance of one’s one and only “life cycle with but one segment of history.” The concept of life review is invoked, and moral seriousness conferred,

¹¹¹ Erikson, *The Life-Cycle Completed*, 65. Joan and Erik Erikson both lived into their nineties; after his death, she took the opportunity to reevaluate the life-cycle stages they had worked to imagine together, cognizant that one is somewhat blinded to the demands of the stage they are currently living. She recognized that ‘integrity’ and ‘wisdom’ carry rather lofty connotations within the life cycle stage beset by dystonic and disintegrating realities, and yet, the roots of these words, she argued, yield insight into the practical virtues of old age. She noted that wisdom’s root derives from the Sanskrit *vēda*—“to see, to know;” likewise, thousands of years ago, “wisdom” and “ear” shared the same word in the Sumerian language. Joan Erikson therefore reasons that “we can see that wisdom belongs to the world of actuality to which our senses give us access...It is also the role of wisdom to guide our investment in sight and sound and to focus our capacities on what is relevant, enduring, and nourishing, both for us individually and for the society in which we live.” The word ‘integrity’ emerged from the root word ‘tact’: “From this element we derive ‘contact,’ ‘intact,’ ‘tactile,’ ‘tangible,’ ‘tack,’ even ‘touch’...Integrity has the function of promoting contact with the world, with things, and, above all, with people. It is a tactile and a tangible way to live, not an intangible, virtuous goal to seek after and achieve.” I believe Joan Erikson’s observations apply to mature conceptions of autonomy as well, which should not remain at the level of theoretical ideal. In the Eriksonian psychological literature, ‘autonomy’ emerges from the physical receptivity of the infant with its mother; later reiterations of autonomy facilitate higher forms of union between persons. In chapter 5 of this work, I strive to illustrate that mature autonomy depends, in part, on the genuine (physical) ecologies of the life cycle as well as personal and physical contact with others in community. Joan M. Erikson, “Preface to the Extended Version” in Erik H. Erikson, *The Life Cycle Completed* (New York: W.W. Norton & Company, 1997), 1-10.

¹¹² I mean to argue that the medicalization of death is very much a response to this existential panic and despair. Erikson, *Identity and the Life Cycle*, 104.

¹¹³ Browning, *Generative Man*, 196-97.

¹¹⁴ Erikson, *The Life Cycle Completed*, 68.

with the assertion that “all human integrity stands or falls with the one style of integrity of which one partakes.”¹¹⁵ I maintain that the achievement of this egoic integrity is an important component of mature autonomy, along with stage-appropriate reiterations of the other life cycle virtues. One may affirm one’s own unique pilgrimage and potentially become a numinous model and tangible source of trust and hope for others.¹¹⁶

The dialectical tensions of this life stage are myriad and temptations to despair and disgust abound, particularly in the context of weak human ecologies and youth-oriented societies that mock aging bodies and incompetence with the latest technologies. Generative impulses to build and maintain community later in life may of necessity be directed to one’s own age cohort; think of grey-haired congregations and retirement communities whose members may be responding to the actions of the younger generation that moved away in pursuit of its own livelihood. (Such self-seclusion might also be a choice informed by a particular vision of retirement premised on the absence of exertion and freedom from “care.”) The “elderlies” in such communities may exhibit concern for one another and seek to take responsibility for the remainder of their lives, but they are not likely to become or to experience themselves as “elders” in the absence of meaningful contact with subsequent generations.¹¹⁷ “Generativity mismatches” threaten the prospect of integrity—if what the older generation has to offer is not wanted by the younger or perceived as relevant to its plight, or the younger repudiated for an identity that the older cannot affirm, the generations will miss the opportunity to strengthen one another. It would be difficult for a sense of wisdom to preponderate in the absence of its recognition.

¹¹⁵ Erikson, *The Life Cycle Completed*, 66.

¹¹⁶ I do not want to minimize the role of grace in this achievement, nor the role of theological narrative in fostering integrity.

¹¹⁷ I borrow these terms from *The Life Cycle Completed* where Erikson defines ‘elders’ as “the few wise men and women who quietly lived up to their stage-appropriate assignment and knew how to die with some dignity,” and ‘elderlies’ as “a quite numerous, fast-increasing, and reasonably well-preserved group” (62).

As an ethical concept, generativity is a norm by which to judge the narrative thread of a life—its master scrap. Browning notes that while psychological sciences are retrospective, speaking to the needs and makeup of the whole person, theology is prospective, projecting the goals of life. Generativity is an ethical concept that mediates between the two and potentially judges both. By attending to the rhythms of biosocial development, Erikson helped to specify what Browning called “the premoral good,” in this case, health—both of the individual and the species.¹¹⁸

Health itself is a basic nonmoral or premoral good...But nonmoral or premoral goods are not necessarily fully moral goods...We do not necessarily call the healthy, wealthy, knowledgeable, agentive, or skillful person a morally good person. This is because there can be conflicts between nonmoral or premoral goods; my claims for health may conflict with yours, my wealth may compete with yours, and my skills may displace yours. I contend that the moral good reconciles conflicting premoral goods, both within the individual self and between self and others. The theoretical literature of some forms of psychotherapy moved too rapidly from their insights into the nonmoral or premoral good of health to the cultural and moral ideal of the morally good person. I...claim that health—psychological and physical—contributes to the morally good but does not exhaust the meaning of the morally good.¹¹⁹

Prospectively, Browning asserts that while

offering health in this world has never been at the core of Christianity or, for that matter, the other Abrahamic religions of Judaism and Islam...[b]ringing to maturity loving and self-giving persons has been the primary concern of Christianity, whether or not this contributes to health and well-being.¹²⁰

Erikson’s theory has been morally fruitful for its ability to unite the prospective view with the retrospective and to attend to the conditions that nurture loving and self-giving persons. I indicated that Browning judged the concept of generativity to contain an inherent “mixed ethic.”

¹¹⁸ Don Browning, “An Ethical Analysis of Erikson’s Concept of Generativity,” 243. In Browning’s corpus, “premorale goods” are objects or experiences that are good to pursue in the nonmoral sense (these can include mental and physical health, “pleasure, joy, friendship, and such cultural values as technology, education, science, and art”—or even the birth of a child—that “can become involved in structures of organization and mediation that are themselves either moral or immoral.” Browning assigns to ethics the task of “impartially organizing, coordinating, and mediating conflicts among premorale goods.” Browning and Cooper, *Religious Thought and the Modern Psychologies*, 141-42.

¹¹⁹ Don S. Browning, *Reviving Christian Humanism: The New Conversation on Spirituality, Theology, and Psychology* (Minneapolis: Fortress Press, 2010), 60.

¹²⁰ Browning, *Reviving Christian Humanism*, 60.

Deontologically, Browning noted that Erikson grounded respect on “the phylogenetic need for ‘mutual recognition of and by another face’”¹²¹ rather than rationality as did Kant. The generative principle based on his restatement of the Golden Rule follows: “it is best to do to another what will strengthen you even as it will strengthen him—that is, what will develop his best potentials even as it develops your own.”¹²² Deontology thus bleeds into a virtue ethics with care at its heart. Finally, from the perspective of narrative ethics, Erikson illustrates how religious narratives can consolidate and extend generativity through ontologies of creation that support “faith in the goodness of life” and potentially extend a person’s sense of kinship “with others indefinitely into the future.”¹²³

A MASTER SCRAP: GENERATIVITY AND SELF-CONFIRMATION

What we should become in life, the kind of adult we should be, the way we should age, and even the manner of facing our death—all of these things are ethical issues, for all of them have to do with how we live together as we all move through the interlocking generations of the human life cycle.¹²⁴

Near the outset of this chapter, I intimated that mature autonomy in the face of death is both possible and morally desirable. I focus now on the ways that Browning’s attention to the ethics of the life cycle interfaces with some broad strokes of his practical theology to suggest how Christian communities of moral discourse and action should consider their task around the nodal point of human death. Browning’s works demonstrate that a critical appropriation of Erikson’s life cycle theory can inform an understanding of how one, in a self-transcendent, creative, and differentiated way, can make the law of love one’s own. A psychoanalytic understanding of the life cycle yields

¹²¹ Erik H. Erikson, *Insight and Responsibility* (New York: Norton, 1964), 94.

¹²² Erikson, *Insight and Responsibility*, 233.

¹²³ Don Browning, “An Ethical Analysis of Erikson’s Concept of Generativity,” 251. See also Erikson’s extensive psychohistories *Young Man Luther: A Study in Psychoanalysis and History* (1958), and *Gandhi’s Truth: On the Origins of Militant Nonviolence* (1969).

¹²⁴ Don S. Browning, “Toward a Practical Theology of Care,” 164.

insight into the human condition, revealing the constitutive crises of the ego and shedding light on the anxiety to which an individual is prone in different phases of life, along with the conditioned freedom and correlative obligation of a person to synthesize a self-confirming consummation of life.¹²⁵

As I turn to attend to Browning's later works, I will be attempting to connect two periods of his work that are often regarded as distinct—his early psychology period with his later practical theology and ethics period¹²⁶—and, furthermore, to extend the exercise of his critical practical theology to its embodiment within Christian congregations (more on this in chapter five). I share Browning's concerns about social fragmentation and technological rationalization: as a *modus vivendi*, medicalization is, I argued, a response to “[t]he twin realities of modernity and liberalism, [which] have worked against the maintenance of shared traditions, social narratives, and communal identities.”¹²⁷ In chapter two, I detailed some of the contemporary “ersatz liturgies” that reflexively condition these forms of fragmentation as they have evolved within hospitals and medical centers. I argued that deaths have become increasingly medicalized and managed by strangers within foreign life-worlds; the so-called “ersatz liturgies” involve more-or-less conscious strategies to address, and sometimes suppress, spiritual and existential distress and terror in the face of death—as “ersatz”, and not integral “liturgies,” they become, according to Browning's categories, nihilistic, functioning to further weaken the links between generations, leaving younger generations increasingly de-skilled and helpless in the face of death. In this chapter, I have attended to how psychological autonomy is

¹²⁵ The early psychosocial crises are particularly foundational in Erikson's thought. Major early deficits in trust and autonomy can severely inhibit the capacity for self-transcendence, although Browning concluded that “some self-transcendence seems possible for everyone who has sufficient symbolic capacities to have a representation of the self.” Browning and Cooper, *Religious Thought and the Modern Psychologies*, 193.

¹²⁶ Browning and Cooper, *Religious Thought and the Modern Psychologies* (Minneapolis, MN: Fortress Press, 2004).

¹²⁷ Don S. Browning, *A Fundamental Practical Theology: Descriptive and Strategic Proposals* (Minneapolis: Fortress Press, 1991), 4.

relationally-activated and further analyzed the significance of strong human ecologies for eliciting strength out of life-cycle crises, with special attention to the activation of psychological autonomy.

By lingering on Erikson's ecological theory of the life cycle, I worked to substantiate that an autonomous consummation of life is strengthened by viable communal rituals of recognition; autonomy need not repudiate tradition, but can be strengthened by it, particularly when psychological autonomy is appreciated for its capacity to sharpen the freedom "to do." My brief foray into Carol Gilligan's developmental psychology crystallized how one is apt to become uncertain about oneself when she does not presume to share the sense of reality projected by the dominant paradigm: how, for example, does one give voice to the self, or effectively make choices that are consonant with one's deepest identity, in an environment where they find little resonance—perhaps a busy ICU or urban hospital? In chapter two, I also analyzed the *Ars moriendi* of Middle Age Christendom to aver that its associated practices were comparatively autonomy-promoting; while formulaic, they centered the dying individual within a community that ostensibly strengthened the identity of individual and group alike. In that analysis, I implicitly invoked Browning's five dimensions of moral reason to which I will turn in a moment. While the *Ars moriendi* is a Christian "classic"—part of the repertoire of Christian tradition with which one may critically engage, I am not recommending its wholesale revivification, but rather point towards new forms of integral re-ritualization that promote persons' moral and psychological autonomy throughout the life cycle, with a particular eye to life's consummation.

Many contemporary persons who still consider themselves "religious" and "spiritual" are nevertheless leaving religious congregations—often for compelling reasons. I am nevertheless arguing for the continued importance of faith communities. When congregations are understood not just as affiliative institutions, but as "vital basic communities," (a phrase I borrow from Karl Rahner,

and to which I give content in chapter five)¹²⁸ they may provide a partial antidote to the disintegrating and fragmenting aspects of contemporary life—a site where generative autonomy is practiced. As communities of moral discourse—that is, places where persons together engage in the tasks of critical practical theology—congregations provide an opportunity for persons to critically correlate their decisions, actions, and postures in the world—including choices made with respect to aging, illness, and death—with their best understanding of the situations they inhabit and with the considered convictions to which they wish to align themselves—convictions shaped by their ultimate concerns and by the classics and traditions of their faith. It is my contention that the method outlined in Browning’s *Fundamental Practical Theology* can help persons to become more morally autonomous in this way. Churches are both inward and outward facing, and thus potential sites of meta-autonomy as well—congregations may help to shape the institutions that shape themselves.¹²⁹ Finally, they are places of intergenerational promise: one of the few places in contemporary culture that provide sustained contact between the generations, in which young and old may recognize, affirm, activate, and strengthen one another. There, sacraments like baptism, the eucharist, reconciliation, foot washing, and anointing could expand into more comprehensive forms of intergenerational care, as I will elaborate in chapter five. In sum, I am proposing that the church may be conceived as a site of moral discourse and meta-autonomy, but also as an intergenerational

¹²⁸ Rahner wrote about “basic communities” (which he elsewhere termed “vital” and “living” basic communities) in the context of the Church of the future, which could not be expected to continue on the basis of historical momentum or traditional sociological structures, but which would require renewal “from below” in the form of “free initiative and association.” In basic communities, persons jointly intend to undertake social responsibility for the world (for love, justice, and freedom) “in the light of...concrete everyday life.” Rahner envisioned that such communities might emerge from, or form into, a Catholic parish, but could also be ecumenically established. They would be experimental “ventures of hope” that “remain positively open to the whole wealth of tradition of spiritual experience, of theological reflection, of liturgical practice, of socio-political theory and practice which the history of the Church offers to us.” Cf. Rahner, “Basic Communities,” *Theological Investigations* 19:12, 159-165; “Modern Piety and the Experience of Retreats,” *Theological Investigations* 16:8, esp. 147-148.

¹²⁹ For example, by working to reform hospice practices that have become overly generic or bureaucratized, or by working to provide these services to their co-religionists so that the dying need not meet such professionals “as strangers.” While not exhaustive, chapter five explores such possibilities in more detail.

laboratory for living out a more intentional life of freedom and responsibility, attuned to the significance of intergenerational cogwheeling, and capable of engaging in the retrenchment of the more dehumanizing aspects of technical rationality—a community that actively seeks to order its life together in the service of strengthening individuals in their own capacities for responsibility and freedom within a framework of ultimate commitments that are discerned and lived out.

Philip Rieff, writing on the psychological culture of detachment after Freud, suggested that the hospital and theater would replace the church (as well as family, party, and nation) as the normative institutions of the future. The analytic attitude would render “psychological man” incapable of sustaining the “unwitting dynamic of moral demands claiming the prerogatives of truth, exercised through creedally authoritative institutions.”¹³⁰ The analytic attitude is indeed a rival “master scrap” in our pluralistic society, as are harmonistic psychologies that elide conflict, scarcity, the need to rationally order nonmoral goods, and occasions for self-sacrifice. While the eclectic scraps that comprise the medicalization of life and death may owe more to therapeutic and consumer-capitalist commitments, the hospital is demonstrably an organizing institution of our society. Contra Rieff, however, Browning constructed a critical—witting, as it were—hermeneutics of the principles of obligation and the deep metaphors that are present in Christian faith; his fundamental practical theology asserted that the rational dimensions of religious communities could reflexively shape the actions and lives of their adherents. His progressive and strenuous normative ideal of human life draws its strength from putting Erikson in dialogical conversation with Reinhold Niebuhr and Louis Janssens.¹³¹ In Browning’s mature work, he admitted that it is possible “that the deep metaphors and principles of obligation of psychoanalytic figures could serve our religious

¹³⁰ Rieff, *The Triumph of the Therapeutic*, 24–25.

¹³¹ Browning and Cooper, *Religious Thought and the Modern Psychologies*, 107.

purposes better than traditional Judeo-Christian ones, hence a critical conversation between them.”¹³² With due respect for the unconscious and instinctual aspects of human life, Browning held that the theological anthropologies of Niebuhr and Janssens attribute to humans the freedom and self-transcendence to deliberate and to “alter, however slightly, the course of our lives” and the grace to accept one’s own life and to affirm it as good.¹³³ Furthermore, under this theological anthropology, the ordering of conflictual premoral goods is not just a task for professional ethicists, but a responsibility for lay persons: “Giving moral order is a responsibility of humans as moral creatures. This gets to the heart of the dominion or special moral responsibility that humans, under God’s guidance, have over creation (Gen. 1:26).”¹³⁴

Browning maintained that traditional religion and modern psychology stand in a special relation to one another because both of them provide concepts and technologies for the ordering of the interior life. Rieff observed that humans are disposed to “an infinite variety of panic and emptiness”—a culture is needed to save them from falling apart, yet “culture without cultus appears, in almost all historical cases, a contradiction in terms.”¹³⁵ Freud’s disciples filled that gap for many, and it has been my contention that different aspects of medicalization continue to function in an ersatz way to relieve individuals of their panic and emptiness. Such relief might even be a “pre-moral good” but one that issues in many serious disvalues by obscuring moral obligations and weakening the cycle of the generations.

Much has been written about Browning’s *A Fundamental Practical Theology*; in it, Browning locates the horizon-analysis he is prescribing with respect to the hermeneutical sciences and theories

¹³² Browning and Cooper, *Religious Thought and the Modern Psychologies*, 107.

¹³³ Browning and Cooper, *Religious Thought and the Modern Psychologies*, 102, 139.

¹³⁴ Browning, *A Fundamental Practical Theology*, 194-95.

¹³⁵ Rieff, *The Triumph of the Therapeutic*, 3, 14.

of ethics, as well as congregational case-studies, in order to establish his place in the field of critical practical theology, and I will not belabor the material here. The points I wish to make with respect to this work are rather simple (even if the course of action he prescribes is morally strenuous).¹³⁶ Browning's methods for gaining critical distance on the issues persons encounter within their segment of life-history, and for evaluating their practices through the five dimensions of practical reason he constructed (the visional, obligational, tendency-need, environmental-social, and rule-role) can help to nurture free and responsible persons, to promote a rational autonomy in which persons choose, act, and cultivate virtues in ways that are consistent with the meanings and narratives they ultimately wish to affirm. Browning recognized a "practice-theory-practice" structure of theology.¹³⁷ Congregations can reflect on the situations in which they find themselves, engage in the practice of critical distanciation¹³⁸ in order to reflect on, for example, what the Christian love ethic demands of them in a given situation, and to then reconstruct or reform their practices in light of their new understanding. Issues as diverse as advance care planning, organ donation and transplantation, Christian funeral and burial practices, health insurance advocacy, and life-cycle rituals are among potential candidates for this kind of critical correlation, which is likely to be invoked when congregants become aware of a conflict between the "Christian and non-Christian aspects of their lives."¹³⁹ The cultivation of perception is a critical task of congregations. Churches educate the

¹³⁶ Like the march of medical progress that brings new moral questions in its wake, the tasks of critical correlation are never finished; the hermeneutical circle "rolls on," and the community must continue to revisit its settled practices in light of new historical situations, empirical understandings, etc.

¹³⁷ Or, more accurately, a "present theory-laden practice to a retrieval of normative theory-laden practice to the creation of more critically held theory-laden practices" structure of theology. Browning, *A Fundamental Practical Theology*, 7.

¹³⁸ Browning draws on the hermeneutical theories of Hans-Georg Gadamer and Paul Ricoeur, the pragmatic idealism of Josiah Royce, and on Aristotelian *phronesis* to argue for a communal approach to the hermeneutic process. Browning is clear that humans cannot achieve pure objectivity with respect to the reflection they are able to bring to bear on the lives they are living; one can only gain relative distance from the pre-understandings and prejudices with which they live in the world, but this modicum of self-transcendence can be transformative, particularly when performed dialogically within a community of wisdom and tradition. Browning, *A Fundamental Practical Theology*, 38-39, 50-51.

¹³⁹ Browning, *A Fundamental Practical Theology*, 45.

habits, virtues, and characters of their congregants (this might be called “forming the conscience” in Catholic communities) so that persons might, for instance, recognize when they have witnessed “a bad death” and thereby be led to describe, interrogate and correlate their understanding of the situation in accordance with a critical and communal understanding of the Christian classics in order to transform their common life and practices.

Browning constructed five “levels” of, or “moments” within practical moral reasoning that may be more or less consciously invoked when persons discern a conflict within their way of life. These levels (famously symbolized by the “VOTER” acronym) include the visional, which makes metaphysical claims about the ultimate context of our lives. The obligational level interrogates the ethical principles that are implicitly used to guide human action and asks about what is ethically normative for the human condition. The tendency-need level “involves anthropological claims about human nature, basic human needs, and a discussion of the pre-moral goods required to meet those needs.”¹⁴⁰ The tendency-need level also includes existential needs, which have traditionally been the province of religion, but are now also informed by the psychological and social sciences. In *Religious Ethics and Pastoral Care*, Browning observes that this level becomes particularly contested “as traditions break down and personal experience becomes confused.”¹⁴¹ A key idea implicit within this dissertation that belongs in this moment of practical reason is the extent to which ontological and developmental anxiety and trust are both interrelated and distinct—I will turn to treat this matter in a moment, as well as in subsequent chapters. The environmental-social level of practical reason raises questions about the social-systemic and ecological constraints on our needs; the rule-role level is concerned with prescriptive concrete actions.

¹⁴⁰ Terry D. Cooper, *Don Browning and Psychology: Interpreting the Horizons of Our Lives* (Macon: GA: Mercer University Press, 2011), 32-33.

¹⁴¹ Don S. Browning *Religious Ethics and Pastoral Care* (Philadelphia: Fortress Press, 1983), 70.

Generativity, as both a principle of health and a theory of obligation, is an important touchstone for Christian communities. Browning wrote that generativity

is not only the instinctive source behind biological procreation and care; it is also the ground for man's [sic] higher attempts to create a total environment ecologically supportive of the general health—not only of family and tribe, but of the entire human species.¹⁴²

Terry Cooper observes that Erikson's ego psychology gives a developmental schema to an old truth: "We truly find our lives by giving them away."¹⁴³ When put into a structured dialogue with normative images, metaphors of ultimacy, and considered convictions about the ends and purposes of life, this psychoanalytic theory may help congregations to enact a practical theology of care that promotes mature autonomy by maximizing the self-transcendence (the ability to make one's self one's own object) of individuals throughout the life-cycle while ministering to the sin that mars its course:

"we moderns [are] aware that at all times throughout the human life cycle, our anxiety over our freedom gets mixed up with the genuine developmental anxieties, deficiencies, assaults, challenges, twists, and traumas that do invariably afflict us all and some more than others...It is not that our interpersonal, familial, or developmental anxieties are one thing and our existential anxieties about life's general contingencies and limitless possibilities are another. There is a continuum between them. Our existential anxieties are always there, and we become progressively aware of them as consciousness matures. Our familial, developmental, and interpersonal anxieties amplify and particularize our existential anxiety. But if the tendency to grasp in overdetermined and desperate ways for security in the face of developing freedom is a universal and ontological feature of human life, then it must be acknowledged that the temptations of sin qualify and are a factor in all our other developmental processes."¹⁴⁴

In other words, an ecologically-supportive environment may well help to nurture psychologically autonomous persons whose firm but flexible egos help them to move through the life cycle with a coherent sense of identity, to enjoy warm and intimate relationships with others, to initiate

¹⁴² Browning, *Generative Man*, 145-46.

¹⁴³ Cooper, *Don Browning and Psychology*, 134.

¹⁴⁴ Browning, *Religious Ethics and the Modern Psychologies*, 130.

important projects, to reform institutions, and to approach the end of life with a sense of integrity, prepared to add their contribution to the life-cycle. Nevertheless, psychological “health” does not banish existential anxiety nor obviate the sinful misuse of one’s freedom—a possible response to this anxiety. Awareness of death as well as the scarcity and genuine limits that are real and proper to human life, induce existential anxiety; one may respond with inordinate self-regard and a turning in on oneself. One might grasp for excessive goods and resources while failing to consider the needs of others.¹⁴⁵ One might also respond to this anxiety by seeking to lose oneself in forms of sensuality that tend toward the dissipation of the self; Niebuhr called this “the sin of hiding”—it represents the attempt to flee the responsibility one has for one’s freedom, a freedom to exercise self-transcendence within the limits of finitude.¹⁴⁶

If the virtue of integrity is, finally, to preponderate in the life of an individual, she will have been able to generate and sustain a narrative thread throughout her life; “the capacity to keep a particular narrative going” is quite significant.¹⁴⁷ Such a narrative will almost certainly take on a rather mythopoetic character in the life of an individual; it will represent an egoic act of weaving life experiences—some, no doubt, highly unfavorable—together with chosen principles, virtues, and communal narratives—the more-or-less consciously adopted norms by which one holds oneself responsible.¹⁴⁸ Such a narrative thread has the potential to become the law or rule of one’s life. A sense of integrity (and mature autonomy) will correspond to one’s capacity to be faithful to it. I trust

¹⁴⁵ Browning, *A Fundamental Practical Theology*, 144-45. Browning relies on Reinhold Niebuhr, *The Nature and Destiny of Man*, vol. 1, Nature (New York: Charles Scribner’s Sons, 1941), 168.

¹⁴⁶ In a feminist critique, Susan Nelson Dunfee argues that for women, the “sin of hiding” can manifest as “the fear of becoming someone” involving the attempt to escape from one’s freedom by losing oneself in others. Susan Nelson Dunfee, “The Sin of Hiding: A Feminist Critique of Reinhold Niebuhr’s Account of the Sin of Pride.” *Soundings: An Interdisciplinary Journal*, vol. 65, no. 3 (Fall 1982), 320ff.

¹⁴⁷ Dan P. McAdams, “Generativity in Midlife,” in *Handbook of Midlife Development*, ed. Margie E. Lachman (New York: Wiley, 2001), 428.

¹⁴⁸ Such a narrative will contain omissions wrought by human fallibility, frailty, moral blindness, and egoic weakness.

that I have adequately detailed the importance of a supportive ecology to this endeavor. Practical theology, in close conversation with theological ethics and the ritualizing life of church community are vital partners in the ecology I am supposing. It is a hallmark of generative persons to bring their powers to bear on regulating the environments that regulate themselves, “precisely the modest but crucial capacity of the spirit for self-transcendence that makes it possible for the members of a community to join together and plan the reinforcements of their common life.”¹⁴⁹

Browning discerned that “basic Christian theories of obligation center around the principle of neighbor-love that instructs us to ‘Love your neighbor as yourself’ (Matt. 19:19; Mark 12:31) and the older and even more universal golden rule that says to ‘Do unto others as you would have them do unto you.’”¹⁵⁰ Theologians have disagreed about whether a correct understanding of *agape* countenances self-affirmation or self-sacrifice. It is important to note here that Erikson’s ethic of generative mutuality (and his own reformulation of the Golden Rule, cited above) was later taken to include the potential for self-sacrifice, drawn from the principles of *satyagraha* and *ahimsa* (“the readiness to get hurt, but not to hurt”)—a transitional moment in the service of truthful action.¹⁵¹ His psychology seems to indicate that such a self-sacrificing action could be highly self-affirming, stemming from egoic strength (rather than self-abnegation). Insofar as Browning’s practical theology incorporates the principle of *ahimsa*, it may have real relevance to aging persons as they engage medical technologies at the end of life; younger generative persons, would not, of course, be exempt from caring for older adults in self-sacrificial ways. A legitimate place for self-sacrifice may inform the obligational and rule-role dimensions of fundamental practical theology, along with the ultimate affirmations of Christian communities (e.g. “Whether we live, we live unto the Lord; and whether

¹⁴⁹ Browning, *Religious Thought and the Modern Psychologies*, 104.

¹⁵⁰ Browning, *Religious Thought and the Modern Psychologies*, 13.

¹⁵¹ Browning, *Religious Thought and the Modern Psychologies*, 201.

we die, we die unto the Lord: whether we live therefore, or die, we are the Lord's (Rom. 14:8, RTMP 131). I continue this theme in the next chapters, turning now to examine an understanding of "spiritual autonomy" and its constitutive connection to neighbor love in the work of Karl Rahner.

CHAPTER 4:

KARL RAHNER: THEONOMOUS DYING

Karl Rahner is renowned for helping the twentieth century Roman Catholic Church to throw open her doors to modernity, to embrace the world, and to welcome the future. His prolific theological writings nevertheless betray a suspicion of one of modernity's hallmarks: autonomy, particularly in relation to death. On his view, attempting an autonomous interpretation of death, whether through suicide or through the construal of death as an exclusively natural phenomenon would be tantamount to damnation: a denial that death is a problem for humans, a rejection of the mystery that is God, a refusal of the transcendence that comprises the person who is addressed by the divine.¹ Nevertheless, Rahner's theological anthropology, famously marked by his turn to the subject, his Christian-existential preoccupation with a human freedom that is oriented to death, the radical responsibility attending this orientation, and his emphasis on the significance of individual choice mark him as a fecund partner for thinking deeply about the nature of freedom and responsibility in relation to medicalized death.

When contrasted with the moral and psychological ideas about autonomy that I have attempted to retrieve and revive in foregoing chapters, the concept of 'theonomy' and particularly the notion of 'theonomous dying' (by which I intend dying according to the will or rule of God) may sound distinctly incongruous. Acquiescence to the divine will might seem, *prima facie*, like physician

¹ "[W]e might...say that mortal sin consists in the will to die autonomously, when death's opening towards God (which is contained in its darkness) is denied and the divine disposal of our supernatural destiny rejected, according to which death is both penalty for original sin and participation in the redeeming death of Christ." Karl Rahner, *On the Theology of Death* (New York: Herder and Herder, 1961), 52-53.

paternalism writ large—an extrinsicism that would demand personal abdication of one’s own freedom and responsibility. While Rahner held that death was ripe with “obediential potency” and lauded martyrdom as the pinnacle of “dying with Christ,” the self-possession and self-positing of that act may be seen to defy conventional categories in order to reveal more profound possibilities engendered by the historical situations of the twentieth and twenty-first centuries.

While Rahner was primarily a theologian, his ethics is one of discernment, even “an individual ethics”—that alone would have interesting implications for patient choice—but this discernment is ultimately rooted in mystagogy, or initiation into experience of the Spirit of God, the reality of which Rahner held to be “identical with Christianity as such.”² Rahner is infamous for his anthropological starting point; by insisting that humans are created to be ‘hearers of the word’ he emphasizes that persons might say ‘yes’ to their “ownmost possibility.” Initiation into this mystery, I will argue, has important implications for the exercise of patient autonomy under a regime of medicalized death; attention to Rahner’s theological writings on death might help us to conceive of deaths that are uniquely generative. To that end, this chapter will proceed in four steps. First, I will explicate Rahner’s theology of death with respect to freedom and responsibility. I will then defend Ignatian spirituality as the most appropriate hermeneutic for integrating Rahner’s works, arguing that Ignatian spirituality offers a uniquely modern and existential approach to the matter of dying “theonomously” in the twenty-first century—an approach to choosing that is capable of traversing the implacable pluralism and “gnoseological concupiscence”³ that mark our contemporary situation.

² Karl Rahner, “Mystik—Weg des Glaubens zu Gott”, in *Horizonte der Religiosität*, 11-24, quoted in Philip Endean, *Karl Rahner and Ignatian Spirituality* (Oxford: Oxford University Press, 2001), 33.

³ “Gnoseological concupiscence” “describes the contemporary situation of contemporary theology in which there are competing and legitimate ideas and it brings to the fore the centrality of pluralism to Rahner’s method that seeks to reflect the unavoidable pluralism of human life.” Francis Schüssler Fiorenza, “Method in Theology,” in *The Cambridge Companion to Karl Rahner*, ed. Declan Marmion and Mary E. Hines (Cambridge: Cambridge University Press, 2005), 80.

I will then contextualize this process through a contemporary medical illustration in order to demonstrate the deep interplay of kenosis and self-possession that are a hallmark of the *Spiritual Exercises*,⁴ arguing, in effect, that a paradoxically robust selfhood inheres in the individual who submits herself to choosing according to the process of Ignatian discernment, and that this process constitutes the “site” where human transcendence and the categorical realities of individuals in their irreducible complexity make contact. Finally, I will work to connect the notion of “moral” or “spiritual” maturity that is implicit in Rahner’s theology of death to his insistence on the identity of love of God and love of neighbor, and to connect this observation with the implications for dying under a regime of medicalization.⁵

A RAHNERIAN THEOLOGY OF DEATH

Rahner’s theology of death (*Zur Theologie des Todes*, 1958) is an attempt to approach the subject by way of “disinterested conceptual elaboration” whose starting point is “the solid ground of [Catholic] doctrine.”⁶ Rahner joins an exposition of Catholic doctrines and the concepts they involve with other types of knowledge in order to paint a fuller picture of the Magisterium’s teaching on death. Elsewhere in his own writings, he is clear that the theology of death encompasses the whole of anthropology:

⁴ The *Spiritual Exercises* were developed by Ignatius of Loyola in the sixteenth century as a structured method of prayer designed to help the one undergoing the *Exercises* to discern God’s will for his or her life.

⁵ Rahner is famously known as a “transcendental Thomist” and much scholarship has been written in that vein, but recent scholarship, including Karen Kilby, *Karl Rahner: Theology and Philosophy* (London: Routledge, 2004) argues convincingly that Rahner is best read nonfoundationally—indeed, that one may struggle to find more coherence than is really there if they take his corpus to build ineluctably on his early *Spirit in the World* and *Hearer of the Word*. This chapter draws on Philip Endean’s argument that Rahner’s turn toward Ignatian spirituality marked a renewal of his theological enterprise; my argument relies on this reading, which has important implications for the ethics of individual discernment explicated in this chapter. Philip Endean, *Karl Rahner and Ignatian Spirituality* (Oxford: Oxford University Press, 2001).

⁶ This text is nonetheless generative of many theological speculations, for example, that the soul might be rendered “all-cosmic” after death. Karl Rahner, *On the Theology of Death*, 24-34.

For, fundamentally, there is no element of a Christian anthropology which, if it is really to be understood in a Christian sense, need not be confronted with the doctrine of death...The orientation of human existence as a whole to death is in reality, as a co-determining factor, part of any treatise on a dimension of human existence, of a theology of mind and knowledge, of a theology of freedom[,] of a theology of human fellowship and love, of a Christian description of the basic realizations of human existence (fear, hope, joy, despair, trust, etc.), and so on, since this 'being for death' co-determines everything in human life and imparts to the latter its uncertainty, its openness to mystery and its ultimate seriousness.⁷

Rahner affirms that death "is one of the most shocking events in human life" but avers that such sober conceptual elaboration is required if we are "to face death with alert hearts and open eyes."⁸

Methodologically, Rahner aims to advance the Church's doctrine on death according to "the concrete necessities of the historical situation" and his initial meditation has significant implications for contemporary considerations concerning medicalized death and the autonomy language surrounding it.⁹ To wit, "death is an event which strikes man in his totality" so that one cannot legitimately reduce death to its physiological or biological manifestations since persons are involved in their totality under both personal and natural aspects.¹⁰ Insofar as the medicalization of death has inchoately recognized this and attempted to respond with totalizing interventions—recall the enterprise of "biopsychosociospiritual" medicine—Rahnerian thought invokes a note of inescapable existentialism, with all of the freedom and responsibility that that entails: death means the definitive end of our state of pilgrimage, so that the modes of development which are proper to human life

⁷ Karl Rahner, "Christian Dying," *Theological Investigations* 18:14, 227-28.

⁸ Rahner, *On the Theology of Death*, 17.

⁹ Rahner, *On the Theology of Death*, 18.

¹⁰ "Nature" defines human beings insofar as they are at their own disposal (includes such things as body, social and cultural environment, religious background, 'world', not as something separate from us but ourselves as the material given to ourselves for self-transformation in freedom. "Person" defines human beings as they freely dispose of or determine themselves by their fundamental option in and through their particular choices, insofar as they possess themselves as their own definitive reality that they themselves produce. True human freedom, then, is the transcendent freedom that belongs to a human being as person." Peter C. Phan, *Eternity in Time: A Study of Karl Rahner's Eschatology* (Selinsgrove, PA: Susquehanna University Press, 1988), 52.

come to an end, so that the person “disposes freely of himself and is, in the last analysis, what he himself, through the exercise of liberty, makes of himself.”¹¹

Reflection on the twentieth century—the “concrete necessities of the historical situation”—caused Rahner to observe that the moment of biological and personal death may not always coincide; a moment’s reflection testifies to the myriad ways in which the self can be eradicated before the body dies. Consider the Holocaust, in which techniques and deprivations were inflicted on a massive scale in order to extinguish the very selves of its victims—even before they “died.”¹² Torture aims at the “unselfing” of the individual—his or her literal dis-integration. Similarly, advanced dementia, while perhaps more prosaically devastating, also appears to kill the personal aspects of the individual, even while he or she physically survives.¹³ One would also be remiss to omit the biomedical category of brain death, which Rahner endorsed.¹⁴ These observations might be taken to relativize the significance of medicalized death: perhaps what occurs at the end of (physiological) life is not all that crucial? Indeed, some support for this view might be found in Rahner’s own writing.¹⁵ Yet, I maintain that the medicalization of death is rightly viewed as a

¹¹ Rahner, *On the Theology of Death*, 21.

¹² “Until the present, not much thought has been given to these changing modes of martyrdom in the history of the Church. Perhaps we are afraid of what could be revealed to us through this startling study. What a contrast if we compare the heaven-storming desire for death of St. Ignatius of Antioch, and the heroic, spirited and enthusiastic death of the martyrs of the Far East in the sixteenth and seventeenth centuries, with the almost anonymous annihilation of many martyrs in our own times. But is not perhaps the martyrdom of anguish and weakness (whereby man is, as it were, killed before he dies, through devilish modern techniques that murder the person, taking man completely from himself before the life of his body is extinguished) an even more intense participation in the death of Christ than any other martyrdom of a more heroic appearance?” Rahner, *On the Theology of Death*, 125.

¹³ “The authors of old certainly did not have occasion to discuss those martyrs whose personalities had been so crushed by inhuman practices, undreamt of in past ages, that they were physically unable to profess their faith, with the result that in the eyes of the world they did not suffer martyrdom at all.” Rahner, *On the Theology of Death*, 89.

¹⁴ “Brain death” was first defined as “irreversible coma” by the ad hoc committee of Harvard Medical School, in part, to facilitate organ harvesting. “A Definition of Irreversible Coma: Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death,” *JAMA*. 1968; 205(6): 337-340. Cf. Rahner: “Since and insofar as death in a theological sense is the end of an historically personal life in freedom, it can be said today that death has come at the point where the functions of the brain as the foundation of this life have irreparably ceased, no matter whether other ‘organs’ of the person continue to ‘live’ or not.” Rahner, “Christian Dying,” 234.

¹⁵ Rahner notes the “stylelessness” of impersonal hospitalized deaths and mentions the possibility of reforming the social and cultural forces that give rise to them, but notes that from a theological perspective, a Christian is “bound to the

significant nodal point for human freedom and responsibility. Medicalized death has become experientially normative for twenty-first century North Americans in ways that profoundly alter the relation of persons to their own temporality and finitude through processes that discourage them from the traditional wisdom of *memento mori* by extending the promise of serialized interventions that lull them away from the consideration of actually dying and dissuade them from the morally serious project of living into that inescapable reality. Medicalized death inhibits us from coming to terms with the understanding of death as a personal act; this incomplete, but dominant, interpretation is bound up with our lived response: “the personal appropriation of this life involves coming to terms with death.”¹⁶ By encouraging a “wait and see” approach punctuated by tentative (medical) decisions that reify death as something to be suffered in the not-yet future, we are seduced away from interpreting and understanding death as a personal act that posits the self for eternity. The many forms of medicalization reflect a lack of hope, a dearth of training in how to be singularly alone with, and responsible for, one’s ultimate decisions and self-disposition, and a denial of human dignity and the ultimate seriousness of the once-and-for-all-ness of the history of human freedom given to the individual who is addressed by the divine.

As Robert J. Ochs notes, Rahner’s *Theology of Death* relates two distinct approaches—the formal, theological one, along with the existential—in order to reveal the full significance of death as the locus of faith, hope, and love in Christian life. Nevertheless, his existential approach, while palpably Heideggerian,¹⁷ is not merely grafted on as an inflection shown to be compatible with

Christian Church’s style of dying in the normal case” which includes receiving the last sacraments (when possible), but even in their absence, the Christian should “have an attitude of readiness to accept death,” and be able to “regard himself as being at peace with God.” Rahner, “Christian Dying,” *Theological Investigations* 18:14, 234.

¹⁶ Robert J. Ochs, S.J., “Death as Act: An Interpretation of Karl Rahner” in Michael J. Taylor, S.J., ed. *The Mystery of Suffering and Death* (Staten Island, NY: Alba House, 1973), 138.

¹⁷ Rahner was in Heidegger’s seminar in Freiberg during the mid-1930s, and the transcendental aspects of his theology are clearly indebted to Heidegger; “Being-in-the-World,” “Being-in-Time” and *Verstehen* structure Rahner’s theology of death, but Rahner’s theology hinges on whether the person in her transcendentality is destined for nothingness, or for

Christian doctrine, but rather springs from “the complex of statements [in Scripture] portraying man as responsible for all of his life before the One who looks beneath the surface and reads the heart.”¹⁸

Death is dark and unmastering; it takes the person from him or herself and appears to threaten everything that has been achieved in one’s lifetime. Granting the genuine incapacities of the dying person (Rahner refers to dying as “the night in which no man can work”) dying is not a moral holiday but rather a consummation of one’s life-time of freedom, in which the final judgment of the person takes place.¹⁹

Catholic doctrine *describes* (but does not *define*) death as the separation of body and soul. Christian revelation attributes “even the free operation of the natural causes of death...to a cause in the moral and spiritual history of man.”²⁰ Death, for Rahner, is still the consequence of sin, and is unavoidably tinged with guilt and understood as punishment—an association vehemently rejected by the naturalistic philosophies of most contemporary hospice and palliative care professionals. Rahner speculates that in the absence of original sin, human life would still have been consummated (and come to an end) but that the individual would not have suffered any violent physical dissolution from without. Yet, actual death as we know it “is a visible expression of the disharmony between God and man in man’s very being which supervened at the beginning of his spiritual and moral history.”²¹ Death can never be merely an unsolved biological problem, as transhumanists would have it, but is rather inextricably related to the “moral tragedy” of the fall.²² But if death is demanded by

God, the Incomprehensible One. Several decades later, Rahner raised the question of an implicit existential ethic in Heidegger’s philosophy, namely whether one could find moral directives for concrete life with respect to the existential givens of *Dasein*. I will argue that over the course of his life Rahner came to appreciate and recommend a more amenable existential ethic in Ignatius Loyola’s Spiritual Exercises. Cf. Karl Rahner, “The Concept of Existential Philosophy in Heidegger” *Philosophy Today* 13:2 (Summer 1969), 136-7.

¹⁸ Ochs, S.J., “Death as Act,” 127.

¹⁹ Karl Rahner “The Liberty of the Sick, Theologically Considered” in *Theological Investigations* 17:9, 105.

²⁰ Rahner, *On the Theology of Death*, 23.

²¹ Rahner, *On the Theology of Death*, 34.

²² Rahner, *On the Theology of Death*, 22-23.

human sinfulness, it is also demanded by human nature; freedom of the spirit makes humans mortal. An interminable existence in which one continued to make incessantly revisable choices would frustrate freedom's urge to realize itself once and for all. Rahner wrote with awareness and concern that persons were increasingly dying in impersonal, anonymous hospitals, but the contemporary preoccupation with, what is in effect a series of "autonomous choices" along with the increasingly managed nature of medicalized death raise grave questions about how today's categorical conditions and freedom of spirit mutually condition one another.

Rahner's *Theology of Death* portrays death as manifold, paradoxical, and hidden (or "veiled"). Among the most important of the dichotomies that Rahner introduces is the observation that human death is both *suffered* and *enacted*. It strikes from without—sometimes imposing personal destruction with little to no warning—but Rahner simultaneously names death *the act of freedom*. How can this be? Christian thought has often described human life as both gift and task. In Rahner's language of "pilgrimage" (the pilgrimage of maturing freedom) he situates life between a real beginning and a genuine end. Time is the condition for this imposed freedom. The key question for Rahner—and the one that, in my view, holds so much promise for thinking more profoundly about autonomy with respect to death—is how to convert an imposed liberty into free liberty: "Although man must die, he is asked how he wishes to do it."²³ Rahner is clear that this "how" involves the attitude that one takes toward death ("Does he run protestingly, or lovingly and trustingly?") as well as one's understanding ("Does he view his end as an extinction, or as a consummation?")²⁴ While a person's death and "dying existence" is of course bound up with his attitude and understanding, it is nevertheless a real *act* interpreted by the deeds of his daily existence: "continually we narrow the

²³ Rahner, *On the Theology of Death*, 93.

²⁴ Rahner, *On the Theology of Death*, 94.

possibilities of the freedom of life through our actual decisions and actual life until it is exhausted completely and we drive life into the straits of death.”²⁵

Rahner admits that a basic mood of disappointment may accompany this realization: time is growing shorter, decisions more constrained and determined by the choices that have already been made, which are themselves the product of both original and personal sin.²⁶ One garners many losses on one’s pilgrimage, and Rahner does not dismiss the attendant darkness and grief.²⁷ Yet, he also proclaims that where there is free liberty there is love for death and the courage to face it.²⁸ By this he does not intend a romanticization of death (and certainly not suicide) but rather a committed drive to posit oneself definitively for eternity. The hope for salvation is the hope that one’s life-time will be judged eternally valid. Here the themes of Rahnerian freedom, time, death, eternity, and the transcendental of the person intermingle; it is necessary to clarify how they fit together.

In the *Theological Dictionary*, Karl Rahner and Herbert Vorgrimler define “time” as “primarily the mode of the becoming of finite freedom.”²⁹ Eternity is the *product* of time; eternity puts an end to time. Put slightly differently, “eternity...is a kind of freedom which has been brought to completion in time.”³⁰ Rahner wishes for us to undergo a de-mythizing with respect to death; eternity is not a linear continuation of time after death but a genuine consummation on which human transcendence and moral seriousness hinge:³¹ “We must say: through death—not after it—*there is* (not: begins to

²⁵ Rahner, *On the Theology of Death*, 93.

²⁶ Rahner, “Christian Dying,” 230-31.

²⁷ Rahner acknowledged that the loss of a loved one is also a loss of part of the self: “thus, as death has trodden roughly through my life, every one of the departed has taken a piece of my heart with him, and often enough my whole heart. A strange thing happens to the man who really loves, for even before his own death his life becomes a life with the dead.” “God of the Living,” in *Prayers for a Lifetime* (New York: The Crossroad Publishing Company, 1995), 144-45.

²⁸ Rahner, *On the Theology of Death*, 95.

²⁹ Karl Rahner and Herbert Vorgrimler, “Time,” in *Theological Dictionary* (New York: Herder & Herder, 1965), 461.

³⁰ Ochs, “Death as Act,” 129.

³¹ “[T]he Christian sense of faith was always and unambiguously sure that death is the end of the history of human freedom, in which that history is raised up into an enduring finality.” Karl Rahner, “Christian Dying,” 242. “We do not mean that ‘things go on’ after death, as though we only changed horses, as Feuerbach puts it, and rode on. It is not a

take place) the achieved definiteness of the freely matured existence of man.”³² In death, one posits *oneself*—who he or she has become in time.

It is probably an understatement to observe that this Christian perspective radicalizes the assorted notions of biomedical autonomy and self-determination by transforming and deepening the ideas of freedom and free responsibility. Nevertheless, the inchoate resonances of “authenticity” that inhere in biomedical autonomy language may find fuller expression here: “Freedom becomes freedom *to become* oneself and not just *to do* some thing.”³³ One offers what one has become to God in a committed relationship of transcendence: “*freedom*—even though it is always exercised on the concrete individual things of experience and through this becomes what it is—is primarily and unavoidably concerned with God himself. Freedom in its origin is freedom of saying yes or no to God and by this fact is freedom of the subject towards itself.”³⁴

I want to demonstrate that biomedical choices are significant; they are expressive of the self, and when they are made in relation to death and serious illness (which Rahner terms *prolixitas mortis*—roughly “harbinger of death” or a genuine confrontation with one’s own mortality) they may uniquely express the spiritual freedom of the person; one is confronted with the knowledge that his or her individual history of freedom is coming to a close. The fulfillment of his or her time is at hand, and the irreversibility of one’s fundamental option will soon be rendered final and irrevocable. While Rahner is clear that “[m]an’s death, in so far as it is his own personal act, extends through his whole life”³⁵ he avers that the situation of approaching death “is really an unusual [one] for liberty,” close as it is to the final ‘Judgement’ of the person, and laden as it is with helplessness and

continuation of the peculiar distraction and vagueness of temporal existence, which is an openness always in need of new determinations and hence basically empty.” Karl Rahner, “The Life of the Dead,” *Theological Investigations* 4:14, 347.

³² Ochs, “Death as Act,” 130.

³³ Ochs, “Death as Act,” 130.

³⁴ Karl Rahner, “Theology of Freedom,” *Theological Investigations* 6:13, 182.

³⁵ Rahner, *On the Theology of Death*, 70.

loneliness—the stark categorical material out of which a person posits his life in trusting faith or in despair.³⁶ A Christian would rightly be troubled at the prospect that his or her decisions near death might not express faith, hope, and love:

Through our decisions we become who we want to be forever. Our actions...combine to shape our character and determine our eternal destiny. Through freedom we have the power to shape the whole of our existence, to decide for or against ourselves, to achieve or thwart our definitive self-fulfillment, to attain salvation or damnation, so that we *ourselves*, and not simply our acts, are good or evil.³⁷

I turn now to begin to explicate Rahner's theology of death in more explicit relation to his anthropology.

Rahner's *Theology of Death* addresses death under three headings, two of which I have already mentioned: death as an act involving the whole man (person) and death as the consequence of sin. Themes of judgment and responsibility are raised under these headings; they presuppose human freedom, but freedom comes to its apotheosis under the third category, the possibility of "death as a dying with Christ." Under this heading, death becomes *the* act of man, and not only the action at the end of life, but an act of *dying* that extends through his whole life. "On Martyrdom," an essay appended to Rahner's *Theology of Death*, deals with the possibility of appropriating this "dying with Christ" under certain historical and personal conditions such that death, which is inherently shrouded, inscrutable, and ambiguous, becomes a radiant and self-evident witness to faith in Jesus

³⁶ Karl Rahner, "The Liberty of the Patient, Theologically Considered," 104-106. In this essay, Rahner demonstrates his responsiveness to the medicalization which was already underway during the writing of the essay; he considers the patient's rights and responsibilities, including especially the right to his free choice of doctor, and tasks doctors and nurses with maximizing the patient's spiritual liberty to enact his own death by communicating with him candidly with respect to his medical condition, alleviating suffering in such a way as to maximize consciousness and serenity of spirit, and even "testing the spirits" of the dying person to facilitate a hopeful resignation to his fate. These duties call to mind the tasks of friends and family prescribed by the *Ars moriendi*; given Rahner's insistence on the ongoing importance of the Church for Christians of the future, it is interesting that he "outsources" these responsibilities to medical professionals, but this is otherwise in keeping with his responsiveness to lived situations as well as his commitment to reforming institutions for the good of persons.

³⁷ Phan, *Eternity in Time*, 52.

Christ instantiating the supreme act of freedom. While even authentic “dying with Christ” can be ambiguous or hidden, in martyrdom certain conditions coincide to produce the possibility of a death in which the appearance discloses the reality of total freedom.³⁸

Martyrdom is a limit case. It is extreme, if not rare. Nevertheless, it illuminates the other modes of dying in such a way as to make freedom’s thwarting or consummation evident. In fact, martyrdom characterizes the nature of human freedom in the light of committed Christianity, as I will explicate. I want to presage here that the “changing modes of martyrdom”³⁹ recognized by Rahner have a constructive bearing on dying in a medicalized context. While “dying with Christ” in a contemporary situation might not in every case rise to the level of martyrdom—perhaps a death that could have been avoided is accepted in freedom without being “violent,” for example—the opportunities and obligations to choose that are now extended to persons as they encounter illness (*prolixitas mortis*) can sharpen reflection on lived freedom and Christian witness.⁴⁰

Rahner walks a fine line in *On Martyrdom*. He thinks that it is not against church teaching to conceive of death “as the comprehensive act of faith or unbelief” and his affirmation of this proposition controls his position.⁴¹ He must distinguish the genuine liberty “to lay one’s life down,”

³⁸ Rahner, *On the Theology of Death*, 104. “All the violence which causes it is only the effective device of God who provides the opportunity for this highest act of liberty” (106).

³⁹ Rahner, *On the Theology of Death*, 125.

⁴⁰ While Christian martyrdom is colloquially understood as the act of being killed by powers inimical to Christ for the sake of Christian faith or morals, Rahner’s essay purports to examine the fundamental connection between witness to Christ and death amid changing historical situations and understandings of death. Whether each of the three elements viz. 1) violent death 2) which could have been avoided and 3) which is, nevertheless accepted in freedom, must be present in martyrdom is somewhat ambiguous, i.e., must the violence be imposed by a hostile power, or is death itself intrinsically and sufficiently violent, as it bears within itself dissolution and apparent destruction? Rahner pays homage to the terrible political deaths of the twentieth century, for lives extinguished and sufferings endured amidst persecution for faith. Perhaps persons like the women who sheltered children with their bodies during the gunman’s rampage at Sandy Hook would be considered martyrs under Rahner’s reconceptualized of the category. In addition, technologies like organ donation may give new meaning to “laying down one’s life for a friend”—while Donation after Cardiac Death (DCD) is yet rare, the organ donor is not brain dead at the time of organ harvesting; his or her “cardiac death” could potentially be reversed by cardiopulmonary resuscitative efforts. Cf. Don Marquis, “Are DCD Donors Dead?” *The Hastings Center Report*, vol. 40, no. 3 (May-June 2010), 24-31.

⁴¹ Rahner, *On the Theology of Death*, 103.

which he thinks to be the essence of Christian dying, following Christ (John 10:18), from suicide (which he equates with despairing of God's grace and hating the world), fanaticism, sectarianism, and that of the brave warrior (who accepts death in the course of struggle, but does not intend it). In contrast to other courageous and voluntary deaths that inspire awe in their own right, martyrdom is an act of "believing charity," an act of obedience and love:

Death has, in its natural personal essence, an obediential potency to function as a testimony to the faith, being, as it is, the summit of the act of faith, which can be adequately interpreted only through this faith.⁴²

Christian death fulfills this obediential potency. Christian death

is the free liberty of faith, which in reality and in truth presides over the whole of life, and leads us to accept the rupture of this mortal existence as the most wise, loving disposition of God.⁴³

These two short passages begin to approach the paradoxical nature of "theonomous dying" I proposed at the outset of this chapter, namely that a form of obedience to God could be the expression of ultimate freedom and the fulfillment of one's highest possibility. The expanded understanding of autonomy that I am forwarding here is not without content or "guardrails"—it proceeds from a Christian anthropological understanding in which persons are "freed for freedom,"⁴⁴ and simultaneously held responsible for their lives before God. For Rahner, radical freedom and responsibility for ultimate self-disposal are one of the "existentials" that define what it means to be human. The self-realization corresponding to this idea of "theonomous autonomy" cannot be conceived as strictly self-wrought, but is rather empowered by God's grace; nevertheless, in being freed to love the neighbor, the individual assents to an "unselfing," which nevertheless empowers him or her to posit their truest self—a history of eternally valid actions and decisions.

⁴² Rahner, *On the Theology of Death*, 122.

⁴³ Rahner, *On the Theology of Death*, 104.

⁴⁴ Cf. Galatians 5:1

These passages presuppose a “committed” Christianity; they involve theological claims made within the context of Christian tradition,⁴⁵ and presuppose that the individual is related to God in such a way that a communication of the divine will can be received and accepted, even *in extremis*. They imply that the liberty that belongs to the human person is a “dying liberty” to dispose over one’s person in an eternally valid way throughout one’s lifetime—not a liberty of license, but the freedom to “take up one’s cross” and to affirm the meaning of human existence:

the act performed in virtue of the grace of Christ, whereby man positively accepts the comprehensive sense of his existence even in face of the dark appearance of senseless death, can and must necessarily be called an act of faith. This means that there must be a surrender of the whole man from his uncontrollable and impenetrable existence to the incomprehensible God. Whenever a man dies in this way, believing in confidence, detached from all that is particular and concrete, and with free trust that he will obtain everything...he does something that could not have been achieved except by the grace of Christ...There, man does not die the death of Adam, the death of the sinner who loves nothingness, autonomously disposed of, but he dies the death of Christ...only this death gained grace for us and only this death has freed our death for the real life of God.⁴⁶

God, the incomprehensible one, is mystery according to Rahner. Death is a dark and unmastering suffering, “the absolute climax of the process of enfeeblement and deprivation of power in man.”⁴⁷

The fruit of mature freedom, even for one who appropriates the grace of Christ’s own death, is ambiguous and shrouded. Even martyrdom, that self-evident witness to faith in Jesus Christ, is only evident to those who view it with the eyes of faith.⁴⁸ In an essay entitled “On Christian Dying” Rahner explores the connection of dying on the physical plane to the existential and spiritual realities he champions in his theology of death. I quote it at length because of its implications for dying “autonomously.”

⁴⁵ I follow Shannon Craigo-Snell and Karen Kilby in a non-foundationalist reading of Rahner; cf. Shannon Craigo-Snell, *Silence, Love, and Death: Saying ‘Yes’ to God in the Theology of Karl Rahner* (Milwaukee: Marquette University Press, 2008), 19. Karen Kilby, *Karl Rahner: Theology and Philosophy* (London: Routledge, 2004).

⁴⁶ Rahner, *On the Theology of Death*, 96.

⁴⁷ Rahner, “On Christian Dying,” 289-90.

⁴⁸ Rahner, *On the Theology of Death*, 122.

The freedom which is exercised on the physical plane is, in fact, that freedom by which man lays himself open to intervention from without, submits to control by another power or powers. The physical side of man's nature constitutes the sphere in which the interplay takes place of action from within himself and passion as imposed from without. As a physical being endowed with freedom man has to take cognizance of the fact that he occupies an intermediary position. He is neither wholly self-directing nor wholly subject to control by another, but half-way between the two. The mysterious interplay between action and passion in the exercise of human freedom appears above all in the fact that it is precisely at the very point at which man freely achieves his own self-perfection [that finality which is the concretization of freedom come to its maturity] that he is, at the same time, most wholly subject to control by another. The ultimate act of freedom, in which he decides his own fate totally and irrevocably, is the act in which he either *willingly accepts or definitively rebels against* his own utter impotence, in which he is utterly subject to the control of a mystery which cannot be expressed—that mystery which we call God. In death man is totally withdrawn from himself. Every power, down to the last vestige of a possibility of autonomously controlling his own destiny is taken away from him. Thus the exercise of his freedom taken as a whole is summed up at this point in one single decision: whether he yields everything up or whether everything is taken from him by force, whether he responds to this radical deprivation of all power by uttering his assent in faith and hope to the nameless mystery which we call God, or whether even at this point he seeks to cling on to his own autonomy, protests against this fall into helplessness, and, because of his disbelief, supposes that he is falling into the abyss of nothingness when in reality he is falling into the unfathomable depths of God.⁴⁹

Put differently, Rahner insists that a disciple of Christ may hear and repeat the words of Christ in the liturgy of her own life and death: “My God, why have you forsaken me? Father into your hands I commend my spirit.”⁵⁰

The foregoing may seem rather stark. How can one ask this of an average individual? In the words of Ochs, “Can we really believe that people anticipate death to such an extent that their basic choice during life is structured by coming to grips with this awesome reality?”⁵¹ Perhaps it seems no wonder that the palliative approach to dying has become so ubiquitous. It would be natural to flee the enormous responsibility for the self here described, particularly when the communal supports that once sustained a theological interpretation of death have largely fallen away. As I detailed in the

⁴⁹ Rahner, “On Christian Dying,” 289-90.

⁵⁰ Rahner, “On Christian Dying,” 293.

⁵¹ Ochs, “Death as Act,” 134.

previous chapter, the cogwheeling of the generations that used to initiate one into a life cycle that culminated in a self-directed death have given way to a very different style of dying. What would it even mean to “consummate” one’s life, given that an “average expectable environment” is no longer expectable?⁵²

I have touched on Rahner’s ideas of “a love for death” and “freedom’s urge to realize itself once and for all.” One might wonder whether such aspirations only afflict William James’ sick souls.⁵³ While Rahner argued that certain “existentials” characterize all persons, not everyone has a classically “existentialist” personality, but perhaps a yearning for personal integrity or the acknowledged desire to have one’s own character be coherent in some sense are more widely recognizable experiences: “Consider the way some people talk about how they want to be remembered—as a good mother, an honest man, a loyal friend, someone who loved the land...Such language conveys a desire for a permanent personal identity.”⁵⁴ It is death that brings the finality of this character to its fruition and that posits what the person has become in time, rendering it unalterable.

While persons may vary in their self-reflectiveness, the person is, for Rahner, “basically defined by freedom.”⁵⁵ A certain amount of violence has already been imposed with the question; it may be actively ignored, but it cannot be unheard: how will you take up, as a task, the freedom that

⁵² In “Quantity vs. Form,” Wendell Berry meditates on the fragmenting consequences of the forms of rationalization that work to increase life expectancy (as well as agricultural productivity) “by any means and at any cost”—he argues that as humans lose touch with the ecological forms of integrity that inform a sense of completion, the “ideal of a whole or a complete life...[has] been replaced by the ideal merely of a long life.” Wendell Berry, *The Way of Ignorance: And Other Essays* (Berkeley, CA: Shoemaker & Hoard, 2005), 66-79. In a different vein, William Schweiker has written about the challenges of respecting and enhancing the integrity of life before God in a globalized environment, cf. “Responsibility and Moral Reality” *Studies in Christian Ethics*, 22.4 (2009), 472-495; *Theological Ethics and Global Dynamics: In the Time of Many Worlds* (Malden, MA: Blackwell Publishing, 2004), 3-24.

⁵³ See William James, *The Varieties of Religious Experience: A Study in Human Nature* (New York: The Modern Library, 1994, 1999), 90-184.

⁵⁴ Craig-Snell, *Silence, Love, and Death*, 124.

⁵⁵ Ochs, “Death as Act,” 133.

has been imposed upon you, the freedom that you have already discovered? Although you have to die, how will you do it? One may evade the question and regard herself as a mere product of her culture and environment and content herself with “drifting” through her life and suppressing her awareness of death rather than aiming at her life’s consummation—but according to Rahner, she will be suppressing the awareness of her liberty and her relation to God, for “existence conscious of itself must unavoidably see the end.”⁵⁶

Rahner’s theological anthropology insists that persons are only truly human in their transcendental: “we always experience the fathomless, we constantly reach out beyond our range into the realm of the incomprehensible where we are impotent, and only then do we exist in a properly human manner.”⁵⁷ This *a priori* openness to the infinite, along with the person’s experience of herself as an actor against this unlimited horizon, form the basis of Rahner’s concept of transcendental experience.⁵⁸ This *a priori* openness to infinity is, theologically speaking, openness to holy mystery—to God. One is able to self-enact, and ultimately, to posit who he or she has become in time, thanks to several interconnected ‘existentials’:

The human being is a corporeal-material being, living in a biological community of life with its material surroundings; a spiritual-personal, cultural being with a diversity of personal communities; a unity of matter and spirit, of spiritualized matter and materialized spirit; a being gifted with freedom by which he or she can self-enact in an eternally valid way; a historical being with a genuine beginning, a definitive end, and an unknown, uncontrollable future; a being called by God to share in his Triune life and ontologically transformed in his or her very nature for this purpose; and yet at the same time a being laden with sin and guilt who must achieve his or her goal gradually and with difficulty by overcoming internal resistance.⁵⁹

⁵⁶ Rahner, *On the Theology of Death*, 93.

⁵⁷ Rahner, *On the Theology of Death*, 93.

⁵⁸ Craigo-Snell, *Silence, Love, and Death*, 24.

⁵⁹ Phan, *Eternity in Time*, 62.

Save for difficulty overcoming internal resistance (concupiscence, on which more later), Jesus Christ, too, shared these existentials, and Rahner's Christian existentialism takes the life, death, and resurrection of Jesus Christ as paradigmatic and transformative, calling it "the imperatively productive model for our death."⁶⁰ Eschewing sacrificial and substitutionary views of atonement, Rahner focuses on the freedom of Christ's dying, of his 'yes' to God despite physical torture, cruelty, mockery, and apparent forsakenness by God, as well as his positing of himself in freedom, which was accepted by God as eternally valid and thereby manifest historically in the resurrection.⁶¹

[H]e was not only put to death, was not only swallowed up and engulfed by the absurdity of existence, but...he himself died. In other words he has made death into his own act, in which he accepts the inconceivable which is beyond all human control, and himself acts out what has to be endured.⁶²

Just as death is, for Rahner, the act of freedom, he avers that the whole of Christian piety is "following the Crucified"—dying with Christ, throughout life. Rahner described "taking up one's cross" as the practice of "patience sustained by faith in the midst of suffering, in the inevitable disappointment and bitterness of life as long as it lasts."⁶³ One might well fear that he is enjoining oppressed persons to resign themselves to unjust and exploitative situations, but Rahner's writings do not support injunctions to racist, sexist, or classist forms of self-abnegation; he is clear that the other is not to be used for one's own self-assertion.⁶⁴ Rahner writes instead of the more prosaic and universal disappointments and sufferings inflicted by life—"the experiences of human frailty, of sickness, of disappointments, of the nonfulfillment of our expectations, and so on"—experiences that he collects under the phrase "dying in installments."⁶⁵ These little deaths will of course be

⁶⁰ Karl Rahner, "Following the Crucified," *Theological Investigations* 18:10, 162.

⁶¹ Craigo-Snell, *Silence, Love, and Death*, 130.

⁶² Karl Rahner, "The Scandal of Death" in *Theological Investigations* 20:11, 140-41.

⁶³ Rahner, "Following the Crucified," 162.

⁶⁴ Craigo-Snell, *Silence, Love, and Death*, 94.

⁶⁵ Rahner, "Following the Crucified," 169.

experienced according to the life histories, social circumstances, and personal constitutions of the individuals who experience them, and it is this individuality and particularity that Rahner surfaces: Rahner emphasizes that to “follow the Crucified” is not simply to demonstrate allegiance to a moral ideal or an abstract moral principle, but is instead a unique and historically conditioned task for each individual who is in principle capable of divinization—of being elevated into the life of God as a member of the body of Christ. To “take up one’s cross” may be more positively construed as “risking the self” in acts of neighbor love and moral decision which are not incidentally eternally valid actions, and furthermore, are experienced as such: Rahner held that acts of neighbor love and free decision banish the suspicion that life is meaningless; they are self-authenticating in their eternity.

When we can manage to act out a full affirmation of moral love—in ways momentous or miniscule—we know that ‘where such a free act of lonely decision is done, in absolute obedience to the higher law or in radical love of another person, something eternal happens, and man becomes immediately aware of his validity as something born of time but taking place outside its mere onward flow.’⁶⁶

“Taking up one’s cross” and “dying with Christ” presuppose a well-formed individual, or in the words of Shannon Craigo-Snell, “a sturdy individuality.”⁶⁷ One risks a reconfiguration of one’s identity—risks life as she knows it—when she opens herself to the self-communication of the divine or to the reality of another person. When encountering another in his poverty or suffering, it is easier (and often socially acceptable) to leave; one risks the reconfiguration of her own life when she stays close, listens to him speak about his own reality, and responds out of her own resources.

Rahner wrote about death over many decades. Peter Phan has discerned a shift over time from Rahner’s emphasis on the more individual, or personal-existential aspects of death to a greater

⁶⁶ Craigo-Snell, *Silence, Love, and Death*, 128, quoting Karl Rahner, “The Life of the Dead” in *Theological Investigations* 4:14, 350.

⁶⁷ Craigo-Snell, *Silence, Love, and Death*, 212.

concern with interpersonal relations as well as sociopolitical and historical perspectives, yet “his basic ideas concerning the relationship of the soul to matter after death,” along with death’s significance as the limit and demand for human freedom to accept or reject the offer of God’s grace remain unchanged.⁶⁸ Both of these aspects, the personal-existential and the interpersonal-sociopolitical bear on our consideration of autonomy, and must be held together. I have already noted that the will to die “autonomously” is anathema to Rahner insofar as it consists in saying “no” to God (a self-contradictory attempt, anyhow), refusing the grace that is offered, and clinging to one’s personal resources rather than allowing oneself to trustfully fall into the apparent darkness of holy mystery—elsewhere termed “modeless mysticism.” Surely, in our sociopolitical milieu, an overweening focus on medical interventions (and I include here psycho-social inventories) along with excessively palliating approaches that eliminate existential anxiety by making the dying person unconscious are part of the categorical material with which human freedom must contend in our time. Granting the ambiguity and uniqueness of every situation, a grasping reliance upon these measures in the face of death would nevertheless seem to pose real hindrances to freedom of spirit. Their existence should be taken seriously as an indication that death and dying have not been practiced throughout life, which thus constitutes an area ripe for practical theological reflection and action since Christians are baptized into Christ’s death.

Despite Rahner’s negative assessment of this “grasping” autonomy that heralds damnation, or what is effectively the same thing, the possibility that one’s life would be judged invalid, Rahner’s theological anthropology holds forth a more profound understanding of autonomy if autonomy is understood as having to do with the depth of one’s freedom, the unlimited nature of one’s responsibility, and the consummate individuality ascribed to the human person who reaches out into

⁶⁸ Phan, *Eternity in Time*, 114.

an unlimited horizon and acts in an eternally-valid way. This “genuine autonomy” is grounded on radical dependence and is experienced in the depths of one’s being when one is grasped by the fact that one comes from God yet is other than God:

all of this can be experienced only when a spiritual created person experiences his own freedom as a reality, a freedom coming from God and a freedom for God. Not until one experiences himself as a free subject responsible before God and accepts this responsibility does he understand what autonomy is, and understands that it does not decrease, but increases in the same proportion as dependence on God⁶⁹

This ‘independent dependence’ or ‘dependent independence’ may not permit an individual to be ‘a law unto oneself’ in the traditional political understanding of autonomy, but Rahner avers that “God speaks us to ourselves” and offers a unique personal identity and history to which we can “say yes” and enact authentically; furthermore, Rahner maintains that this identity forms an ontological ground for the lives of others and exerts an enduring influence on the world.⁷⁰

In *On the Theology of Death*, Rahner engages in a theological speculation that the soul might become “all-cosmic” at death, that is, might surrender “her limited bodily structure” becoming “open towards the ‘all’ and, in some way, a co-determining factor of the universe precisely in its character as the ground for the personal life of other spiritual-corporeal beings.”⁷¹ He avers that this is what Christ’s death did in transforming the possibilities of life and death for others, and he suggests that our lives may so participate. Rahner extends “the possibility that in death, this relationship which he has to the world is not abolished, but is rather, for the first time, completed, giving way to a fully open, world embracing relationship, no longer mediated by the individual body.”⁷²

⁶⁹ Karl Rahner, *Foundations of Christian Faith: An Introduction to the Idea of Christianity*, trans. William V. Dych (New York: Crossroad, 1978), 79.

⁷⁰ Karl Rahner, *Christian at the Crossroads* (New York: The Seabury Press, 1975), 66.

⁷¹ Rahner, *On the Theology of Death*, 31.

⁷² Rahner, *On the Theology of Death*, 32.

The theory of the all-cosmic soul implied that in death, the person through his or her eternally valid acts, might become a “law” for others, part of the structure of the universe that brings history to its consummation.⁷³ Scholars of Rahner observe that he seems to have quietly dropped the theory of the all-cosmic soul in his later works, in part because he came to appreciate the inherent permeability of the body which cannot rightly be thought to be “fixed” within the boundaries of the skin; the body’s matter is continuously in flux throughout a lifetime thanks to the processes of metabolism, for instance.⁷⁴ He also seemed to judge that it did not cohere with the relationship between time and eternity that I have already outlined and that he wished to maintain. Nevertheless, his later works continued to insist that the exercise of liberty (as well as the accumulation of objectified guilt) create the categorical material out of which others exercise their own liberty. The eternally valid actions of interconnected human beings help to bring history to its consummation. One nevertheless encounters resistance in any attempt to exercise her liberty; we act and suffer the acts of others within the common space of the world.⁷⁵

I gesture to these interpersonal-sociopolitical considerations of liberty and responsibility in order to highlight the paradoxical tension at the heart of Rahner’s contribution to a genuine autonomy. An individual is formed in community, his or her acts enduringly influence the community, and yet lonely decisions are still demanded of the person; in particular, the darkness of death demands its decision—a personal act of faith. Beyond any biomedically autonomous choice that would purport to control or palliate death, Rahner assures his readers that in death, all the props and resources that sustain our lives will fall away. The response demanded of the individual cannot be offloaded to anyone, or anything, else.

⁷³ Rahner, *Foundations of Christian Faith*, 283-84.

⁷⁴ Craigo-Snell, *Silence, Love, and Death*, 146-47.

⁷⁵ Craigo-Snell, *Silence, Love, and Death*, 150.

We know that we shall simply be thrust into the inexorable loneliness of death where no-one can accompany us any further, where the chatter of life ceases, and no-one can hide behind his fellow any longer. No-one can appeal to the opinion of another. The only thing that still counts at this stage is what one can take with one in death: that is I myself as I was in the ultimate depths of my own heart, that heart that was either full of love or full of spite and hidden selfishness, a nuisance to myself and others. We take nothing with us into this state of abandonment except what we ourselves are in the ultimate and radical decision of our own hearts... We should practice, even in this life, how to die, for surely it is clear that while we shall certainly pass out of life in the biological sense, it is not so clear that we have the ability to die a death that is truly human.⁷⁶

Rahner paints a dark and unmastering death where all the supports of life are stripped away; only here, Rahner thinks, is faith truly expressed. By abandoning oneself into holy mystery at the point where knowledge ceases, and by enacting the death that must be suffered, the dying person posits what he or she has become in time. The unity of the virtues is here displayed as Rahner terms “theological hope” “the free and trustful commitment of love to the ‘impossible’, i.e. to that which can no longer be constructed from materials already present to the individual himself and at his disposal...[it is] self-commitment to that which is beyond one’s power to control.”⁷⁷ Faith, hope, and love reach their apotheosis in the situation of “dying with Christ”—a graced situation in which the virtues are definitively realized in the trusting self-abandonment that is radicalized in death—here, God may be definitively loved for God’s own sake after all categorical justifications of faith have passed away.⁷⁸ The person who dies with Christ also bears generative witness to love to his or her neighbors through his or her testimony of freedom, born of hope of eternal life.⁷⁹ It is this self-commitment, the risking of the self, in love, that must be practiced throughout a dying life if one is to achieve that most profound and paradoxical self-possession: to find oneself through self-abandonment, surrender, and commitment.

⁷⁶ Rahner, “The Scandal of Death,” 141.

⁷⁷ Karl Rahner, “Ideas for a Theology of Death,” *Theological Investigations* 13:11, 177.

⁷⁸ Rahner, “Christian Dying,” 255.

⁷⁹ Rahner, “Christian Dying,” 255, 253-54.

IGNATIAN EXISTENTIALISM

The genuine autonomy supported in Rahner's writings is well-characterized as spiritual autonomy. That this genuine, spiritual autonomy is equivalent to saying 'yes' to "theonomy," (the will of God) appears paradoxical, but can be justified on the basis of Rahner's anthropology as I have already begun to demonstrate. On this basis I now turn to defend the genuine goods raised by the biomedical autonomy movement: personal inviolability, authenticity, and a vindication of individuality as divinely bestowed. According to Rahner, "freedom is first of all the subject's being responsible for himself, so that freedom in its fundamental nature has to do with the subject as such and as a whole."⁸⁰ Freedom and responsibility for oneself are indissolubly and radically linked: the person posits herself—what she has become in time, what she has "made of herself" given the categorical material of her life, her social and historical milieu. Decision and choice are highly significant exercises of free responsibility on this view, flowing, as they do, out of one's "fundamental option." In this section I will explicate the enduring influence of Ignatian spirituality on Rahner's works and explore its special significance for medical decision-making. In the context of medicalization, persons face many significant choices, not least of which is the point at which death will no longer be opposed.

Recall that in the last chapter, I argued that Don Browning's practical theology, informed as it was by the developmental psychology of Erik Erikson, offered a robust notion of psychological autonomy scaffolded by intergenerational cogwheeling. In that chapter, psychological autonomy was portrayed as relationally activated. Browning's fundamental practical theology offered a method for promoting autonomy through communities of moral discourse—namely churches—that could

⁸⁰ Rahner, *Foundations of Christian Faith*, 94.

reason together about the moral pluralism that contemporary persons encounter, and go forth in the world to act according to the practical moral decision-making in which they collectively engaged.

While neighbor-love is a central norm for both Browning and Rahner, with perhaps surprising connections to autonomy that I will continue to exegete, the differences between the thinkers are deep, and I hope ultimately, productive. Both thinkers claim Kant as part of their intellectual heritage, but for Rahner, the human transcendentalism that comprises the person is ultimately explicitly spiritual; God can deal with the individual directly, a claim that opens the door to a self-consciously “individual ethics.” For Rahner, the champion of this “turn to the subject” was not so much Kant, but rather that “medieval modern”—Ignatius of Loyola.

Thus far I have offered little explicit indication that many theologians point to “the experience of grace” as the theme that integrates Rahner’s some-four thousand diverse writings.⁸¹ I follow Karen Kilby (among others) in reading Rahner in a nonfoundationalist way so that I do not hold his mature theological thought to be logically or conceptually dependent on his early philosophical works (*Spirit in the World* and *Hearer of the Word*).⁸² Rahner never worked out a theological method like his contemporary Bernard Lonergan, preferring to respond to the issues he encountered in his lifetime in an ad hoc style—his five-volume *Theological Investigations*, for example, are compilations of searching and speculative essays. Rahner famously remarked that “all (real) theology is pastoral theology,”⁸³ an assertion backed by his many pastoral and sapiential publications aimed at a more general audience. These works aim to facilitate the reader’s awareness of the experience of God with whom he or she is always and already related. Rahner’s method is thus mystagogical; he attempts to

⁸¹ Cf. Leo O’Donovan, *A World of Grace: An Introduction to the Themes and Foundations of Karl Rahner’s Theology* (New York: The Seabury Press, 1980). Anne Carr, *The Theological Method of Karl Rahner* (Missoula, MT: Scholars Press, 1977), 207-208.

⁸² Karen Kilby, *Karl Rahner: Theology and Philosophy* (New York: Routledge, 2004).

⁸³ Declan Marmion and Mary E. Hines, *The Cambridge Companion to Karl Rahner* (Cambridge: Cambridge University Press, 2005), 9.

initiate the reader into an *experience* of mystery—to lead humans into their deepest truth as individuals graced by God. Subsequently, his works seek to enable the reader to discern wisdom for practical living. A Rahnerian ethics is thus an ethics of discernment and discipleship, and one can observe the deep influence of Ignatian spirituality in both his pastoral and more academic works.

In 1983—just a few months before his death—Karl Rahner was interviewed and asked what he would like to leave as his last will and testament. He offered “Ignatius of Loyola Speaks to a Modern Jesuit” with the caveat that “It is much more a résumé of my theology in general, and of how I tried to live.”⁸⁴ The work is Rahner’s attempt to set out his opinion on the importance of Ignatius for his time (c. 1978); in it Rahner adopts the persona of a “transposed” Ignatius speaking to a contemporary Jesuit. Philip Endean notes that as a spiritual testament, “its argument rambles” and that it is hardly a general theological treatise, as much of the work “deals with topics immediately relevant only to Jesuits.”⁸⁵ With respect to the topic at hand, however, it is of mimetic significance, and thematic importance, for Rahner self-consciously strove to conform himself to these theological convictions. Rahner viewed old age as a grace and a task, “a chance to sum up one’s entire life, to get oneself together before the final mystery.”⁸⁶ In the final years of his life, he moved to Innsbruck and did not hesitate to explain to his former students that he had gone there to die because he had people there who would pray for him.⁸⁷ Insofar as Rahner was self-consciously seeking to posit himself at the end of his life, his professed “last will and testament” seems to bear a particular

⁸⁴ Karl Rahner, *Faith in a Wintry Season: Conversations and Interviews with Karl Rahner in the Last Years of His Life* (New York: Crossroad, 1990), 104.

⁸⁵ Philip Endean, *Karl Rahner and Ignatian Spirituality* (Oxford: Oxford University Press, 2001), 14. On this point I disagree with Endean. While several sections are addressed specifically to Jesuits, the themes have broader relevance outside the order: they prompt consideration of resisting the temptations of power and prestige, thinking about what poverty and humility mean in one’s own time and place, and extending the obligation to work for social justice as part and parcel of neighbor love.

⁸⁶ Karl Rahner, *I Remember: An Autobiographical Interview with Meinold Krauss*, trans. Harvey D. Egan, S.J. (New York: Crossroad, 1985), 6.

⁸⁷ Harvey D. Egan, *Karl Rahner: Mystic of Everyday Life* (New York: Crossroad, 1998), 193.

hermeneutical weightiness. He elsewhere expressed “that the spirituality of Ignatius himself, which one learned through the practice of prayer and religious formation, was more significant for [him] than all learned philosophy and theology inside and outside the order.”⁸⁸

Rahner would be the first to admit that one is not necessarily at the height of his powers at the end of life, and would appreciate the opacity that one encounters upon attempts at self-reflection, as well as the ambiguity of self-definition. One does not necessarily “mean” for others what he “meant” or intended to—but lest one dismiss the significance he ascribed to “Ignatius Speaks” as a dying man’s performative expression of pietism or societal fraternity, Philip Endean has painstakingly argued that the *Spiritual Exercises* of Ignatius Loyola “implied a thoroughgoing renewal of the whole theological enterprise, to which Rahner devoted his whole professional life.”⁸⁹ When Rahner’s Ignatius speaks

I encountered God, I knew him...I knew God himself, not simply human words describing him. I knew God and the freedom which is an integral part of him and which can only be known through him and not as the sum total of finite realities and calculations about them⁹⁰

the effect is unambiguously autobiographical.

“Ignatius of Loyola Speaks to a Modern Jesuit” recapitulates the major themes of Rahner’s works in a style accessible to a more general audience. The turn to the experience of grace is central. As the voice of Ignatius, Rahner illustrates what “dying with Christ” meant for the founder of his order, offering content to a phrase that remains somewhat formal in his academic theological writings. One follows Jesus by “travelling through life and dying a true death”⁹¹ and Rahner’s Ignatius is clear about the kenotic implications of this endeavor: Ignatius relinquished the prestige of

⁸⁸ Karl Rahner, *Karl Rahner in Dialogue: Conversations and Interviews 1965-1982*, eds. Paul Imhof and Hubert Biallowans, trans. Harvey D. Egan (New York: Crossroad, 1986), 191.

⁸⁹ Endean, *Karl Rahner and Ignatian Spirituality*, 3.

⁹⁰ Karl Rahner, S.J. and Paul Imhof, “Ignatius of Loyola Speaks to a Modern Jesuit” in *Ignatius of Loyola*, trans. Rosaleen Ockenden (London: Collins, 1979), 12.

⁹¹ Rahner and Imhof, “Ignatius of Loyola Speaks to a Modern Jesuit,” 21.

his prominent familial origins, refused powerful ecclesiastical positions that threatened to entangle his freedom, surrendered his status, and embraced life on the margins. He and his companions lived as beggars, slept in poorhouses, worked on behalf of prostitutes and homeless persons, cared for syphilitic invalids, and catechized “tiny children covered in lice.”⁹² Rahner’s Ignatius ponders the future of his order; his rule had sought to preserve the Jesuits in poverty and humility, but he notes that they had evolved into “an Order of schools and schoolmasters” with all of the attendant temptations and ecclesiastical imbroglios entailed thereby. One senses that Rahner’s own thoughts were not far from his own legacy with respect to the Second Vatican Council and the reactionary ecclesiasticism generated in its wake. When his Ignatius proclaims that “a critical attitude to the official Church is in itself devout” Rahner’s own voice comes through clearly.

This critical attitude is not commended for its own sake, but it is a consequence of the “legitimate existentialism” Rahner located in Ignatius Loyola, which he saw himself as having worked to reclaim.⁹³ Rahner’s Ignatius, that “medieval modern” thus speaks:

I can be counted, of course, among those people who stand at the gateway to the ‘new era’ in Europe. In spite of medieval characteristics in my life and work, what is new and individual in me is typical of the modern era, which is now approaching its end, even if no one can say what will come after it. It could be said that my ‘spirituality’ is typically modern, as much in its mystical individualism as in its rational and psychological technique and it also is nearly at an end... But be wary and sensible. The individual can never lose himself fully in the community. Solitariness before God, security in his silent immediate presence is man’s sole possession...⁹⁴

The gravity of this existentialism is found in Ignatius’ *Spiritual Exercises*, the undertaking of which prohibits a person from taking flight in the masses, whether in the church of the sixteenth century or in a postmodern social movement. Ignatius’ expressed desire to “care for souls” underscores the

⁹² Rahner and Imhof, “Ignatius of Loyola Speaks to a Modern Jesuit,” 33.

⁹³ Endean, *Karl Rahner and Ignatian Spirituality*, 4.

⁹⁴ Rahner and Imhof “Ignatius of Loyola Speaks to a Modern Jesuit,” 37.

primacy of the individual—in conscience, freedom, responsibility, and equality before God. The “master” of the *Exercises* (a “spiritual director” in the parlance of today) does not attempt to indoctrinate the exercitand (the one undergoing the *Exercises*) with the teachings of the church, but tries to facilitate an opportunity for the exercitand and God “to meet together truly and directly” so that he or she might grow “in faith, hope, love and nearness to God.”⁹⁵ Concomitantly, Rahner’s Ignatius speaks of an acceptable “de-mythologizing” with regard to obedience; a Jesuit need not obey his superior if his conscience deem otherwise, and the duty to refuse obedience to ecclesiastical authority (and by extension, any other extrinsic authority) in fidelity to one’s own conscience is clear.⁹⁶ Rahner’s Ignatius describes his theonomous autonomy thus: “I wanted something that my foolish love of Jesus Christ inspired in me as *the law of my life*, with no deviation to left or right...being on the fringe of society and the Church was for me a free practice, as it were, for dying with Jesus.”⁹⁷

The history of Christianity is rife with charismatic movements claiming special revelation and the authorizing experience of the Holy Spirit. These have often been met with ecclesiastical charges of antinomianism and efforts to batten down the hatches of orthodoxy and orthopraxy. While I am arguing that Ignatian spirituality, and particularly the *Exercises*, can contribute to a more profound rethinking (and practice) of biomedical autonomy, the specter of antinomianism lingers. When it comes to medical decision-making, the Catholic manualist tradition has been in decline for some time, but the Ethical and Religious Directives for Catholic Health Care Services remain

⁹⁵ Rahner and Imhof, “Ignatius of Loyola Speaks to a Modern Jesuit,” 13, 26. In affirmation of the lay apostolate, Rahner affirms that “Everyone who is baptized is consecrated a pastor” but avers that the care of souls is self-care—doing one’s own duty, “doing what one can,” yet safeguarding the liberty of another to deal with the living God in the sanctuary of his own heart. Karl Rahner, “The Consecration of the Layman to the Care of Souls,” in *Theological Investigations* vol. 3, 266.

⁹⁶ Rahner and Imhof, “Ignatius of Loyola Speaks to a Modern Jesuit,” 31.

⁹⁷ Rahner and Imhof, “Ignatius of Loyola Speaks to a Modern Jesuit,” 22, emphasis mine.

authoritative in Catholic hospitals, to name but one example. Ecclesiastical critics would not likely find Rahner's embrace of a "legitimate pluralism" of discipleship very assuaging, particularly when he embraces pluralistic expressions of ostensibly theonomous autonomy that appear to conflict. Nevertheless, Rahner's Ignatius proclaims that "The Church is a Church of the spirit of the infinite and incomprehensible God, whose perfect unity can only be mirrored in this world in many different facets."⁹⁸ His Ignatius enjoins "creative courage" over "orthodox prudence."⁹⁹

Any honest assessment of the patient autonomy movement that displaced centuries of physician paternalism must reckon with the observation that patients were thrown back on themselves just as medicine was becoming powerful and morally complex. This shift echoes the turn to the subject that happened as 'modernity' dawned after the Middle Ages. For Rahner, Ignatius' *Exercises* are a foundational document demarcating the rupture:

Medieval man thought and lived on God and the world, on universals and order formulated in appropriate norms. His personal reflection upon himself, his spirit and his freedom was conducted, if it occurred at all, in relation to these objective realities in which he knew from the start he was included as a part in the whole...The modern period radically altered this picture...The central fact is that of the individual subject itself...as a person directed to God...[an individual's] subjectivity...is revealed as a primary certainty. The state of creative freedom can no longer be understood as an instance and application of a general norm.¹⁰⁰

Rahner commended the *Spiritual Exercises* as having "a whole theology" hidden within them—one freshly relevant to the decisions demanded of contemporary persons who live in a highly pluralistic world and who are beset by "gnoseological concupiscence."¹⁰¹

While a full treatment of Rahner's theological reworking of the concept of 'concupiscentia' would take us too far afield of this dissertation, it suffices here to say that Rahner worked to

⁹⁸ Rahner and Imhof, "Ignatius of Loyola Speaks to a Modern Jesuit," 28.

⁹⁹ Rahner and Imhof, "Ignatius of Loyola Speaks to a Modern Jesuit," 29.

¹⁰⁰ Karl Rahner, "Modern Piety and the Experience of Retreats," *Theological Investigations* 16:8, 139.

¹⁰¹ Karl Rahner, *The Practice of Faith: A Handbook of Contemporary Spirituality* (New York: Crossroad, 1983), 120-124.

neutralize the theological concept of ‘concupiscentia,’ which had traditionally been bound with (inordinate) desire, disordered appetite, and the sensitive aspect of the person; concupiscence was regarded as sinful, particularly in the history of thought that by way of Augustine, made it practically synonymous with inordinate sexual desire.¹⁰² Rahner sought to do justice to revealed truths as well as experience, and to recognize the historic conditioning of the latter. He concluded that “it is by no means clear why concupiscentia should always be conceived of as a ‘rebellion’ precisely of the ‘lower’ man against the higher;” the ethically relevant point is not “that the ontically lower in man is intrinsically at variance with the higher, but that man is divided against himself.”¹⁰³ In the narrowest theological sense, Rahner posits that concupiscentia “is man’s spontaneous desire, in so far as it precedes his free decision *and resists it*.”¹⁰⁴ It is neutral because spontaneous desire can also resist a bad moral decision. For the purposes of this discussion, it is important to note that concupiscence is implicated in choice because decisions about finite objects

are the disposition of self as before God. Every decision tends toward total self-disposition and self-enactment. Concupiscence is the influence of nature on spirit. Comprehending the spontaneous movements of appetites, it is somewhat akin to Freud’s id. These erupting appetites are non-free, pre-moral. Their presence influences personal disposal of oneself in free decisions.¹⁰⁵

Along with arguing for a *neutral* reappraisal of concupiscence, Rahner also argues that concupiscence is *natural* when contrasted with “the gift of integrity” (which according to Catholic tradition, was lost in the Fall). I will turn to a more explicit consideration of the integrated person in the later section on spiritual maturity; for the moment it is important to note that Rahner’s appraisal of concupiscence involves an explicit acceptance of complexity, ambiguity, and the myriad forces that

¹⁰² Karl Rahner, “The Theological Concept of Concupiscentia” *Theological Investigations* 1:11, 347 ff.

¹⁰³ Rahner, “The Theological Concept of Concupiscentia,” 354.

¹⁰⁴ Rahner, “The Theological Concept of Concupiscentia,” 360.

¹⁰⁵ Stephen J. Duffy, “Experience of Grace” in *The Cambridge Companion to Karl Rahner*, eds. Declan Marmion and Mary E. Hines (Cambridge: Cambridge University Press, 2005), 55.

bear down upon the human person. He thought that theology should likewise defend ‘gnoseological concupiscence’—“the contemporary situation of contemporary theology in which there are competing and legitimate ideas”¹⁰⁶ drawn from many sources and disciplines.¹⁰⁷ Rahner’s method reflects and respects the unavoidable pluralism of human life, along with its inherent ambiguity, but his Christian existentialism insists upon the lonely decisions demanded of the individual. Selectivity and decision are required if one is to craft an integrated and enduring character. For Rahner, Ignatian spirituality bridges the chasm between competing choices that may each bear their own forms of legitimacy and the decision that an individual may prayerfully come to know will further his or her own freedom. Thus, his Ignatius speaks:

The man...who has won through to God’s eternal freedom no longer needs to claim as his own everything that there is, in order to secure his own position. If one is in modest but certain possession of one’s own position, one does not need to be excessively anxious to follow every fashion. Man’s own future must grow from his own situation.¹⁰⁸

I turn now to examine one man’s situation along with the forms of freedom and responsibility that might be discerned within it.

FRED: A CASE-STUDY IN MORAL CHOICE AND IGNATIAN DISCERNMENT¹⁰⁹

“Fred” is a middle-aged white man living with kidney failure, for which he is being dialyzed several times per week. He is comfortably middle-class and adequately insured. He has no contraindications for kidney transplant—the standard of care for someone in his socioeconomic position who, like him, enjoys a stable and supportive social environment. Nevertheless, Fred is a

¹⁰⁶ Fiorenza, “Method in Theology,” 79-80.

¹⁰⁷ While he does not use the phrase, Rahner’s “The Mature Christian” has an excellent description of ‘gnoseological concupiscence.’ *Theological Investigations* 21:7, 116-118.

¹⁰⁸ Rahner and Imhof, “Ignatius of Loyola Speaks to a Modern Jesuit,” 36.

¹⁰⁹ This case-study is hypothetical, but I draw from my experience during the MacLean Clinical Medical Ethics Fellowship. In case studies, I witnessed that religious convictions, experiences of guilt from past actions, and issues of conscience do influence the ways that patients make health care decisions, even to the point of self-sacrifice.

would-be faithful Christian who has recently become aware of some perturbing research about “organ flows” demonstrating that donated organs move from poor donors to rich recipients, from blacks to whites, and from women to men. His conscience is pricked by what he has learned about the social injustice of the organ transplant market, and from his potential role in it. He is, nevertheless, concerned for his health; while he fears the increased risk of cancer that accompanies immune-suppressing anti-rejection drugs that he would need to take for the rest of his life if he received a kidney, it is his understanding that transplantation is likely to grant him a longer lifespan when compared with remaining on dialysis.

Fred has a family that he loves and a fulfilling vocation teaching history in a parochial high school; he is a deacon in his church, and he coaches the high school swim team. Fred’s church has no prohibition against organ transplantation—it is, in fact, supportive. He feels fortunate that the school where he works grants him the flexibility to teach only in the afternoons so that he can receive dialysis during weekday mornings. He has begun to develop some unlikely friendships at the dialysis center with others who, because of advanced age, lack of social support, and unchecked alcoholism, are not themselves eligible as organ recipients.

According to the dominant medical paradigm, Fred should probably be consulting with his physician about how to best manage his anti-rejection drugs post-transplant. Instead, Fred is considering taking a pass on an organ, largely on the basis of a burgeoning sense of solidarity with his new friends at the dialysis center and an inchoate desire to act justly in the wake of what he has learned about systems of health care in the United States. Attracted to the Jesuit conviction that “God may be found in all things,” but unsure of how to make this vital decision, Fred decides to consult a spiritual director to administer the Ignatian *Exercises* that, in their full form, will take about

a month. In this structured form of imaginative prayer, Fred will spend the first week deepening his awareness of being a forgiven sinner, and then up to three weeks contemplating the life, death, and resurrection of Christ. He hopes that the process will help him to make this important life decision.

There are three principle models or ‘times’ of Ignatian choice in which the exercitant may experience “a kind of synthesis or harmony between the imagined object of [his or her] choice...and a particular privileged moment in experience.” Rahner focused on the second time, a time of “experiment” or experiential testing of “how an initial decision, taken provisionally, matches the fundamental directedness of the mind...”¹¹⁰ The *Exercises* offer a method for parsing the experience of consolations (or desolations) that may accompany the imaginative experiment. While these may seem like simple forms of ethical intuitionism, the *Exercises* are designed to cultivate a self-disposition of *indiferençia* to the Election—a radical indifference to the decision that will be elicited—fostered by the earlier imaginative prayers that focused on the kenotic (self-emptying) elements of Christ’s cross. One yields one’s personal preferences in radical openness to the divine freedom. If it were not yet clear that the method is not designed to elicit a superficial “patient preference,” it should be noted that the third model of Ignatian choice enjoins the exercitant to imagine his deathbed and to consider how he will then regard the choice now facing him.

In Rahner’s view, Ignatius’ *Spiritual Exercises* could help individuals to make, what he understood to be, a “fundamental option.” Rahner’s consideration of moral freedom joins the conversionary character (*metanoia*) of this fundamental option with the implications for positing the self discussed earlier in the chapter:

¹¹⁰ Karl Rahner, “The Logic of Concrete Individual Knowledge in Ignatius Loyola” in *The Dynamic Element in the Church*, trans. W.J. O’Hara (Freiberg: Herder, 1964), 161-62, 140-41. Philip Endean, *Karl Rahner and Ignatian Spirituality* (Oxford: Oxford University Press, 2001), 114-15.

man's free decision is an act by means of which he disposes of himself as a whole. For originally and ultimately moral freedom is not so much a decision with regard to an objectively presented individual value-object as a decision with regard to the freely operative subject himself.

The option is “fundamental” because

in the last resort...the morally free agent comes to a decision not so much with regard to his attitude to the finite good presented to his mind as to his relationship to God's absolute reality as value. Because man can only be free in regard to the finite good in virtue of his dynamic orientation to the infinite good, every free decision is a disposition made by man in respect of his situation before God...In this way the free decision tends of itself to dispose of man as a whole...Thus the free decision is essentially a disposal of himself made by man, and one which proceeds from the inmost centre of his being.¹¹¹

While the election at the center of the *Exercises* was originally intended for vocational choice or ‘state of life’ decisions (e.g., whether to become a monastic, to pursue the priesthood, or to remain a layperson and marry), this method was also used to locate the *magis* or “greater good” with regard to particular decisions of lesser magnitude for individuals and communities, for example, the *Exercises* could be used to make decisions concerning almsgiving—whom to give to and how much, et cetera. Theological and ethical attention to the *Spiritual Exercises* is fitting because the decisions enjoined by modern medicine are particularly beset by the gnoseological concupiscence affirmed in Rahner's theology. Organ transplantation, assisted reproductive technologies, and critical care interventions that sustain and even extend human life, along with the difficult decisions about how and when to use them, rival and are at least analogous to the ‘state of life’ decisions envisioned by Ignatius. The consequences of choosing for or against these medical interventions can be rather enormous, involving whether one lives or dies, bears genetically-related children or not, spends significant swaths of one's life undergoing dialysis with all the attendant sequelae, or consents to be added to an organ transplant list. Additionally, these choices have a political character that routinely goes unacknowledged: issues of scarcity, justice, and the common good lurk behind medical decisions.

¹¹¹ Rahner, “The Theological Concept of Concupiscentia,” 360-362.

Medicine is complicated; one deals with shifting probabilistic variables as he or she typically struggles to comprehend a diagnosis and to choose among treatments according to the idiosyncrasies of one's own physiology as well as his or her values. Furthermore, I am arguing that genuine moral and spiritual autonomy demand a personal encounter with one's obligations and freedom, even when one is sick. While it is easy for even the religiously faithful to get swept away with the dominant medical paradigm (i.e., "if you can, you should,") the ethics of discernment call one to deeper freedom, responsibility, individuality, and particularity—realities that the patient autonomy movement sought to respect in the first place.

With respect to Fred, it may be said that the categorical elements of his life are the material for a mystical encounter; the *Exercises* are mystagogical insofar as they were intended to initiate the exercitant into an experience of grace—of God's self-communication. Rahner relates experience of the Spirit to existential choice, "the free act of a human being in which he has ultimate control over himself before God," thusly:

Man's free control of his own transcendent nature, raised up by grace, either in acceptance or rejection, comes about through an existential decision which always involves historically limited, categorical material. This is where freedom is expressed and mediates the subject to itself.¹¹²

Reflecting on the multiplicity of decisions demanded by the modern person, the pluralisms he or she encounters in life, and the observation that life plans are not nearly as "foreordained" as he supposes they were in the medieval period, Rahner observed that the genuine objects of choice are today more difficult to discover than they were formerly; he avers that the exercitand usually discovers "his real concrete question of life" by bringing a situation to the *Exercises*.¹¹³ Nevertheless,

¹¹² Karl Rahner, "Experience of the Spirit and Existential Commitment," *Theological Investigations* 16:2, 24-26.

¹¹³ Rahner, *The Practice of Faith*, 122.

the *Exercises* are and remain choice and decision in a concrete life situation and not a mere theoretical initiation into the essence of Christianity...the basic, total *metanoia* (fundamental option), which is not just a theoretical—and not concretely possible only as theoretical—cultivation of Christianity, is possible only in the concrete life situation and that situation's origin in decision...man will come to know what is really meant by God, sin, grace, forgiveness, Christ, discipleship of Christ, cross, only in a question of actual existence posed concretely, faced squarely and not brushed aside, and accepted in free responsibility.¹¹⁴

Several important implications for conceptualizing medical autonomy must be elaborated here.

Rahner is clear that the practice of Ignatian spirituality enables one to discover individual tasks and duties—potentially idiosyncratic ones at that. His Ignatius speaks: “one of you may, if he is a biologist, investigate the spiritual life of the cockroach if he will”—if he has surrendered himself to mystery and tested to see if it serves the purpose (presumably of bringing greater glory to God).¹¹⁵

The *Exercises* might lead one to make rather unorthodox medical decisions, given the categorical material of his or her life. Lest the acceptable pluralism and individuality of discovered duties be mistaken for normlessness, Rahner's Ignatius suggests that the *Exercises* are self-authenticating in their fruits: “the true prize for this experience is the heart that gives itself in faith and hope and neighborly love.”¹¹⁶ The a priori openness of the person to God is made thematic in the *Exercises* when the individual allows God to dispose of his or her judgment, will, and heart. Both this transcendental experience of fundamental option and the self-donation characteristic of neighbor love are kenotic, ‘self-emptying’ experiences—transcendental forms of dying with Christ.

Obediential potency is readiness for the cross, or, in Fred's case, a decision that, when viewed from the standard medical paradigm might seem to border on foolish self-sacrifice for love of the anonymous neighbor.

¹¹⁴ Rahner, *The Practice of Faith*, 123.

¹¹⁵ Rahner and Imhof, “Ignatius of Loyola Speaks to a Modern Jesuit,” 16.

¹¹⁶ Rahner and Imhof, “Ignatius of Loyola Speaks to a Modern Jesuit,” 15.

Fred's situation illustrates the concept of *prolixitas mortis*—serious illness confronts us with the truth that we must die. *The Exercises* are designed to foster a deep freedom of choice with respect to even this most anxiety-producing realization. The experience of *indiferençia* fostered by the *Exercises* is characterized by an attitude of detachment involving long life versus short life or health versus illness—it is “the calm readiness for every command of God,” equanimity, a formal attitude “towards all thoughts, practices, and ways: an ultimate reserve and coolness towards all particular ways.”¹¹⁷ In light of previous chapters in this dissertation detailing the tremendous existential anxiety attested at the end of life, along with totalizing interventions designed to palliate patients and their families, Rahner's intention for pastoral care is significant:

Men can always be taught to demolish the finite images of idols which obstruct their paths or to pass them by calmly; can be taught not to make anything absolute; to become ‘equable’ and ‘calm’ in the face of all sorts of powers and forces, ideologies, goals and futures. In this way they learn what God is and that their freedom is not as empty as it seems.¹¹⁸

The theology implicit in the *Spiritual Exercises* thus contribute to a more profound reconsideration of autonomy by recovering responsibility—a consideration of the patient's duties, here held to be individual duties, discoverable in prayer—with a fuller understanding of freedom that includes freedom *of* spirit, freedom *from* attachments, and freedom *to* posit the self in an increasingly integrated way.

Rahner's existential ethics rely on the unique and eternal significance of the acting person; morality cannot be merely syllogistic, for while he affirms the moral law, there is no universal ‘man’ to apply it, but only men and women with unique, potentially discoverable vocations willed by God. He avers that “God is interested in history not only in so far as it is the carrying out of norms, but in

¹¹⁷ Karl Rahner, “The Ignatian Mysticism of Joy in the World,” in *Theological Investigations* 3:19, 290.

¹¹⁸ Rahner and Imhof, “Ignatius of Loyola Speaks to a Modern Jesuit,” 38.

so far as it is a history which consists in the harmony of unique events and which precisely in this way has a meaning for eternity.”¹¹⁹ Fred undertook the *Spiritual Exercises* not to strengthen a weak will and thereby avoid a morally bad decision, but because he had begun to wonder whether a morally acceptable choice (receiving a kidney transplant) could in fact be an eternally valid act for him. Rahner suggests that such an existential ethic has the capacity to revise the dominant theory of sin (*viz.* offence against a universal divine norm) as also and perhaps more importantly “an offense against an utterly individual imperative of the individual will of God, which is the basis of uniqueness,” and hence “as the failure of the personal-individual love of God.”¹²⁰

While the *Exercises* are, on the face of things, concerned with discernment, and therefore knowledge, they are mystagogy—an initiation into ‘mystery’ which is not, Rahner writes, a defective mode of knowledge, but rather eternal and total immediacy of God in God’s abiding incomprehensibility.¹²¹ ‘Mystery,’ Rahner writes, “is not merely a way of saying that reason [*ratio*] has not yet completed its victory. It is the goal where reason arrives when it attains its perfection by becoming love.”¹²² One cannot grasp, manage, or manipulate God, but if one learns to give himself over to the holy mystery he may find, Rahner suggests, that “the seemingly known and perspicuous” proves to be the provisional.”¹²³ While one undergoes the *Exercises* in order to make a decision, one engages God in freedom and experiences God in the unity of knowledge and love. *Rahner’s Ignatius* writes:

¹¹⁹ Karl Rahner, “On the Question of a Formal Existential Ethics,” *Theological Investigations* 2:7, 228.

¹²⁰ Rahner, “On the Question of a Formal Existential Ethics,” 232.

¹²¹ Karl Rahner, “The Concept of Mystery in a Catholic Theology,” *Theological Investigations* 4:2, 41-42.

¹²² Rahner, “The Concept of Mystery in a Catholic Theology,” 43.

¹²³ Rahner, “The Concept of Mystery in a Catholic Theology,” 41.

The unfolding of God's affection for something that is not God and that through this affection, unalloyed, can no longer be separated from God is experienced first when something is felt to be willed by God in contrast to something else.¹²⁴

While the above example was a hypothetical one that I conceived in order to give content to Rahner's thought about death in a contemporary medical context, I trust that the reader can now imagine analogous situations in which a person might bring his or her self and insistent particularity to the *Exercises*. In the midst of his own unique situation, "Fred" brought his question about whether to become a kidney recipient or to remain on dialysis to a process of Ignatian discernment. By God's grace and in the encounter, he surrendered himself to the mystery; he cultivated *indiferençia* through this prayerful practice of dying to himself and emerged with a decision that would express faith, hope, and neighbor-love. Whether his decision was marked by what we might think of as medical prudence and good sense, or something that looked more like martyrdom, either might constitute Fred's free call to the 'foolishness' of the cross, and his ultimate self-realization.

MORAL AND SPIRITUAL MATURITY IN THE MIDST OF MEDICALIZATION

Fred's case study raises an evident problem. Truly critical medical decisions do not permit an individual to take a month to decide; they must be made immediately and often *in extremis*.

Additionally, a fundamental option ought to orient one's life and not only to conclude it. While the *Exercises*, in their full form, are a method for making transcendence thematic, their basic structure—the basic structure of the spiritual life—is *indiferençia* or 'unattachment' to particular things. When one orients oneself to holy mystery, a developmental process is already underway, and transcendence

¹²⁴ Rahner and Imhof, "Ignatius of Loyola Speaks to a Modern Jesuit," 18.

may become thematic in one's life more generally, and in an increasingly comprehensive way. Thus, Rahner's Ignatius spoke of God becoming transparent: "the experience develops and God will meet man in everything and not only at special 'mystical' moments."¹²⁵ Spiritual maturity consists, therefore, in the human being synthesizing her "'basic orientation to God' with her own 'order of love,' an attitudinal structure shaped by a history of decision."¹²⁶ This process consists in ongoing conversion and self-interpretation; a priori openness to God is accepted and affirmed when the individual trustingly surrenders to the movement of divine freedom discerned in his or her everyday life, which may be accompanied by a perceptible change in values and self-awareness.

Rahner explicitly took up the themes of moral and spiritual maturity in essays as diverse as "The Mature Christian," "Self-Realisation and Taking Up One's Cross," and "Reflections on the Problem of Gradual Ascent to Christian Perfection." He grapples with the biblical witness, which asserts that an individual's growth in holiness and love of God is normative, assumes that the individual can become more perfect, and presupposes that the "life of the man endowed with *pneuma* is capable of growth and progress."¹²⁷ Yet he avers that no real description or definition of the stages of ascent are given in the Bible. While he notes that modern ascetic literature identifies different stages of the spiritual life, having joined these to "the different objective values of the classes of moral acts," reflection on observed experience shows these couplings to be artificial; a spiritual "beginner" could perform heroic acts of moral supererogation, and thus act perfectly, for example, skipping entire stages laid out in the ascetic literature.¹²⁸ When one reflects on attaining holiness

¹²⁵ Rahner and Imhof, "Ignatius of Loyola Speaks to a Modern Jesuit," 14.

¹²⁶ Endean, *Karl Rahner and Ignatian Spirituality*, 208.

¹²⁷ Karl Rahner, "Reflections on the Problem of Gradual Ascent to Christian Perfection" *Theological Investigations*, vol. 3:1, 5.

¹²⁸ Rahner, "Reflections on the Problem of Gradual Ascent to Christian Perfection," 13.

analogous to the way one gradually becomes rich—squirreling away sanctifying grace through good works done in the state of grace and through fruitful reception of the sacraments over a lifetime—the ontic holiness imputed by these acts still do not seem to add up:

we will not say of every aged Christian on his death-bed that he has become holy or that he has really covered a great part of the way with which we are dealing here, and this in the realm of what we can experience, i.e. in a 'pheno-typical' manner...all this shows an at least apparent discrepancy between ontic and moral holiness at the end of a long life.¹²⁹

Experience attests that not every Christian who lives a long time becomes “a mature Christian;” some people just get old. While Rahner acknowledges the inherent ambiguity and the unsearchable depths of the human being that make it impossible to truly judge the actions of another or even to know whether one herself is in the state of grace, he continues to grasp for a spiritual maturity that is experientially verifiable, akin to how martyrdom “discloses the reality of total freedom.”¹³⁰ The scholastic theory of virtue fails, too.

The usual, commonly accepted conception of the step-by-step development of the spiritual life presupposes that, in passing through this development, man grows in perfection, acquires an ever-increasing treasure of perfection and sanctity, and becomes ‘more virtuous’. This conception is often expressed in such a way as to state that a person acquires many virtuous habits...This in its turn is explained as meaning that the person acquires a permanent inclination and facility in the further exercise of the particular acts of a virtue by frequent repetition of these acts.¹³¹

Rahner’s suggestion that these firm associational complexes and trained reactions might even be harmful signals a definitive break with traditional Thomism. Habituation in virtue means, at most, the *possibility* of greater perfection—he offers in support of his position

the well-known picture of the old ascetic who has become ‘hardened’ in virtue...the picture of a person who engages in countless moral ways of acting by force of habit, without seeming to

¹²⁹ Rahner, “Reflections on the Problem of Gradual Ascent to Christian Perfection,” 11-12.

¹³⁰ Rahner, *On the Theology of Death*, 104.

¹³¹ Rahner, “Reflections on the Problem of Gradual Ascent to Christian Perfection,” 17.

realize these moral values in the truly spiritual and personal or genuine and original way which was originally intended for such behaviors.¹³²

Rahner offers an alternative vision for spiritual maturity that is far more consonant with the Ignatian spirituality detailed above—a spirituality marked by growth in the union of *gnosis* and love, the capacity to “take up one’s cross,” a calm toleration of gnoseological concupiscence and in the concomitant courage to make a lonely decision, along with a growth in the intensity of one’s moral acts—a direct consequence of an individual’s capacity to commit herself existentially—to posit her self in believable acts of neighbor-love.

I averred that “mature autonomy” involves an increase of freedom and responsibility over a lifetime. In Rahner’s thought, persons bear unlimited responsibility for themselves; they ultimately decide to say ‘yes’ or to attempt an incoherent ‘no’ to God’s offer of God’s self. Freedom, on this view, is the power to realize oneself once and for all within one’s finite lifetime. Progress in the spiritual life, or spiritual maturation, is a function of the human capacity for transcendence:

Persons exhibit a restlessness and resistance toward stasis along with a dynamism toward further development, that reveal their capacity for transcendence. Since the human spirit is open and boundless, dynamically striving toward the horizon of infinite being, persons are constantly transcending who they presently are as they actualize their potentialities and grow in greater degrees of being.¹³³

While transcendental freedom is always exercised with respect to categorical objects—“the concrete individual things of experience”¹³⁴—which would include medical decisions like the one detailed in the previous section—these objects or decisions have value only in relation to another person or persons (an “intramundane Thou” or “Thous”). Freedom may therefore be apprehended as “a

¹³² Rahner, “Reflections on the Problem of Gradual Ascent to Christian Perfection,” 17.

¹³³ Jennifer Erin Beste, *God and the Victim: Traumatic Intrusions on Grace and Freedom* (Oxford: Oxford University Press, 2007), 18.

¹³⁴ Karl Rahner, “Theology of Freedom,” *Theological Investigations* 6:13, 182.

dialogic capacity of love”: “Freedom is always self-realisation of the objectively choosing man [sic] seen in view of his total realisation before God. In this way, considered as the capacity of the ‘heart’, [freedom] is the capacity of love”.¹³⁵ The “theonomous autonomy” I am supposing is thus not without content, and cannot be simply construed as a choice between one object and another, even if one’s freedom is mediated by such categorical choices (as in Fred’s process of Ignatian discernment, analyzed above). Jennifer Erin Beste affirms that the significance of substantive criteria “discerning what constitutes an authentic self and freedom intensifies if one affirms a theological framework” as I do here:

a theological framework that affirms a God who creates persons out of love for the purpose of loving others and sharing in divine being, the ‘authentic self’ is not open-ended but is measurable in terms of God’s intentions for creation...Theological freedom involves ultimate self-disposal whereby one accepts or rejects communion with God...substantive criteria are also essential when discerning what constitutes an authentic self and freedom in a theological framework.¹³⁶

Rahner concludes that the commandment of love “imposes a person as a task on himself”¹³⁷—a task that relativizes the moral law and necessitates an “individual ethics”—a personal response from the individual who is capable of being elevated by God’s grace into the life of God. “Love of God is the only total integration of human existence,”¹³⁸ Rahner avers, yet one cannot love God as one object among others—God is, rather, “always given as the subjectively and objectively all-becoming ground of experience.”¹³⁹ And yet there is, he argued, “a mysterious unity of the love

¹³⁵ Rahner, “Theology of Freedom,” 186.

¹³⁶ Beste, *God and the Victim*, 82-83.

¹³⁷ Rahner, “Theology of Freedom,” 188.

¹³⁸ Rahner, “Theology of Freedom,” 187.

¹³⁹ Karl Rahner, “Reflections on the Unity of the Love of Neighbor and the Love of God,” *Theological Investigations* 6:16, 244.

of God and of neighbor,”¹⁴⁰ a thesis of radical identity he defends on the basis of the Gospels¹⁴¹ as well as on theological reflection: “It is radically true, i.e. by an ontological and not merely ‘moral’ or psychological necessity, that whoever does not love the brother whom he ‘sees’, also cannot love God whom he does not see, and that one can love God whom one does not see only *by* loving one’s visible brother lovingly.”¹⁴² A person realizes his or her essential freedom in a self-risking love of the neighbor that must progress in history and time.

On this point, Rahner and Browning may be seen to converge, with the former offering a transcendental gloss to Browning’s norm of generativity. In the next and final chapter, I will examine the intersubjective nature of this free, personal, and responsible self-realization in love, and attend to the conditions under which persons might further their responsible freedom in life together.

¹⁴⁰ Rahner, “Reflections on the Unity of the Love of Neighbor and the Love of God,” 234.

¹⁴¹ Rahner, “Reflections on the Unity of the Love of Neighbor and the Love of God,” 234-36. Cf. Matthew 25:34-46, 25:40 and John 2:8.

¹⁴² Rahner, “Reflections on the Unity of the Love of Neighbor and the Love of God,” 247.

CHAPTER 5:

MATURE AUTONOMY: LAYING DOWN ONE'S LIFE

AUTONOMY REDUX

The “turn to the subject” and increasing approbation for autonomous persons—however protean these conceptions have been—are hallmarks of modernity. They hail from powerful philosophical intuitions about human dignity, morality, individuality, and authenticity—even personhood itself. Ascriptions of autonomy have been unevenly applied, more or less consciously adopted as the province of high-status men, and even rejected by the religiously faithful as sinful self-assertion. Nevertheless, the luster of autonomy lingers: through Kant, we received a deontological strain that was concerned with the quality of the will and the capacity and duty of the rational creature to give the objective law to itself—a formal enterprise that he held to be equivalent to freedom, tinged with the promise of self-transcendence where the subject’s autonomous will is held to be the site where the rational creature makes contact with the noumenal world (*Fundamental Principles of the Metaphysics of Morals*, (1785)). While Kant’s moral autonomy is doubtless part of our effective history, Mill’s conception of personal autonomy is more at home in our late-capitalist consumer culture. Enshrining personal sovereignty, his consequentialist vision promotes individual pursuits of happiness and self-expression (so long as they do not deprive or impede others’), and lauds the freedom of “pursuing our own good in our own way.”¹

In earlier chapters, I established that these competing conceptions of autonomy are contradictory and not readily synthesized. They nevertheless constitute the philosophical

¹ J. S. Mill, *On Liberty* (London: Penguin, 1859, 1974), 72.

justification for medical autonomy and the “liberal bioethics”² under which medicine and medicalization currently operate, comprising, I argued, a *modus vivendi* that Don Browning succinctly encapsulates:

Kantianism and utilitarianism are competitors in liberal societies for a rather simple reason. Liberal democracies need formal and procedurally oriented mechanisms for resolving conflicts. Such societies gravitate toward procedures that de-emphasize the various moral traditions that people bring to their moral disputes. The Kantian principle of universalization and the utilitarian principle of the aggregate good seem to be useful neutral courts of appeal for people who begin their moral disputes with vastly different presuppositions.³

Taken together with medicalization (“a process by which human problems come to be defined and treated as medical problems”)⁴ I argued that these ersatz ways of getting along in a pluralistic society elide questions about the meaning and purpose of life and postpone any true reckoning with death, that they evade these questions by focusing on the medicalized struggle to keep animated matter in motion,⁵ and reduce “autonomy” to a narrow conception of choice about which interventions the patient would like to try, or to deflect. I worked to demonstrate that the medicalization of death includes the promotion of patient autonomy at the level of theory, but that its subtle and yet totalizing machinations are deeply subversive of the patient autonomy it purports to respect.

I remain sensitive to philosopher Gerald Dworkin’s suggestion that in light of the broad conceptual variations among different theories of autonomy that “[t]he only features that are held constant...are that autonomy is a feature of persons and that [it] is a desirable quality to have,”⁶ a concept that is potentially so broad as to be unhelpful or perhaps even meaningless. Nevertheless, I

² Cf. Thomas May, *Bioethics in a Liberal Society: The Political Framework of Bioethics Decision Making* (Baltimore, MD: The Johns Hopkins University Press, 2002).

³ Browning, *A Fundamental Practical Theology*, 100-101.

⁴ John Z. Sadler et al., “Can Medicalization be Good? Situating Medicalization Within Bioethics,” *Theoretical Medicine and Bioethics* (2009) 30: 412.

⁵ Jeffrey P. Bishop, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (Notre Dame, IN: University of Notre Dame Press, 2011).

⁶ Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988), 6.

maintain that this concept is worthy of deep and ongoing engagement: autonomy is a fundamental aspect of moral theory: it is, I argue, an affirmation of the proposition that human persons are both *free* and *responsible*. Likewise, it is my position that the patient autonomy movement was a response to rightly intuited (and ongoing) realities: patients are vulnerable in the midst of illness and incapacity; they are unequally situated with respect to physicians and other medical professionals who hold knowledge they lack and are skilled in the techniques they require. What patients experience in the hospital may profoundly impact their remaining days and intimate relationships: survival, disability, body image, self-concept, and the meaning they ascribe to themselves, to name but a few possibilities. The patient autonomy movement sought to secure a measure of freedom for patients in the midst of all this, to affirm the prerogative of the patient as the one who must suffer the consequences of what is attempted within the hospital, to permit patients to seek care in accord with their deepest values, and with respect to the end of life, to enable the patient-person to face death with integrity on his or her terms. Yet, to paraphrase William F. May, whom I quoted in chapter one, “no system itself can bring [mature autonomy] to us. We need to bring [mature autonomy] to the system so that its benefits may sustain us more fully.”⁷

In this work, I have sought to thicken and contextualize the concept of patient autonomy and to put forth two comprehensive visions of autonomy in relation to death that are saturated by Christian practical theology and situated within history and life-history, psychology, and politics—visions that I hold to be consonant with Protestant and Catholic theological anthropologies alike, which themselves add power and transcendence to the reciprocal concepts of freedom and responsibility that are, in the Christian tradition, normatively expressed through an expansive

⁷ Cf. page 43 of this work. William F. May, *The Physician's Covenant: Images of the Healer in Medical Ethics*, Second Edition (Louisville, KY: Westminster John Knox Press, 1983, 2002), 220.

neighbor-love. This project was conceptualized and entitled with reference to John 10:11-18 and 1 John 3:16 in which Jesus Christ, respectively, asserts his authority to lay down his life for “the sheep” and authorizes his disciples to do likewise: “No one has greater love than this, than to lay down one’s life for one’s friends.” Taken together with his final words as attested in John 19:30 (“it is finished”) along with the indication that he “gave up his spirit,” the Christian witness has contributed a constellation of ideas about death, the place of self-conscious self-sacrifice as an act of love in which the Christian disciple may participate, and the possibility of “consummating” one’s own life in an analogous way into the moral imagination. The characterology of the maturely autonomous person that I am forwarding is also indebted to the notion of “spiritual autonomy” suggested (but not named) in Hauerwas’ and Pinches’ treatment of how Christians should be sick;⁸ recall their emphasis on the role of the Christian community in forming individuals in the theological virtues within a community of practice so that when illness strikes, the community can face the reality of the situation squarely, acknowledge the inherent sorrowfulness of the human condition, and absorb the suffering contained therein without needing to hasten the end of life, to rely on frenetic diversions, or to place their faith in medicine’s ability to “tame” illness and death.⁹ The ideal of a mature spiritual autonomy for which I am working to account is guided by their evocative contentions that the theological virtue of patience “is the radiant embodiment of ultimate integrity,” and that through patience “*man [sic] possesses his soul.*”¹⁰

It has been my claim that medicalization and related forms of biopower undermine freedom and responsibility. Medicalization introduces heteronomy into human lives; it encourages persons to

⁸ Stanley Hauerwas with Charles Pinches, “Practicing Patience: How Christians Should be Sick” (1997) in John Berkman and Michael Cartwright, eds., *The Hauerwas Reader* (Durham, NC: Duke University Press, 2001), 353.

⁹ Cf. Chapter 1 of this work, pp. 42-44.

¹⁰ Stanley Hauerwas with Charles Pinches, “Practicing Patience: How Christians Should be Sick” (1997) in John Berkman and Michael Cartwright, eds., *The Hauerwas Reader* (Durham, NC: Duke University Press, 2001), 353, n. 24.

adopt medicalized identities and goals, offering choices untethered to categorical imperatives, shorn of the expectation of reversibility or universalizability, and detached from cultural traditions or religious norms. The practice of medicalization relieves the patient of the obligation to choose in a way that is responsible to others and thereby consigns the patient to “moral oblivion” and “moral abandonment,”¹¹ prematurely pushing her or him from the company of moral actors, thereby failing to recognize one source of the dignity of the person that the autonomy movement originally sought to uphold.

I have aimed to counter the thin and incoherent notion of medical autonomy—the right to “choose one’s choice” (while beset with the insidious forms of medical “management” I detailed in chapter two)—with a comprehensive vision of mature autonomy that holds human freedom and responsibility together. By this, I construe autonomy to be a moral good, an *achievement*, that is supported in the Christian witness. Scripture affirms the inalienable responsibility of the individual before God, as well as the freedom for which Christ has set us free (Galatians 1:5), along with the capacity of the person endowed with *pneuma* to progress in holiness and perfection. I contend that a Christian ethic prescribes mature and responsible freedom. I have worked to flesh this out with the works of two diverse and yet ultimately practical theologians: Don Browning’s theology was deeply informed by the developmental, social, and egoic psychology of Erik Erikson; I have used his works to attend to a particular understanding of psychological autonomy as well as how maturely autonomous, well-integrated Christians are disciplined and sustained in community. The works of Karl Rahner, as I have read them, surface “a legitimate existentialism” in Christian thought, particularly in relation to death. Rahner’s reflections on the inexorable loneliness of the individual’s “pilgrimage of

¹¹ These phrases are William F. May’s, *The Physician’s Covenant: Images of the Healer in Medical Ethics*, Second edition (Louisville, KY: Westminster John Knox Press, 1983, 2002), 46.

maturing freedom” provide an important polarity with respect to Browning’s works; we are disciplined in community, yes—many of our deepest capacities are activated by loving others—but we are also obligated to exercise personal discernment, to discover individual vocations, and to bear responsibility for ourselves before God. The “mature autonomy” I explicate in this chapter weaves insights from the more psychological understanding of autonomy I gleaned from Browning’s works with the notion of spiritual autonomy advanced in Rahner’s. I now will work to integrate and contrast these distinct positions by attending further to selected contemporary aspects of medicalization, and to offer constructive possibilities for fostering mature autonomy within Christian congregations.

MATURE AUTONOMY IN A PLURALISTIC AND MEDICALIZED SOCIETY

“The land of a rich man produced plentifully, and he thought to himself, ‘What shall I do, for I have nowhere to store my crops? And he said, ‘I will do this: I will tear down my barns and build larger ones, and there I will store all my grain and my goods. And I will say to my soul, ‘Soul, you have ample goods laid up for many years; relax, eat, drink, be merry.’ But God said to him, ‘Fool! This night your soul is required of you, and the things you have prepared, whose will they be?’ So is the one who lays up treasure for himself and is not rich toward God.’ (Luke 12:16-21, ESV).

Jesus’ parable of the rich fool, excerpted here, will like all parables bear a great deal of interpretation. This parable has been a favorite of existentialists, and the Heideggerian gloss is rather obvious: the rich man perceives death as “not-yet” and therefore no threat;¹² he takes comfort in the promise of ample goods that will prolong his inauthentic existence. But death can strike suddenly. To quote Jesus again, “what will it profit a man if he gains the whole world and forfeits his soul? Or what shall a man give in return for his soul?” (Matthew 16:26). I will venture a bit of critical correlation, and suggest that one does well to consider a newly powerful and efficacious practice of medicine along

¹² Martin Heidegger, *Being and Time*, trans. Joan Stambaugh (Albany, NY: State University of New York Press, 2010), 243.

with gleaming and ever-expanding medical campuses as analogues, respectively, of the rich man's plentiful yield and the larger barns he proposes in which to store it. Sprawling medical complexes boast the latest life-extending treatments in which so many North Americans more or less consciously place their hopes—modern medicine holds out the promise that some persons might postpone a real reckoning with the soul and once again resume lives oriented by the implicit promises of perpetual health and ease. Meanwhile, as Richard Coble observed, near any major urban medical center, one is sure to spot homeless persons struggling to survive while living under a bridge.¹³ Augustine, commenting on the Lukan passage above, claimed that the rich fool “didn't realize that the bellies of the poor were much safer storerooms than his barns.”¹⁴ If, as I have argued, mature autonomy is normatively expressed through love of the neighbor, identical on Rahner's view with love of God, the wise and well-integrated person will engage medicine with a justice-seeking orientation that is responsive to the needs of the neighbor, for death is, as Bonnie Miller-McLemore writes, “far more than biological cessation of human activity. It involves questions of moral and spiritual commitment to life in community, to values that make life meaningful, and to the source of all life.”¹⁵

A Christian moral universe is evoked in the New Testament passages I quoted above: the hearer is confronted with the incomparable value of the soul and with the possibility of having forfeited it once “the way” is ended.¹⁶ In the harsh light of death, the plans the rich man conjured,

¹³ Richard Coble, *The Chaplain's Presence and Medical Power: Rethinking Loss in the Hospital System* (Lanham, MD: Lexington Books, 2018), 1.

¹⁴ Saint Augustine, Sermons 20-50 in *Works of Saint Augustine: A Translation for the 21st Century*, trans. Edmund Hill O.P. (New City Press, 1991), 180.

¹⁵ Bonnie Miller-McLemore, *Death, Sin, and the Moral Life: Contemporary Cultural Interpretations of Death* (Atlanta, GA: Scholars Press, 1988), 36.

¹⁶ Compare Augustine's treatment of Luke 12: “When is “the way” ended? It is not ended at the same hour to all. Each several man hath his hour when he shall end his “way.” This life is called “the way;” when thou hast ended this life, thou hast ended “the way.” We are going on, and the very living is advancing. Unless peradventure ye imagine that time

which might otherwise seem reasonable or rational, appear finally as inordinate self-concern and are revealed as a misuse of freedom, a squandering of the gift of life—or in Rahner’s words, the possibility that one’s life would be judged “invalid.” The normatively kenotic thrust of Christian discipleship is implicit: one saves one’s life not by storing it up, but by pouring it out on behalf of God and the neighbor. Covetousness, whether of goods or more life, ironically leads to their forfeiture. I read, in these words of Scripture and Christian tradition, an implicit commendation of the ethical, morally strenuous life that Don Browning borrowed from William James and of the need to make dispositive choices within pluralistic societies amidst the temptations of inordinate self-love and self-preoccupation. Browning quotes James, who observed:

The millionaire’s work would run counter to the saint’s; the *bon-vivant* and the philanthropist would trip each other up; the philosopher and the lady-killer would not well keep house in the same tenement of clay. Such different characters may conceivably at the outset of life be alike *possible* to a man. But to make any one of them actual, the rest must be more or less suppressed. So the seeker of his truest, strongest, deepest self must review the list carefully, and pick out the one on which to stake his salvation.¹⁷

James’ words sound Rahner’s theme: options can be *fundamental*; they shape and posit the self. A mature autonomy consists not in tentative options retained but in a free and full offering of one’s life that emanates from the seemingly paradoxical practice of “taking up one’s cross”—practices of self-denial and renunciation that anticipate death and free the self to receive the fullness of God:

the possibilities available to free action are always greater than what can be realized...the ability calmly to let things go past is one of the great arts of life which are necessary to make our existence free and bearable.¹⁸

advances, and we stand still! It cannot be. As time advances, we too advance; and years do not come to us, but rather go away.” Augustine of Hippo, Sermon LIX on the New Testament.

¹⁷ Don S. Browning, *Pluralism and Personality: William James and Some Contemporary Cultures of Psychology* (Lewisburg, PA: Bucknell University Press, 1980), 97.

¹⁸ Karl Rahner, “Self-Realisation and Taking Up One’s Cross,” *Theological Investigations* 9:15, 253-255.

Despite, or perhaps in spite of, the effective history of the passages from Luke and Matthew invoked above, palliative care and chaplaincy practices that aim to procure “a good death” marked by an absence of distress and the survivors’ efficient social functioning have had great difficulty accommodating the traditional Christian affirmation that death renders a personal judgment upon the individual. It is this affirmation that seems to be squarely in the sights of spiritual assessment models which “include the basic assumption of diagnosis that some spiritual beliefs and practices are unhealthy or unsupportive of the patient’s experience.”¹⁹ A dying person’s fear or anxiety with respect to such a final judgment is chief among religious beliefs liable to be categorized as “limited or immature”²⁰ and diagnosed as “spiritual distress” that professional chaplains would seek to relieve. Whether in theistic terms or not, the feeling of impending judgment, a sense of the preponderance of despair over integrity, or a dying person’s panicked realization that she is “on the hook” for the life that she lived are held to be detrimental to the biomedical enterprise or perhaps a sign of mental illness, but are not understood to bear a genuine relationship to moral reality. These forms of spiritual distress appear to be driving the push for terminal sedation for existential suffering—an apotheosis of the “managed, muted expiration” that Stephen Jenkinson witnessed during his time in palliative care.²¹

A “wide mercy” must necessarily inform the practice of hospital chaplaincy (or “spiritual care departments” as they are now increasingly called).²² Richard Coble writes movingly of the accompanying presence that chaplains provide to patients and healthcare professionals alike, a mission “to be present to sick, hurting, and dying people” that, he argues, is simultaneously

¹⁹ Coble, *The Chaplain’s Presence and Medical Power*, 37.

²⁰ Coble, *The Chaplain’s Presence and Medical Power*, 37.

²¹ Cf. p. 91 of this work. Stephen Jenkinson, *Die Wise: A Manifesto for Sanity and Soul* (Berkeley, CA: North Atlantic Books, 2015), 13.

²² Wendy Cadge refers to hospitals’ approach to spirituality as “least-common-denominator.” See *Paging God: Religion in the Halls of Medicine* (Chicago: The University of Chicago Press, 2012), 14.

“subversive of biopolitics that can only speak of life, obscuring death.”²³ I grant Coble’s argument, as well as the grace conveyed in the personal encounters he describes, but I cite Jesus’ parable above in support of Christian affirmations about the moral seriousness of human life and also to raise the question of what it means to prepare to conclude one’s life well. My goal in this section is to continue my analysis of the ways that biopsychosocial ministrations have become “nihilistic,” and function to undermine the processes of socialization that help to produce maturely autonomous—free and responsible (as well as capable and skilled)—persons with respect to death. I will then offer some constructive suggestions for a way forward.

Browning affirmed that existential needs—those concerning the insecurities and anxieties created by human self-transcendence, finitude, and contingency—are basic human needs that religion has everywhere specialized in meeting or addressing.²⁴ Religious and cultural pluralism and the rise of “the nones” or the religiously unaffiliated have obviously altered this picture;²⁵ basic existential needs have not gone away, but for so many persons, these needs are experienced outside of “a church’s total ministry;”²⁶ if these needs are being met, it is likely in an ad hoc manner by interfaith chaplains, by psychotherapists and psychiatrists, in practices like yoga and meditation. These options extend a certain freedom of choice and affiliation to individuals, but Browning maintains “that establishing a moral universe” is both the proper role of the church, as well as “a key ingredient in mental health.”²⁷ He argues that the church contributes to emotional and mental well-

²³ Coble, *The Chaplain’s Presence and Medical Power*, 4, 152.

²⁴ Don S. Browning, *A Fundamental Practical Theology: Descriptive and Strategic Proposals* (Minneapolis, Fortress Press, 1991), 166-67.

²⁵ A 2014 “Religious Landscape Study” conducted by the Pew Research Center found that 35 percent of “Millennials” (born 1981-1996)—perhaps the current vanguard of the “generative” generation according to Erikson’s life cycle theory—identified themselves as religiously unaffiliated. www.pewforum.org/religious-landscape-study/

²⁶ Browning, *A Fundamental Practical Theology*, 166-67.

²⁷ Terry D. Cooper, *Don Browning and Psychology: Interpreting the Horizons of Our Lives* (Macon, GA: Mercer University Press, 2011), 47.

being by “minimiz[ing] value confusion” and “clarify[ing] the objects and values worthy of people’s loyalty.”²⁸

Browning makes two major contributions to the explication of “mature autonomy” that I am forwarding. First, he carries forward the Eriksonian psychological insight that autonomy is relationally-activated—which is simultaneously an acknowledgement that this kind of autonomy is vulnerable to socio-political forces and forms. Second, his works advance thought about the exercise of “higher order” autonomy, which is to say that free and responsible humans are capable of shaping the institutions that shape themselves. His *Fundamental Practical Theology* works on this second premise. The five dimensions of practical thinking he outlines there can be used to elicit description and interpretation of contemporary experience in order to correlate these with the moral demands of the Christian witness in order to transform practices so that individuals and congregations may more closely embody their deepest considered convictions. I now turn to an exposition of contemporary hospital chaplaincy practices (which are part and parcel of medicalized death, as I argued in chapter two) as an arena in which these forms of practical thinking are germane, and also to demonstrate how medicalized ideas about death do not limit themselves to hospitals, but spill over into culture more generally, and even into Christian congregations. Critical interpretation of the contemporary situation, including a cultivated awareness of the “powers and principalities” that bear down upon us makes a freer response possible.

In *Paging God: Religion in the Halls of Medicine*, sociologist Wendy Cadge undertook to research how religion and spirituality interfaced with illness and death within American hospitals. Interviews with hospital chaplains were a major focus of her research. Although her work took place across a variety of academic hospitals, the chaplains indicated that Ash Wednesday services were the busiest

²⁸ Cooper, *Don Browning and Psychology*, 47.

of their calendar years, attended by a large number of patients and hospital staff alike—“perhaps” she conjectured, “because of its connection to repentance and death.”²⁹ Her study of how increasingly professionalized chaplains negotiate religious pluralism within hospitals indicates a widespread desire for the traditional religious rituals that engage existential needs and help to order the interior life among patients, medical professionals, and hospital staff alike. Nevertheless, she observes a concomitant drive among professional chaplains to “neutralize” religious particularity as evidenced by hospital chapels in which directors of chaplaincy have opted to remove permanent religious symbols from their hospitals’ chapels and to replace these, if at all, with water walls or nature scenes. Cadge documents this trajectory as one of “symbols to silence,”³⁰ and observes that chaplaincy’s often-stated goal of providing non-anxious “presence” to patients emanates from a mélange of mid-twentieth-century theological liberalism, philosophic pragmatism, Freudian psychology, and religious existentialism as transmitted through Clinical Pastoral Education (CPE); she observed that the categories of “presence” and “spirituality” were especially incoherent to Orthodox Jewish and Muslim patients when disconnected—that is, offered as “more than” or “primary to”—religious practice.³¹ Her interview with the director of chaplaincy at “Eastern Hospital” is noteworthy, as he “went so far as to speak of religion/spirituality as ‘*a distraction* to the kind of crisis the person is experiencing in the here and now,’ which is where he should be focused. The director continued,

More often than not...we have a person from a completely different [religious] tradition who is the chaplain. The care-seeker and the chaplain establish a relationship, and the traditions are then forgotten, which is, in my mind, the essence of great spiritual care.

²⁹ Wendy Cadge, *Paging God: Religion in the Halls of Medicine* (Chicago: The University of Chicago Press, 2012), 69-70.

³⁰ The title of chapter 3, Cadge, *Paging God*.

³¹ Cadge, *Paging God*, 26, 196-97. Cadge notes that Evangelical Christians are underrepresented as professional chaplains (12.5 percent) with respect to their share of the U.S. population (26.3 percent) because they “tend to avoid...the increasingly interfaith and inclusive nature of the work” (pp. 83, 48).

Cadge notes

This approach, shared by other chaplains, is revealing in that it situates spiritual care outside the bounds of specific religious traditions and takes place when religious traditions are ‘forgotten’ rather than being a source of engagement.³²

If this analysis seems remote from the consideration of mature autonomy I am constructing, I remind the reader of the claim that I worked to support in chapter three via the work of Don Browning and the psychological insight of Erik Erikson: “individual autonomy is relationally activated. Social fragmentation and dislocation weaken ego integrity, personal identity, and thus the cycle of the generations.”³³ Hospitalized patients who seek to deploy their own religious resources in times of medical crisis or impending death must increasingly do so *ex nihilo*—or, at least, with fewer religious symbols, familiar rituals, or known members of their faith community—that is, outside a common moral universe.

Sociologists like Wendy Cadge bear up Browning’s concern about the fragmentation of contemporary life and highlight the concomitant challenge of coming to maturity and then expressing one’s freedom and responsibility as integrity. As many hospitals have ceded their original religious and denominational foundings in order to serve a pluralistic populace, the place of the hospital—a liminal one for so many patients, who are now sicker and more chronically ill than ever before—has become set off from the community. A modern hospital may record a patient’s stated religious affiliation upon intake, make provision to accommodate religious dietary restrictions and arrange for the provision of spiritual care, but it is no longer an extension of the communal milieu that religious hospitals, often formerly attached to ethnic communities, used to be; for the most part,

³² Cadge, *Paging God*, 97, emphasis mine.

³³ Cf. p. 83 of this work.

patients no longer meet with physicians and nurses with the expectation that they are together co-religionists.³⁴

In 1996, HIPAA (the Health Insurance Portability and Accountability Act) was enacted in order to protect patient medical privacy; since that time, hospital staff no longer invite pastors to meet with their fellow-adherents on the wards, and the flow of information from hospital to house of worship has been stanchd. Today, churches must likewise negotiate visitation of the sick; the temptation to relinquish that work to the professional chaplains on the hospital staff is great, particularly in an era rife with busy, bi-vocational pastors, and persons who travel far from home to receive specialized care who leave their communities and houses of worship behind altogether. Recall that the autonomy movement helped to liberalize patients' rights to keep company with their preferred visitors throughout their hospital stay; it is somewhat ironic that in some hospitals, the directors of professional chaplaincy programs shared with Cadge that they had worked to drive out volunteer chaplains (who may have more closely shared patients' religious identities), expressing to her the suspicion that volunteer chaplains would disrupt the rhythms of the hospital or undermine the prevailing biomedical system of values within which they have worked to gain respect and professional standing.³⁵ Chaplains who may have sought to serve "whole persons" and to mitigate the powers of medicalization are mightily tempted to perpetuate them.

Many chaplains that Cadge interviewed expressed the desire to be more broadly of service, there is no question that chaplains are largely tasked with "managing death;" "they become a part of the trajectory of dying for individuals and participate in the ways hospitals manage death as institutions."³⁶ While their work varies widely by hospital, professional chaplains may, depending on

³⁴ See Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987).

³⁵ Cadge, *Paging God*, 116.

³⁶ Cadge, *Paging God*, 189.

staffing capacity, be called to attend some or all deaths and to attend the removal of life support; they may sit on palliative care teams and arrange memorial and bereavement services within the hospital. Coble argues that chaplains hold space in which the real loss of death may be acknowledged by speaking about it within an institution that is loath to admit that people die there, however, Cadge observed chaplains helping to hide death by sequestering dying patients and their families in quieter parts of the hospital, managing the emotions of family members to contain “spill over” to other patients, families, and staff, working as the ‘designated requesters’ for organ donation, moving dead bodies to the morgue and facilitating viewings of the body for family members, and managing “decedent care,”—coordinating with mortuaries and funeral homes to account for dead bodies and to facilitate their transport.³⁷

Cadge observed that despite chaplains’ expressed desire to minister more broadly to patients, they remain fairly low-status employees within the hospital hierarchy, often called upon to manage death only when physicians have determined that they can do no more. Cadge’s interviews with physicians indicate that many are “death-phobic;” they perceive deaths that they cannot prevent as failures, and they call chaplains in order to distance themselves from the discomfort of sitting with grieving families, propping up, in my judgment, a “God of the gaps” theology in which institutionally-sanctioned forms of religion and spirituality are called in to function as palliatives.³⁸ Even as chaplains attempt to subvert biopolitics by speaking of death, they also perpetuate and give cover to the subtle forms of biopower that “work on us through norms and institutions that shape our ideas and behavior.”³⁹ Coble argues that biopolitics “is the operation—as well as the contestation—of what Foucault terms ‘biopower,’ the power of life itself, or the power ‘to make live

³⁷ Cadge, *Paging God*, 184-89.

³⁸ Cadge, *Paging God*, 177-78.

³⁹ Coble, *The Chaplain’s Presence and Medical Power*, 5.

and let die” and includes “disciplinary power, the ordering of bodies and minds toward institutional and productive regularity.”⁴⁰ He characterizes biopolitics by three trends that I see mapping on to chaplains’ work as just described: “the promotion of life” (approaching the family to request their consent to donate the organs of their dying loved one so that another, less-critically ill patient might live); “the production of knowledge” (developing an evidence-based professionalized practice of chaplaincy through published research that demonstrates chaplaincy’s value with respect to medicalized goals); and “the division of people” (conducting spiritual assessments in order to categorize a class of patients as “spiritually distressed” and thus in need of treatment in order to function more smoothly within the ambiance of the institution, physically moving dying patients and grieving families to more isolated wings of the hospital so as not to disrupt other patients and families, surreptitiously shuttling dead bodies to the “underworld” of the morgue).

The foregoing analysis of contemporary chaplaincy practices hardly exhausts the scope of medicalized death, but is sufficient to revivify the issues raised earlier in this work so as to connect them to the distinct visions of autonomy that I have gleaned from the works of Browning and Rahner. With Richard Coble, I concur that “[m]edicine has produced knowledge of death in order to treat it, to ward it off or to manage it. In doing so, patients, families, and loved ones are separated from their own experiences of decline and mortality.”⁴¹ Nevertheless, if “mature autonomy” is a global quality or achievement that an individual takes with her wherever she goes—in other words, if one is truly and maturely “autonomous” and sturdily “well-formed,” do the workings of medicalization or biopower really matter, and if so, to what extent? Put another way (and to repeat the question that I posed in the previous chapter) ‘how do ‘today’s categorical conditions and

⁴⁰ Coble, *The Chaplain’s Presence and Medical Power*, 5.

⁴¹ Coble, *The Chaplain’s Presence and Medical Power*, 7.

freedom of spirit mutually condition one another?⁴² Rahner's work, in particular, suggests the possibility of a spiritual autonomy that is somewhat impervious (although expressed in relation) to external conditions. I argued that his vision of mature spiritual autonomy is "marked by growth in the union of *gnosis* and love, the capacity to 'take up one's cross,' a calm toleration of gnoseological concupiscence⁴³ and the concomitant courage to make a lonely decision, along with a growth in the intensity of one's moral acts [of neighbor-love]."⁴⁴ I am reminded of St. Francis of Assisi who bucked prevailing norms in order to preside over his own death in a highly idiosyncratic, liturgical, and autonomous way,⁴⁵ and of martyrs who clung to their faith in perfect self-possession. These are, to be sure, rather extreme examples, perhaps even works of spiritual genius, but might mature autonomy also be expressed in subtler and more ordinary ways? Consider the hypothetical example of Fred from chapter four who, when faced with kidney failure and the option to join the transplant waiting list, experienced a pricking of his conscience within the particular circumstances of his life history and then sought prayerfully to further his freedom and integrity through a process of spiritual discernment in which he opened himself to the possibility of making a medically sub-optimal choice in order to stand in solidarity with less fortunate others.⁴⁶ Consider, too, this passage from *Paging God* depicting a scene of unassuming competence and know-how:

Beth, a chaplain resident at Overbrook, was in the emergency room when a young woman died unexpectedly. Her large family assembled, and Beth brought them to the dead woman's side, expecting that she might say a prayer. "Instead, the older sister of the patient and one of the aunts...came into the room and then went straight for the head of the bed,...and I just stood back. They had their hands on her hands and on her forehead, and they were each sort of praying quietly to themselves. Eventually the prayer got louder, and they started

⁴² Cf. p. 142 of this work.

⁴³ In chapter 4, I characterized 'gnoseological concupiscence' as "the contemporary situation of contemporary theology in which there are competing and legitimate ideas drawn from many sources and disciplines;" I argued that Rahner appraised this situation rather neutrally, indicating his acceptance of the inherent ambiguity and pluralism of human life.

⁴⁴ Cf. p. 177 of this work.

⁴⁵ Michelle Harrington and Daniel P. Sulmasy, "Spiritual Preparation" in Lydia Dugdale, ed., *Dying in the Twenty-First Century: Toward a New Ethical Framework for the Art of Dying Well* (Cambridge, MA: The MIT Press, 2015), 87-106.

⁴⁶ Cf. 166ff. of this work.

joining together, ...and it got more and more strong and powerful until they were done.”
“They knew how to call God into a room,” Beth later reflected. “They didn’t need me to do it.”⁴⁷

The family simply took the situation into their own hands, and brought their own spiritual resources to the grievous situation. Might mature autonomy involve simply sidestepping or politely declining heteronomous forms of medical management?

Rahner’s contribution to this consideration of a mature autonomy is less communal and more mystical than Browning’s. His wide-ranging works point to the possibility of a mature spiritual autonomy and to the concomitant responsibility to seek it under the historical conditions that have made it possible, and thus obligatory, to do so. He credits Ignatius of Loyola as a “medieval modern” whose *Spiritual Exercises* demarcated the historical and philosophical turn to the subject, a fitting analogue, I argued, to the modern autonomy movement which emerged alongside a newly powerful medical enterprise that brought with it a burgeoning comprehension of the human and moral questions called forth by its interventions; the waning grip of medical paternalism now obligates persons to make choices that will fundamentally alter the trajectories of their lives and the manner in which they will face their deaths. These are questions of freedom and responsibility for particular persons in particular situations, and Rahner blesses the individual’s freedom and obligation to respond, exhorting a practice of prayerful discernment in which Christ’s kenosis and passion function as critical moments. His Ignatian spirituality calls forth a norm of *indiferencia* that prohibits Christ-followers from making idols of medical hope, of clinging to technology or medical interventions in such a way that the reality of death and the opportunity to actively lay down one’s life in a hortatory act of consummation are occluded. As a Christian existentialist, he advances a vision of autonomy that accentuates the inalienable task of living one’s own life, the significance of

⁴⁷ Cadge, *Paging God*, 181.

decision, and the importance of opening oneself to the divine freedom to discern the will of God—and thus one’s own true self.

Rahner’s *On Martyrdom* elicits some important caveats; one must be careful not to glorify needless self-sacrifice, despair of life masquerading as virtue, or fanaticism unto death.⁴⁸ Yet, he also reminds us that Christians need not preserve life at all costs; the kenotic thrust of his theology does not deny that the highest expressions of love and faith involve laying down one’s life for his or her friends. Rahner’s thought indicates that Christians are called, as individuals, to discern when and to what extent they will engage the genuine goods of medicine in order to remain in life and thereby continue to love their neighbors by pouring themselves out on their behalf, or whether they are being called to cast themselves by faith into the embrace of the living God in a more or less conscious act of consummation. I emphatically do not mean to imply here that illness, disability or dependence preclude individuals from loving their neighbors or to reify the notion that the sick, frail, or elderly are dispensable or should view themselves that way. I also want to emphasize that I do not mean to promote some kind of fatalism with respect to medicine, but rather responsible and clear-eyed engagement, according to one’s capacities. In this sense, the works of both Rahner and Browning contribute to visions of mature autonomy that seek to increase persons’ capacities for conscious, active, and responsible activity.⁴⁹ Nevertheless, Rahner’s works often seem to sound a note of existential harshness or to constitute a “hard word;” essays like “Proving Oneself in Time of Sickness” speak to the profound unity of body and soul, the deep dis-ordering of both experienced when one is ill, and to the revelatory nature of illness to disclose one’s progress (or lack thereof) in

⁴⁸ Karl Rahner, *On the Theology of Death* (New York: Herder and Herder, 1961), 122.

⁴⁹ Rahner defines “true Christian hope” as “a radical acceptance of death in which nothing is veiled.” “Ideas for a Theology of Death,” *Theological Investigations*, 13:11, 184.

spiritual maturity (there, “existential patience”).⁵⁰ I have argued, in principle, against “moral holidays,” and believe that reflection upon the moral life and spiritual growth of patients, including their responsibilities, are badly needed, but wonder whether Rahner’s depiction of illness might be read to countenance a lonelier experience than we ought to affirm. In this sense, Browning offers an important corrective: the intergenerational cogwheeling implicit in his depiction of mature autonomy, which is marked by an Eriksonian-inflected, “generative integrity,” includes the capacity to allow oneself to be cared for without unmanageable shame and doubt—this achievement is both a mark of egoic integrity and a hortatory witness that calls forth and “activates” the capacities of care in others. This is a particularly important point to press on behalf of women and other marginalized persons who may spend their lives caring for others but then fear to “burden” their loved ones as they age or grow ill. Mature autonomy is grounded by the trusting receptivity established in the earliest stages of life; integrity includes the recapitulation of this receptivity at a higher level, potentiating new and higher forms of union among other persons. As my cousin related to me after the death of his father, who had suffered from dementia for over a decade, “I thank God for to the opportunity to have served my dad in this way [through regular visits, feeding him by hand, praying with him, massaging his feet]—being with him in these final years helped me to realize just how deeply I loved him.”

The psychological concept of generativity contains a spiritual truth that Browning and Rahner espoused in their distinctive ways: the love of an individual can extend through time, even after a person has died (or become incapacitated by dementia, for that matter). Whether through Rahner’s theory of the all-cosmic soul⁵¹ or later insistence that the exercise of liberty creates the

⁵⁰ Karl Rahner, “Proving Oneself in Time of Sickness,” *Theological Investigations* 7:25.

⁵¹ Rahner’s theory of the all-cosmic soul held that the soul might surrender “her limited bodily structure” at death becoming “open towards the ‘all’ and, in some way, a co-determining factor of the universe precisely in its character as

categorical materials out of which others exercise their own liberty,⁵² or through Browning's more naturalistic understanding that loving persons engender new loving persons (and institutions) who extend love and care through time, "generativity" is a theoretical concept that acknowledges a real and recognizable reality: "love generates the future."⁵³ One's own dying ought to be understood as an important opportunity; the capacity to *receive* facilitates the mature autonomy of others by calling forth their own capacities for love and care.

Despite the antipathic trends of aging and disability that so often attend the end of life, Eriksonian thought holds that human life is normatively oriented toward the final stage of integrity, in which the virtues brought forth during the earlier stages of life, including autonomy and generativity, are recapitulated and integrated at their higher levels: "wisdom" is the strength attributed to the individual whose mature expression of autonomy allows her to "hold on" and "let go" in ways that do not compromise her existential identity; she will be characterized by a grand-generativity of widening and yet detached concern with life in the face of death that renders her a numinous model of love and care who projects the fundamental virtues of trust and hope, and thus strengthens others. This form of psychological autonomy is premised on an ethic of care and mutuality. It is fostered through "intergenerational cogwheeling," the observation that human capacities are activated and called forth through the interactions of the different generations with one other throughout the lifecycle; the mutual confirmations of identity conferred through intimate relationships are also crucial. This is an inherently socially-activated autonomy which is fragile and needful of a generative ecosystem of care that strengthens humans at each stage of the life cycle.

the ground for the personal life of other spiritual-corporeal beings." Karl Rahner, *On the Theology of Death* (New York: Herder and Herder, 1961), 31.

⁵² Shannon Craigo-Snell, *Silence, Love, and Death: Saying "Yes" to God in the Theology of Karl Rahner* (Milwaukee, WI: Marquette University Press, 2008), 150.

⁵³ William Schweiker, "The Don S. Browning Memorial Service," *Criterion* 48:2 (2011), 13.

Mature autonomy, and finally, integrity, recapitulate the earlier-stage strengths of initiative and industry, including the capacities to “do for oneself;” Browning, following Erikson, was dismayed by the age-stratifications of contemporary society that keep children, adults, and elders separated from a common world and thus inhibit their mutual strengthening. These observations yield a vital question: if the mutually-activated forms of competence and initiative are lost, how do we recover them?

The account of autonomy I glean from Browning is not only less mystical and more communal than Rahner’s, but more conservative as well. Both Rahner and Browning wrote against the background of an increasingly disorienting pluralism and of “future shock,”⁵⁴ the state of psychological overload brought on by widespread perceptions of accelerating technological and cultural change. Where Rahner counseled a mature autonomy marked by the calm toleration of competing perspectives navigated by personal spiritual discernment, and preached confidence in the God and the Church of the future, Browning’s corpus is, comparatively, a testament to the necessity of communal retrenchment and control. Contra popular notions of autonomy, Browning’s works testify to how fragmented and dissolute human lives can become apart from normative visions of the good within which to operate; in this respect, he parallels Rahner—renunciation of penultimate forms of life can be basically freeing. His *Fundamental Practical Theology* posits that churches should serve as robust communities of practical wisdom in which congregants can together become witting about the powers that bear down upon them in order to manifest deeper freedom and responsibility in their lives. Churches are centers where committed persons can conspire about how to live in light

⁵⁴ A phrase coined by futurist Alvin Toffler (*Future Shock*, New York: Random House, 1970) to describe the widespread angst that stems from the experience of accelerating change and impermanence.

of their ultimate commitments by critically correlating contemporary concerns with their preferred sources of authority.

The method of critical correlation outlined in *A Fundamental Practical Theology* was designed to foster the processes of retrenchment and control—to help congregations impose order on the cacophony of contemporary life through the processes of strategic theological thinking that help congregants to interpret their situation in light of their best understanding of the central Christian witness, and to reform their practices in light of that interpretation. It has been my contention that the forms of pluralism expressed through and exacerbated by medicalization alter one’s relation to herself, to the social world, to time, and to the other, even for those who claim a Christian identity. Medicalization functions as a *modus vivendi*, or way of “getting along,” filling the vacuum of lost competencies, and even bleeding into religious practices themselves. Browning’s five dimensions of practical thinking (visional, obligational, tendency-need, environmental-social, and rule-role) can help congregations to analyze how the assumptions of medicalization may be distorting the practices they ought to embody. For instance, when I began this project, I noticed that some churches were hosting congregational drives to promote the completion of advance directives; while this can be a healthy activity, indeed a manifestation of mature autonomy when held inside a “total moral universe” that includes a robust theology of death and discipleship, it becomes nihilistic when promoted outside of it, as itself constitutive of sufficient preparation for death. Consider, too, a Christian funeral in which the fact of the deceased’s organ donation figures prominently: large banners bearing the name of the organ procurement organization line the church’s vestibule, and the life-saving benefits of organ donation are espoused in the funeral homily, and invested with quasi-salvific significance, at least for the recipient, in a way that crowds out traditional Christian affirmations about death and the meaning of life. While the willingness to donate one’s organs after

death can be a salutary example of kenotic self-donation, the discourse around organ donation easily veers into the medicalized obligation to “keep matter in motion,” thereby reifying the discourse of biopower. Even apart from the issues of justice involved in organ donation raised in chapter four, with which individuals and congregations must contend, the language of organ donation has a tendency to acquire overtones of the ultimately salvific; while organ donation may constitute a “pre-moral good,” churches should nevertheless seek to reconcile this with other, potentially conflicting, pre-moral goods in the light of bringing loving and self-giving persons to maturity.⁵⁵

For Browning, tradition, cultural standards, and the collective past are not threats to the exercise of autonomy, but rather resources to be leveraged in constructing one’s life. While he privileged the place of the congregation in the task of critical practical theology, he realized that congregations are differently situated and that their responses would, and should, differ from one another. In *A Fundamental Practical Theology*, Browning used his case-studies of several different churches to analyze the adequacy of the practical theological thinking they had instantiated; for instance, he called the “Wiltshire Congregation” to the mat for its lack of concern for the people outside its gates and its rather uncritical acceptance “of the modern split between public and private worlds that technical rationality has created” as well as for its tendency to attempt assuage the anxieties aggravated thereby through efforts to grasp more wealth, resources, energy, and space than could be justified “within the ecological limits of our finite world.”⁵⁶ Such discussions, he averred, “are even more important for interpretations and normative proposals in areas of medical ethics, reproductive technologies, and family ethics.”⁵⁷ Normative proposals flow from the correlation of

⁵⁵ Cf. p. 125ff. of this work. A ‘pre-moral good’ can refer to a great diversity of goods or values that enhance health, wealth, joy, or general welfare, but can be used or ordered morally or immorally.

⁵⁶ Browning, *A Fundamental Practical Theology*, 167-68.

⁵⁷ Browning, *A Fundamental Practical Theology*, 167-68.

the congregation's situation with the various dimensions of practical thinking, so that an African-American congregations like the Apostolic Church of God that Browning also studied might be grappling with the devastation of elevated black maternal mortality rates and other unjust healthcare disparities among its congregants; its situation, interpretation, correlation with the "Christian classics" and transformation of the situation would necessarily be quite different from the Wiltshire Congregation's; there, the process of disciplining individuals toward mature autonomy might include strategies to facilitate rightful self-assertion and ordinate self-love in the face of racist structures of oppression and to create and influence the structures of care beyond the church that are contributing to premature deaths.

Browning's works prioritize ethics, the universalizability and reversibility of moral decisions, à la Kant and Kohlberg, and put forth a view of human nature that is finite, limited (although capable of self-transcendence) and liable to identity confusion. On this view, mature autonomy is intimately related to a firm sense of identity nurtured through ecologically viable rituals of recognition conducted within a "world" intentionally scaled to humans. The psychoanalytic norm of "generativity," as a principle of health and a theory of obligation, remains an important touchstone for Christian communities, who must consider how best to extend love and care through time within their particular historical circumstances and social location. Browning's fundamental practical theology provides a method by which congregants might identify and address practices distorted by medicalization, to imagine responses that are, individually and collectively, more faithful to their ultimate commitments and expressive of their Christian identity, and to seek to embody those. The congregation is also the site where ritualistic decomposition can be combatted; anxiety and dread of death are real and proper to humans, but religious practice offers persons the concepts and technologies with which to order their interior lives. When engaged seriously, baptism and the

eucharist are sacraments in which one's own death may be "rehearsed;" these Christian sacraments may give rise to other forms of creative re-ritualization and deeper existential engagement with death and dying; I will offer more suggestions in short order.

If one takes seriously that communal discernment in the service of mature autonomy (that is, discipling congregants into loving and self-giving persons) ought to yield different discussions and normative prescriptions across diverse congregations, what of the diversity that characterizes the individuals *within* congregations? Who, within the congregation, contributes to the process, or raises the issues that are addressed? Are women left out? Do they still need to recover their own voice (à la Carol Gilligan in chapter three)? Do others need to develop the capacity to hear them into speech? As a Roman Catholic and prominent architect of the *aggiornamento* of the Second Vatican Council, Rahner worked to reform the Church's clericalism and to justify the shift away from theological preoccupation with law and sin in favor of a theology emphasizing the exercise of freedom and discernment. Rahner supported the lay apostolate, arguing that it is baptism that consecrates (lay)persons to the care of souls⁵⁸—a ratification that might be read to elevate the role of women or other marginalized persons in the church community, and to justify their equal participation in processes of congregational discernment and pastoral care, as well as to affirm the priority of individual conscience. This affirmation nevertheless occurs in a context that underscores the inexorable loneliness of the individual, and the "individual ethics" that flow from his transcendental anthropology: the individual can (and must) deal with God directly, and the duty of priest and layperson alike with respect to the care of souls is to facilitate this encounter:

no one knows the living God in the heart of the other; each one of us is called to manifest Him in an utterly unique way in his own being as fashioned by his own decisions, yet as the

⁵⁸ Rahner, "The Consecration of the Layman to the Care of Souls," *Theological Investigations* 3:18, 271.

ideal for this purpose. For a decision is always something more than a mere application of universal laws and rules, even though it must be made in accordance with them.⁵⁹

To ask about individual autonomy vis-à-vis the community or congregation is, again, to press on the commensurability, or lack thereof, between the visions of autonomy set forth by Browning and Rahner. The necessity of an individual ethics is latent in both thinkers. While a fundamental practical theology may be employed to help congregants construct individual and communal responses to the moral issues of their day, and thereby strengthen group, and hence, individual identity, Browning admits that the generative personality is a personal work of art—“the product of a reasonably favorable environment, many years of struggle, and perhaps a bit of genius.”⁶⁰ Still, it is important to recall Carol Gilligan’s criticism of Erikson’s theory here. She argued that Erikson’s theory of generativity involves an ethic of recognition based on a male model of human development that took separation and independence, rather than relationship and interdependence, as normative precursors to the stage of generativity. Gilligan averred that on this model, women’s typical patterns of psychological and moral development appear comparatively deficient and immature and that girls and women are not confirmed in their distinctive moral patterns of reasoning in service to an ethic of care (rather than achievement). Faced with the double-consciousness of what they ought (or ought not) to speak, and the comprehension that their speech would not find resonance amidst the dominant paradigm, Gilligan observed that adolescent women “lose” their voices and learn to equivocate, and to mask desire and conflict in the service of maintaining relationships.⁶¹ The implications of Gilligan’s work for women’s autonomy and integrity at the end of life are potentially vast, and deserve a more thorough treatment than I can offer here, but I shall nevertheless raise the

⁵⁹ Rahner, “The Consecration of the Layman to the Care of Souls,” 266.

⁶⁰ Browning, *Generative Man*, 171.

⁶¹ Carol Gilligan, *In a Different Voice: Psychological Theory and Women’s Development* (Cambridge, MA: Harvard University Press, 1982, 1993), xvi, 24, 71, 164.

issue. While Browning's theory of generativity remains a care ethics that draws strength from a mix of deontological, narrative, and virtue strands, and its norm is one of expansive love and care, theories reflect the perspectives and prejudices of their authors and can introduce distortions into praxis. In this case, one might ask about the forms of integrity that women are able to synthesize in the last stage of life, and about the quality of the egoic strength that results from a lack of adequate confirmation in earlier life cycle stages. From a medical ethics context, the epigenetic nature of Erikson's theory posits that women's adolescent loss of voice might have real and cumulative implications for the kinds of medical decisions they are able to make later in life with respect to advance directives, for summoning the confidence to receive care, and for the manner in which they are able to face their deaths.

Awareness of potential distortions among communities of moral discourse is a prerequisite of ameliorating them, and Browning's correlational method remains sufficiently flexible to accommodate new insights and to yield reformed practices. Nevertheless, Rahner's transcendental anthropology—his insistence that the individual can, and must, deal with God directly—holds out the promise of a tantalizing “divine therapy” that affirms the primacy of the individual in conscience, freedom, responsibility, and equality before God. A person who may not have received adequate confirmation or recognition of her unique identity or style of mastering experience while she was growing up is, nevertheless, capable of disposing of herself in freedom, of experiencing in prayer a harmony between the imagined object of her choice and a privileged moment in experience, of “discovering the law of her life that her love of Jesus Christ inspires in her.”⁶² He was clear that this process of Ignatian discernment might give rise to idiosyncratic decisions. He recommended the

⁶² I am paraphrasing Rahner. Karl Rahner, S.J. and Paul Imhof, trans. Rosaleen Ockenden, “Ignatius of Loyola Speaks to a Modern Jesuit” in *Ignatius of Loyola* (London: Collins, 1979), 22.

process as one that could help modern individuals to navigate ‘gnoseological concupiscence.’ It might also enable persons to transcend (ostensible) developmental deficiencies and to address the anxiety over our freedom that “gets mixed up with the genuine developmental anxieties, deficiencies, assaults, challenges, twists, and traumas that do invariably afflict us all and some more than others.”⁶³ Nevertheless, Rahner emphasizes a “primal trust” in God that must be awoken “through participation in the life of another person who, in his [sic] serenity and love, may be able to provide a fruitful model for this primal trust;” transcendental experience of God (as experienced, for instance, in the process of Ignatian discernment) “link[s] up with experiences which the consciousness declares are clearly and existentially important”—he names early childhood experiences of love, faithfulness, and security between persons as key for the establishment of this primal trust.⁶⁴ One’s transcendental freedom is awoken by love—concrete acts of neighbor love and participation in loving relationships.

LAYING DOWN ONE’S LIFE: CONSTRUCTIVE PROPOSALS

Meeting one’s own death in a pluralistic and medicalized society is a vexing proposition; one is apt to be managed by external forces through an event that the Christian faith has traditionally regarded as uniquely revelatory of the person, and as the limit and demand for one to accept God’s grace. I have been investigating how individuals might make the law of love their own with reference to their deaths, in a time when death is routinely medically managed—biologically, psychologically, sociologically, and spiritually. Might one, following the Christ, really “lay down” his or her life in a conscious act of self-consummation? I have chosen “mature autonomy” to indicate that the

⁶³ Browning, *Religious Thought and the Modern Psychologies*, 130.

⁶⁴ Karl Rahner, *The Practice of Faith: A Handbook of Contemporary Spirituality* (New York: Crossroad, 1983), 61.

distinctive visions of self-law or self-rule that I have gleaned from the works of Browning and Rahner are not normless; in both cases, these thinkers envision a view of the human lifespan in which a person's freedom and responsibility increase over time. In Browning's vision, the person who reaches the final stage of life, in whom integrity preponderates (rather than despair), will possess an ego sufficiently strong and flexible to meet the situation and will be able to "hold on" and "let go" in ways that do not compromise his or her existential integrity—an egoic capacity with significant implications for how one engages a totalizing medical enterprise. On this view, the maturely autonomous person, having been activated and confirmed throughout life by caring others will potentially be able to reiterate the virtue of generativity into a "grand-generativity," of widening and yet "detached concern with life itself in the face of death itself"⁶⁵ —he or she will have introduced their loving contribution into the world and will thus ground the lives of others. The "generative person" is a normative anthropology indicating that life should be marked by widening care and responsibility for what one has generated; when combined with the method outlined in Browning's fundamental practical theology, the congregation becomes the potential site where maturely autonomous persons can be scaffolded, nurtured, and witnessed, and where practical responses to contemporary situations can be discerned and responded to in ways that maximize persons' capacities for widening responsibility and for the freedom to love their neighbors as themselves.

As I have already indicated, when compared to Browning, the vision of mature autonomy put forth by Rahner is more individualistic, existential, and explicitly oriented to death as the locus of faith, hope, and love in the Christian life. As Shannon Craigo-Snell writes,

For Rahner, self-abandonment into the mystery of God is the most important moment of self-constitution. It is precisely in this openness to the divine other (an openness enacted

⁶⁵ Browning, *Generative Man*, 196-97.

throughout our lives in love of the concrete others of our neighbors) that we step into full self-possession.⁶⁶

At the heart of Rahner's theology is the conviction that death is a personal *act* involving the whole person that cannot be offloaded to anyone else in which one's history of maturing freedom is finalized. I have argued that medicalization changes persons' relation to time, and encourages them to postpone considerations of death through frenetic efforts "to keep matter in motion" which displace traditional practices of *memento mori*; I have also observed that patient autonomy is routinely reduced to the efforts of medical professionals to secure patients' consent to medical interventions (or to document their refusal), and that the processes of medicalization heteronomously "manage" patients through the liminal situation of dying and death. Against this background, Rahner's insistence on more profound understandings of freedom and autonomy are significant:

Freedom is not the power constantly to change one's course of action, but rather the power to decide that which is to be final and definitive in one's life, that which cannot be superseded or replaced, the power to bring into being from one's own resources that which must be, and must not pass away, the summons to a decision that is irrevocable... If, therefore, man [sic] *is* personal freedom, then it follows that he is one who uses the resources of his own innermost nature to form himself by his own free act, for by the exercise of this freedom of his he can definitively determine the shape of his life as a whole, and decide what his ultimate end is to be, the ultimate realization of his own nature, beyond all possibility of revision.⁶⁷

While Rahner allowed that the finality of one's personal acts of freedom may not strictly coincide with biological death, he nevertheless maintained that death remains "the supremely decisive event in man's history"⁶⁸ and furthermore, that the situation of approaching death "is really an unusual one for liberty," which is to say that decisions made during this time may be uniquely expressive of the spiritual freedom of the person who is rendered increasingly helpless and lonely as death

⁶⁶ Shannon Craigo-Snell, *Silence, Love, and Death: Saying "Yes" to God in the Theology of Karl Rahner* (Milwaukee, WI: Marquette University Press, 2008), 141.

⁶⁷ Karl Rahner, "On Christian Dying", *Theological Investigations* 7:26, 287.

⁶⁸ Rahner, "On Christian Dying," 285.

approaches; Rahner held that faith, hope, and love are definitively unveiled only when everything that propped up one's life has fallen away: "freedom must accept this powerlessness while hoping to the very end."⁶⁹

While these competing conceptions of mature autonomy could each do much to oppose the excesses of medical management of death, it remains to be seen whether these insights can be synthesized in a meaningful and constructive way. This stems, in large part, from Rahner's insistence on the logic of existential and practical reason; heretofore, Ignatian discernment presupposed "a solitary event proper to the individual person" in which one allows her innermost freedom to be disposed of by God, positing herself through free decisions that proceed from "the inmost centre of [her] being."⁷⁰ The role of the Church or community with respect to the individual (apart from directing the individual to his or her personal dealings with God) is ambiguous in Rahner's writings, but crucial in Browning's, where persons are constituted in community, become firm in their identities, reason together, and develop moral virtues and psychological strength in concert with others. Nevertheless, one of Rahner's late essays (c. 1974) indicates that he had begun to consider a new social structure for the postmodern Church in the form of "vital basic communities."⁷¹ It is my contention that such vital basic communities would well serve mature autonomy by reclaiming the myriad tasks of chaplaincy I related earlier. In what follows, I will justify such a constructive role for contemporary churches, as I further seek to synthesize the visions of mature autonomy put forth by Browning and Rahner in concert with two popular authors whose writings have encouraged persons

⁶⁹ Karl Rahner, "Christian Dying," *Theological Investigations*, 18:14, 233, 246.

⁷⁰ Karl Rahner, "The Theological Concept of Concupiscentia" *Theological Investigations* 1:11, 360-362.

⁷¹ Cf. pp. 125-6, n. 128 of this work. Rahner proposed "vital basic communities" as "new forms of social structure" that represent "new types of genuine community life which correspond to the new groupings in society for which mankind is searching today." Comprised of united groups or Churches, vital basic communities would engage in collective spiritual discernment, effect a more thoroughgoing integration of the liturgy with daily life, and make concerted attempts to be socio-politically responsible to the world through their life together. Karl Rahner, "Modern Piety and the Experience of Retreats," *Theological Investigations* 16:8, 147ff., 174.

to confront the medicalization of death with concrete suggestions for increasing their own competence and self-direction.

PROSPECTS FOR MATURE AUTONOMY WITHIN VITAL BASIC COMMUNITIES

“Aren’t you a person of body and soul?” Rahner, asks. “Isn’t it necessary for the innermost reality at the core of your being to express itself bodily?”⁷² Frankly, Rahner is somewhat ambiguous on this account. When it comes to the medicalization of death, Rahner observes that the “stylelessness” and impersonal nature of hospital deaths “may be deplorable and need not simply be accepted as inevitable” but regards this “shapelessness” as proper to death and dying “which in the last resort is beyond our control.”⁷³ While he observed that medicalization displaces *memento mori*, his explicit and constructive response to medicalization seems rather thin: Rahner insists only upon the patient’s free choice of doctor. Presumably, the patient is supposed to be permitted to choose a physician who would subordinate his primary task as a doctor (the duty “to defend and preserve life”) to his patient’s autonomous choice to be allowed to die, that is, to his patient’s “total and entire life history.”⁷⁴ Rahner’s essay gives some indication of the shifting ground between medical paternalism and the good of patient autonomy, but offers perhaps an overly individualistic and impracticable solution to a systemic human problem.⁷⁵ He elsewhere privileges the cultivation of attitudes, particularly of resignation in response to life’s losses: “the most important thing [more important than receiving the Last Sacraments] even for Catholics, is that the dying person should arrive at a religiously existential *attitude* towards death.”⁷⁶ Praying the rosary, fasting, and abstinence

⁷² I am using Rahner’s words as quoted in Harvey D. Egan, *Karl Rahner: Mystic of Everyday Life* (New York: Crossroad, 1998), 95.

⁷³ Rahner, “Christian Dying,” 233-234.

⁷⁴ Rahner, “Christian Dying,” 233-234.

⁷⁵ Rahner, “The Liberty of the Sick, Theologically Considered” *Theological Investigations* 17:9, 108.

⁷⁶ Rahner, “The Liberty of the Sick, Theologically Considered,” 108, emphasis mine.

are personal bodily modes of thematicizing and practicing these basic realizations throughout life, and for deepening patience and trust in response to disappointment. “One must live a “living death,” Rahner writes, “a renunciation which we make in anticipation of our final end because in the end we must renounce all things.”⁷⁷

These practices construe freedom as inner dispositions and attitudes deepened by voluntarily undertaken renunciations and practices of prayer, but obscured in these considerations are the “love for death and the courage to face it”⁷⁸ that supposedly stem from the desire to bring one’s own history of real and eternally valid acts of neighbor love and moral commitment to its consummation, or the sense of “joy in the world” that emanates from the practice of Ignatian discernment in which one readies oneself for the adventure of seeking God in all things.⁷⁹ While I argued that the theology implicit in the *Spiritual Exercises*

contributes to a more profound reconsideration of autonomy by recovering responsibility—a consideration of the patient’s duties, here held to be individual duties, discoverable in prayer—with a fuller understanding of freedom that includes freedom *of* spirit, freedom *from* attachments, and freedom *to* posit the self in an increasingly integrated way⁸⁰

the third element seems lacking on the foregoing account. In what might the freedom to posit oneself in an increasingly integrated way mean for life in community, for communal practices, for corporeal works of mercy and liturgical life, particularly given the significance that Rahner ascribes to death as the locus of the Christian life?

Rahner’s proposal for vital basic communities seems to emanate from a recognition of the dis-integrating features of (post)-modernity and of its attendant loneliness. He observes that

[m]en are searching today for higher forms of social structure, given that western civilization with its rational and technical methods is becoming dominant all over the world. These social

⁷⁷ Rahner, “On Christian Dying,” 290.

⁷⁸ Rahner, *On the Theology of Death*, 8.

⁷⁹ Karl Rahner, “The Ignatian Mysticism of Joy in the World,” *Theological Investigations*, 3:19, 291.

⁸⁰ Cf. p. 172 of this work.

structures seek to reconcile the dignity and value of the individual with the social character of man and also face the social and material demands which are necessary for survival both now and in the future.⁸¹

Such vital basic communities share a real affinity with Browning's conception of the congregation as a site of moral discourse,⁸² but are even more important as a place where individuals and even the community itself can embody the forms of freedom and responsibility they are discerning:

the Church is not just the hierarchy but is the pilgrim people of God in which each has an active part and a specific task...the call for *vital basic communities* which build up the Church from below and are not individualistic groups founded on mutual sympathy, but are *genuine communities* in society based on shared faith in the Gospel and the power of the liberating spirit of Jesus; the liturgy as the real expression of a community's life and not merely an officially conducted ritual which the individual pious Christian attends, a change which the reform of liturgy may have brought about in principle but which is far from being completely carried through...new structures of law will be developed in the Church in which the freedom of the individual may be safeguarded without destroying the Church as a body, but rather revealing its unity and its spiritual power to integrate the individual in a new and clearer way.⁸³

Rahner proposed vital basic communities as a new form of social structure that would incorporate Ignatius of Loyola's practice of the '*deliberatio communitaria*'—a form of deliberation not only *in* but *of* the group—"where the logic of existential choice was to apply and operate for the group as a whole,⁸⁴ and would be integrated with communal liturgical life.⁸⁵ He nevertheless maintained that the life and death of an individual must be "borne by the individual on his own" "even if [the life and

⁸¹ Karl Rahner, "Modern Piety and the Experience of Retreats" *Theological Investigations* 16:8, 146.

⁸² Rahner admits the possibility that "a parish institutionalized in the first place from above could and should also be at the same time a living basic community from below" as well as the possibility that basic communities could be ecumenical, "undertaking social responsibility for justice, love, and freedom...action in the light of [responsibility] in concrete everyday life, so that the liberating power of the Gospel is attested in deed and truth before the world." "Basic Communities," *Theological Investigations* 19:12, 161, 164. See also "Basic Christian Community" in Karl Rahner, *The Practice of Faith* (New York: Crossroad, 1983), 170-71.

⁸³ Rahner, "Modern Piety and the Experience of Retreats," 147, emphasis mine.

⁸⁴ For examples of how Jesuits have approached existential choice for whole communities, see Jules J. Toner, S.J., "A Method for Communal Discernment of God's Will," *Studies in the Spirituality of Jesuits* Vol. III, No. 4 (St. Louis, MO: September 1971). John Carroll Futrell, S.J., "Communal Discernment: Reflections on Experience," *Studies in the Spirituality of Jesuits* Vol. IV No. 5 (St. Louis, MO: November 1972). Ladislav Orsy, S.J., "Toward a Theological Evaluation of Communal Discernment," *Studies in the Spirituality of Jesuits* Vol. V, No. 5 (St. Louis, MO: October 1973).

⁸⁵ Rahner, "Modern Piety and the Experience of Retreats," 145.

death of the individual, which always remain unique events] should be brought into the higher forms of the religious community life and into their self-expression.”⁸⁶

There is a loneliness inherent to aging and death that cannot be eradicated, Rahner attests; one should not seek to lose herself in the group or to evade the demands of one’s freedom as she struggles “to get [herself] together before the final mystery.”⁸⁷ Granting this existential loneliness, however, does not mean that we ought to countenance deaths that are lonelier or more externally managed than they have to be; possibilities for self-realization through love of the neighbor persist until death, and each of us needs help to realize our freedom in love. While the forms and tasks of vital basic communities must change in relation to their historical circumstances, I argue that reintegrating death and dying back into Christian communities is a pressing contemporary task that will help to produce maturely autonomous, loving and self-giving persons, as well as an important part of promoting personal integrity in a time when aging and death are overly medicalized and life-worlds are fragmented by technical rationality.

GAWANDE AND DOUGHTY: CONSTRUCTIVE PROPOSALS FOR VITAL BASIC COMMUNITIES

In the first chapter, I promised to explore the “contours” of the genuine freedom and self-mastery that Christians might inhabit with respect to death, along with the practices of personal and communal formation that might inform the visional and obligational aspects of medical decision-making and self-disposition.⁸⁸ Now that I have elaborated two theoretical accounts of autonomy, I aim to make good on that pledge by putting these theories into contact with two contemporary popular authors who have worked to lift the obfuscating veil of medicalization and to encourage

⁸⁶ Rahner, “Modern Piety and the Experience of Retreats,” 154-155.

⁸⁷ Rahner, *I Remember*, 6.

⁸⁸ See p. 45 of this work.

their readers to engage the end of life more autonomously. I will press into the narrative dimension of a generative ethics, sharing stories that spark the moral imagination. This effort is warranted by the arguments raised earlier in this work: medicalization is excessively palliating; moving aging and death back into the purview of families and religious communities provides the opportunity for deeper existential engagement with the life cycle and with one's own profound forms of freedom and responsibility. Vital basic communities, as I conceive them here, will seek to structure their life together with an eye towards death; through the self-conscious integration of dying and death into their common life, they will strengthen the life cycle, facilitate genuine contact with grief, and allow themselves to be confronted with the metaphysical realities of death and dying—the questions of meaning, purpose, responsibility, and freedom that medicalization so often elides. Like Paul Ramsey, I am here advocating a “shattering” confrontation with reality and with “the claims of the dying not to be deserted, not to be pushed from the circle that specially owes them love and care, not to be denied human presence...”⁸⁹ In this way, these communities will keep themselves in touch with what is essential—and hence truly vital—the disposal of oneself in freedom, and the extension of love through time.

Following Browning, I, too, maintain that the ego is a body-ego; we are inspirited bodies who activate capacities and competencies in one another through acts of loving recognition and care. We also exercise diverse forms of transcendence; we can shape the institutions that shape ourselves and prayerfully open ourselves to infinite mystery in order to posit ourselves in momentous choices. Furthermore, as Rahner paradoxically claimed, prayerful dependence on God

⁸⁹ Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics*, Second Edition (New Haven: Yale University Press, 1970, 2002) 132-36.

may lead to increasing freedom and responsibility in the realm of neighbor love. I turn now to Atul Gawande in order to integrate these affirmations with some practical propositions.

Gawande is an American surgeon whose *Being Mortal: Medicine and What Matters in the End* was a New York Times bestseller. *Being Mortal* mixes contemporary research on aging and medicalization with personal stories about autonomy in relation to medical treatment and relates best practices for maximizing persons' capacities to "author" their own lives in relation to these realities. Gawande argues that our society "faces the final phase of the human life cycle by trying not think about it"⁹⁰—a strategy of avoidance that defaults to medicalization, in which elderly persons who typically suffer from multiple chronic comorbidities acquiesce to the default pathway of serial medical interventions; although their physicians may have promised them that they can refuse treatment at any point, they rarely know when to step off the pathway:

This is a modern tragedy, replayed millions of times over. When there is no way of knowing exactly how long our skeins will run—and when we imagine ourselves to have much more time than we do—our every impulse is to fight, to die with chemo in our veins or a tube in our throats or fresh sutures in our flesh. The fact that we may be shortening or worsening the time we have left hardly seems to register. We imagine that we can wait until the doctors tell us that there is nothing more they can do. But rarely is there nothing more that doctors can do. They can give toxic drugs of unknown efficacy, operate to try to remove part of the tumor, put in a feeding tube if a person can't eat: there's always something...the default is: Do Something. Fix Something. Is there any way out of this?⁹¹

Gawande is clear that ignorance and desperation, as well as an unrealistic expectation of what medicine can do mark these choices:

People die only once. They have no experience to draw on. They need doctors and nurses who are willing to have the hard discussions and say what they have seen, who will help people prepare for what is to come."⁹²

⁹⁰ Atul Gawande, *Being Mortal: Medicine and What Matters in the End* (New York: Henry Holt and Company, 2014), 76.

⁹¹ Gawande, *Being Mortal*, 173.

⁹² Gawande, *Being Mortal*, 186.

This can be a task for congregations, too, if they are willing to pool their collective experiences, to reason together, and to engage in personal and communal exercises of discernment around these issues. In so doing, they might revivify older forms of wisdom about how to die well, recover a role for dying persons, and cultivate a faithful *'indiferencia'* for when the time comes to make these choices—a freedom of spirit that thwarts the panic of death with equanimity, enabling individuals to make decisions that will express their own freedom and responsibility with integrity. Gawande attests that most patients and their families do not have this—“they remain riven by doubt and fear” when faced with the prospect of opting out of “all-out treatment.”⁹³ Vital basic communities, or congregations committed to building up the church “from below,” that is, “genuine communities in society based on shared faith in the Gospel and the power of the liberating spirit of Jesus” can change this.⁹⁴

Rahner, you will recall, wrote about *proximitas mortis*—the genuine confrontation with one’s own mortality that is heralded by serious illness. While contemporary life is not devoid of such confrontations, Gawande writes that “ODTAA syndrome” is now more characteristic of life’s closing phase. Gawande describes “One Damn Thing After Another syndrome” as

a mounting series of crises from which medicine can offer only brief and temporary rescue. It does not have a totally predictable path. The pauses between crises can vary. But after a certain point, the direction of travel becomes clear.⁹⁵

This “syndrome” makes it difficult to define or to inhabit ‘a dying role.’ At some point, however, independent living becomes impossible. A hospital discharge, a fall, or an incident of cognitive confusion is likely to bring talk of a nursing home in its wake; for elderly persons, the dislocations are profound. Gawande’s reflections give credence to Erikson’s theory: autonomy is relationally-

⁹³ Gawande, *Being Mortal*, 186.

⁹⁴ Rahner, “Modern Piety and the Experience of Retreats,” 147.

⁹⁵ Gawande, *Being Mortal*, 208.

activated, and tied to one's place in the world. When remembering his visits with patients who had moved to assisted-living institutions, he repeatedly observed that the 'light' had gone out from their eyes—they grieved the enormous losses of home (with all of the connotations of place and privacy inherent therein) and sometimes a spouse who had recently died or still lived at home. Gawande finds Erving Goffman's description of the nursing home as "a totalizing institution" an apt one.⁹⁶ In its quest for patient safety and institutional regularity, patient liberty is strangled and responsibility absolved. Gawande portrays the expropriation of nursing home residents' responsibility as a death-knell; although many express the desire "to be useful," there is nothing to do and no one to care for—the institutionalized languish in front of televisions; they may launch small rebellions over forbidden, smuggled, or hoarded foods; in some institutions, such skirmishes might be met with physical or pharmaceutical restraints:

In the horrible places, the battle for control escalates until you get tied down or locked into your Geri-chair or chemically subdued with psychotropic medications. In the nice ones, a staff member cracks a joke, wags an affectionate finger, and takes your brownie stash away. In almost none does anyone sit down with you and try to figure out what living a life really means to you under the circumstances, let alone help you make a home where that life becomes possible.⁹⁷

When these conditions are typed out in black and white they shock the conscience and reveal some combination of our culture's disregard for elderly, enfeebled, or dependent persons, our collective political indifference about the people who care for them, and the wicked problems inherent in the social fragmentation that multiple generations have chosen. Gawande cites research to indicate a worldwide trend of separation between parents and children: "Whenever the elderly have had the

⁹⁶ Cf. Erving Goffman, *Asylums* (Garden City, NY: Anchor, 1961). Charles W. Lidz, Lynn Fischer, Robert M. Arnold, *The Erosion of Autonomy in Long-Term Care* (New York: Oxford University Press, 1992).

⁹⁷ Gawande, *Being Mortal*, 76.

financial means, they have chosen what social scientists have called ‘intimacy at a distance,’⁹⁸ preferring not to live in multigenerational homes. He shares a narrative about Shelley, her husband, Tom, and her ninety-year-old father, Lou, who moved in to their suburban Boston home when he could no longer live alone. The case is illustrative of the difficulties inherent in attempting such an arrangement: in this case, Lou adjusted reasonably well, but his middle-aged daughter was strained to the brink trying to care for her elderly father, who was still unattended for long hours while she was at work. At home, she worked to prevent his frequent falls, tended to his urinary incontinence, tried to ameliorate his isolation in suburbia (he could neither drive nor walk to a more convivial place), worked to accommodate his personal food preferences, and partial deafness. She and her husband were still raising their two adolescent children who also needed their parents’ attention—today, the ostensibly “generative” stage of life is, for good reason, known as “the sandwich generation.” Because of the intensely medicalized nature of old age, Gawande argues that caregiving today is more burdensome than it would have been a hundred years ago—“an overwhelming combination of the technological and the custodial”:

Lou was on numerous medications, which had to be tracked and sorted and refilled. He had a small platoon of specialists he had to visit—at times, nearly weekly—and they were forever scheduling laboratory tests, imaging studies, and visits to other specialists. He had an electronic alert system for falls, which had to be tested monthly. And there was almost no help for Shelley. . . [she] had become a round-the-clock concierge/chauffeur/schedule manager/medication-and-technology troubleshooter, in addition to cook/maid/attendant, not to mention income earner. Last-minute cancellations by health aides and changes in medical appointments played havoc with her performance at work, and everything played havoc with her emotions at home.⁹⁹

The logic, if not the ethics, of the nursing home comes into view. The “productive” generation needs its custodial function, and covets its capacity to shield them from the harsh realities of human

⁹⁸ Gawande, *Being Mortal*, 21. Cf. L. Rosenmayr and E. Kockeis, “Propositions for a Sociological Theory of Aging and the Family,” *International Social Science Journal* 15 (1963): 410-24.

⁹⁹ Gawande, *Being Mortal*, 85-86.

decline and the intransigent need for assistance. While this dissertation centers on the autonomy of patient-persons, narratives like this one make clear that our freedom and responsibilities are bound up with others'. What do the freedom to love and freedom to give and to receive care mean in these situations? How should persons responsibly adjudicate the realities of intergenerational life when the liberal autonomy predicated on freedom from interference proves so woefully insufficient?

Echoing the claim that medicalization functions as a *modus vivendi*, Gawande attests that “[t]he problem with medicine and the institutions it has spawned for the care of the sick and the old is not that they have had an incorrect view of what makes life significant. The problem is that they have had almost no view at all.”¹⁰⁰ Medicalization provides ‘a way of getting along’ by focusing on the attempt to return patients to health, and most Americans acquiesce to it, allowing medicine to define their final days. Nevertheless, our choices, including tacit medical choices, have far-reaching effects on others; consider something as commonplace as how a patient’s inappropriate request for antibiotics—say for a viral infection—can contribute to the spread of antibiotic-resistant bacteria that can seriously harm others. A generative integrity implies one’s commitment to understanding one’s medical condition in sufficient depth to make responsible choices and the willingness to include a widening circle of others in one’s considerations. In practice, this may often involve an attenuation of the *demand* for medical care, a foregoing of the request that a physician “do something.” Such an act is one of individual discernment, and might require egoic strength and moral courage. One needs to be able to rely on their own nonmedical resources, and on other forms of care.

Persons, families, communities, and congregations are differently situated; they face complicated tasks of individual and communal discernment with respect to both special and general

¹⁰⁰ Gawande, *Being Mortal*, 128.

ethics: how will they care for their own kin (particularly when they may live far apart), for their fellow congregants, and for the stranger? Care for “the least of these” is a central tenet of Christian ethics; we care as though for Christ. Using one’s freedom, accepting the responsibility to care for the weak is never futile or wasted, but is to be esteemed in Christian communities: these are eternally-valid actions, to use Rahner’s concept. It is nevertheless exhausting; the work must be shared more widely and caregivers need personal and political support. Retrenchment of economic structures may well be needed to prioritize caregiving for children and elders alike (recall Browning’s proposal of a 60-hour workweek to be shared between spouses so that they might better share child—or in this case—elder care).¹⁰¹ There is much strategic practical theological thinking to be done within congregations about how to promote the autonomy of women (especially elderly women and women who find themselves “sandwiched” between the generations), how to integrate multigenerational communities, to advocate for governmental policies that ensure that no senior citizen has to live in one of the “horrible places,” and to embody care for the aging in ways that promote their liberty and continued responsibility.

Gawande has offered some practical ideas for doing just that—ideas that ‘vital basic communities’ could use if they took their life in common seriously. In this way, liturgical life might really become “the work of the people.” From Keren Brown Wilson who, with her husband, opened Park Place, the first “assisted living” facility as a real alternative to nursing homes in order to help people like her own mother who had suffered a stroke, Gawande gleaned that medicalized priorities for safety and institutional regularity could be subsumed to the promotion of privacy, connection with others, control over possessions and time-use, and help with continuing preferred activities—all without actually sacrificing health. Park Place tenants

¹⁰¹ See p. 116, n. 101 of this work.

had private apartments with a full bath, kitchen, and a front door that locked... They were allowed to have pets and to choose their own carpeting and furniture. They were given control over temperature settings, food, who came into their home and when. They were just people living in an apartment, Wilson insisted... But, as elders with advancing disabilities, they were also provided with... help with the basics—food, personal care, medications. There was a nurse on-site and tenants had a button for summoning urgent assistance at any time of day or night... here the care providers understood they were entering someone else's home, and that changed the power relations fundamentally. The residents had control over the schedule, the ground rules, the risks they did and didn't want to take.¹⁰²

Five years after opening their first facility in 1983, the state of Oregon published the results of their experiment; residents'

satisfaction with their lives increased, and at the same time their health was maintained. Their physical and cognitive functioning actually improved. Incidence of major depression fell. And the cost for those on government support was 20 percent lower than it would have been in a nursing home.¹⁰³

“Assisted living” went on to share the same fate as Dame Cicely Saunders’ “hospice.” The term spread, but the key concepts were diluted. It takes effort, skill, and intentional openness to the other to use one's own freedom to promote someone else's, as well as a tolerance for certain “inefficiencies.” This is nevertheless warranted, in Rahner's view, by a legitimate Christian existentialism and its attendant anthropological and theological convictions about persons:

Human beings for their part in their unity and incalculable quality are not merely random specimens of a genus or of a collective entity but also unique individuals who help to shape their own lives in inalienable freedom... old age is not merely a social and cultural-historical phenomenon in a socio-cultural context but also a part of the ever unique individual that every human being is.¹⁰⁴

Helping the aged to exercise their freedom is a form of kenotic self-donation that helps individuals to realize their own. This is no simple matter; there remains the individual work of self-entrustment to God, the point at which all these props—a private apartment, preferential foods—fall away, a

¹⁰² Gawande, *Being Mortal*, 91.

¹⁰³ Gawande, *Being Mortal*, 92.

¹⁰⁴ Karl Rahner, “A Basic Theological and Anthropological Understanding of Old Age,” *Theological Investigations* 23:5, 52.

point at which no one can accompany the dying person any longer. I will turn to these legitimate forms of autonomous resignation in a moment. For now, though, I turn to Gawande's example of physician Bill Thomas in order to interrogate the forms of "vitality" that might inform 'vital basic communities.' As Rahner reflected in his final years, "we old people live in a strange and unique state of tension between the courage to live here and now and the hope of eternal life...the fact remains that we are still living and we should have the desire really to live the life still remaining to us and live it to completion."¹⁰⁵

Gawande portrays Bill Thomas as radiating a charismatic and uncompromising self-directedness. A Harvard-trained family physician, Thomas returned to his hometown of New Berlin, New York after residency and accepted the job of medical director of Chase Memorial Nursing Home—a day job with predictable hours that would allow him to maintain his four-hundred-acre homestead and, with his wife Jude, to raise their five children. Chase Memorial housed eighty elderly residents; about half were physically disabled and most had cognitive disabilities, including forms of dementia like Alzheimer's.¹⁰⁶ Life in the nursing home contrasted markedly with "the most authentically true life" Thomas felt himself to be living; while the staff "saw nothing especially problematic about the place," Thomas "saw despair in every room."¹⁰⁷ He proposed some heretofore radical aims to combat the "Three Plagues" of nursing home existence: "boredom, loneliness, and helplessness." He sought to inject spontaneity in ways that flouted standard nursing home regulations: "To attack the Three Plagues they needed to bring in some life. They'd put green plants in every room. They'd tear up the lawn and create a vegetable and flower garden. And they'd

¹⁰⁵ Rahner, "A Basic Theological and Anthropological Understanding of Old Age," 58.

¹⁰⁶ Gawande, *Being Mortal*, 111.

¹⁰⁷ *Ibid.*

bring in animals.”¹⁰⁸ When the plan was implemented, the nursing home had two dogs and four cats, and each resident’s room contained a caged parakeet and live plants. The nursing home got a playground in the back, and the children of staff would come to hang out after school. The “glorious chaos” earned its share of pushback; nurses who had been hired to help run an institution were maddened by the responsibilities and messes that the animals created and that they were expected to assume. Their routines were disrupted, but the nursing director encouraged them to view themselves as helping to run a home where everyone shared responsibilities—and then the residents “began to wake up and come to life” and to assist with feeding the animals and watering the plants:

‘People who we had believed weren’t able to speak started speaking.’ Thomas said. ‘People who had been completely withdrawn and nonambulatory started coming to the nurses’ station and saying, ‘I’ll take the dog for a walk.’”¹⁰⁹

Living things, in Thomas’ view, provide spontaneity, companionship, and the opportunity to care for another being—a reason to live that quite literally ‘activates’ persons. Compared to a nearby nursing home, deaths at Chase Memorial fell 15 percent, and the number of prescriptions per patient by half, with a marked decrease in psychotropic drugs for agitation.¹¹⁰ The opportunity to be generative and responsible appears to be life-giving.

When all was said and done, Chase Memorial added a colony of rabbits, a flock of laying hens, on-site child care for the staff, and a new afterschool program.¹¹¹ The presence of children marks several of the remarkable programs that Gawande describes. Yet another retirement

¹⁰⁸ Gawande, *Being Mortal*, 116.

¹⁰⁹ Gawande, *Being Mortal*, 122.

¹¹⁰ Gawande, *Being Mortal*, 123.

¹¹¹ Gawande, *Being Mortal*, 123.

community, NewBridge on the Charles, located outside of Boston, had become symbiotic with a private kindergarten-through-eighth-grade school.

Residents who didn't need significant assistance worked as tutors and school librarians. When classes studied World War II, they met with veterans who gave firsthand accounts of what they were studying in their texts. Students came in and out of NewBridge daily, as well. The younger students held monthly events with the residents—art shows, holiday celebrations, or musical performances. Fifth and sixth graders had their fitness classes together with the residents. Middle schoolers were taught how to work with those who have dementia and took part in a buddy program with the nursing home students. It was not unusual for children and residents to develop close individual relationships. One boy who befriended a resident with advanced Alzheimer's was even asked to speak at the man's funeral.¹¹²

NewBridge typified the wisdom of Eriksonian “intergenerational cogwheeling,” and instantiated Rahner's belief that the tasks of the elderly, which may be modest, nevertheless serve important “intermediary” and “buffering” functions. He averred that one need not reserve “grandparenting” for any grandchildren one may have; it may be shared more widely: “giving counsel, handing on traditions, and serving as a stabilizing force,” are tasks for the old, according to Rahner.¹¹³ According to Eriksonian theory, these interactions grant powerful forms of recognition to young and old alike. The old need others to listen to their stories and to confirm their lives. The young thrive under the affectionate warmth of a delighted countenance. A sense of belonging and personal activation are conferred on both parties, now and into the future. Ordaining time for children to be with, to become skilled in caring for, and to open themselves to the lives of those who might be relegated to the margins is a powerful repudiation of technical rationality and a preparation for mature autonomy, a commitment that might yield genuine inner freedom and a widening sense of responsibility for others.¹¹⁴

¹¹² Gawande, *Being Mortal*, 132.

¹¹³ Rahner, “A Basic Theological and Anthropological Understanding of Old Age,” 56-57.

¹¹⁴ Compare the homily Pope Francis offered in which he told a story that is illustrative of the significance of intergenerational cogwheeling and the examples of integrity that one hands on to subsequent generations: “There was a

The residents at NewBridge were not wealthy. Gawande reports that 70 percent had depleted their savings and were on government assistance. The retirement community received substantial philanthropic support from the Jewish community. Christian congregations might well examine whether they can support analogous communities. Creative courage and the impetus to reform social structures might spur individuals and congregations to discern ways of going further. Architecture and city-planning frequently determine whether senior citizens will be able to remain in their homes and to maintain connections with others. Persons in these vocations may “plan” for generative communities, and congregations should advocate for them. Vital basic communities might consider undertaking more committed forms of life together, such as forming a co-housing community in which more dependent seniors might live amongst college students, single persons, and families with children, who may each contribute their skills and expertise toward the flourishing of the community. Such an arrangement would be rather atypical for Americans whose housing choices are typically expressive of liberal individualism, but has the potential to embody a deep integrity. Such a vital basic community could be formed around the liturgy and marked by the cogwheeling of mutual care.

I earlier argued that vital basic communities should reclaim many of the tasks now currently undertaken by professional chaplains. Many of those tasks had to do with the disposition of bodies after death—facilitating a process in which families and communities had little contact with corpses

father, mother and their many children, and a grandfather lived with them. He was quite old, and when he was at table eating soup, he would get everything dirty: his mouth, the serviette ... it was not a pretty sight! One day the father said that, given what was happening to the grandfather, from that day forward he would eat alone. And so he bought a little table, and placed it in the kitchen. And so the grandfather ate alone in the kitchen while the family ate in the dining room. After some days, the father returned home from work and found one of his children playing with wood. He asked him: ‘What are you doing?’ to which the child replied: ‘I am playing carpenter’. ‘And what are you building?’ the father asked. ‘A table for you, papa, for when you get old like grandpa’. “Grandpa’s Table,” *L’Osservatore Romano*, Weekly ed. in English, n. 47, 22 (November 2013).

that had not already been prepared by morticians—and were typically made up to look as “lifelike” as possible. In this section, I will argue, with Caitlin Doughty, that the American funeral industry is very much a product of medicalization, that it is death-denying and emblematic of the ritualistic decomposition that weakens relationships between the generations, and that it enervates the capacities for embodied care.

Doughty’s project began when she was eight years old: she witnessed the death of another young girl, who had climbed up and tipped over the second-floor railing at the mall. Her father, trying to shield her from the harsh reality, made light of the trauma, and encouraged her to “just take the escalator, OK?” At that moment, Doughty understood viscerally that one day she would die, too, but her parents never spoke of “the incident” again—effectively “sealing up” talk of metaphysical concerns. Years later, in the course of the studies spurred by the traumatic incident, she realized that only a hundred years ago, “[a] child who had never seen a death would have been unheard of.”¹¹⁵

Doughty went on to receive her degree in medieval history from the University of Chicago and then set out to become a radical mortician; her work aims to demystify the undertaking trade, and to dispense with the unnecessarily medicalized aspects of decedent care (i.e., routine embalming) in order to facilitate unvarnished contact with dead bodies, to explore “green burials” and other more environmentally responsible forms of bodily disposition, and to re-skill persons in caring for their loved ones who have died—measures that happen to make funeral costs less exorbitant. In this last sense, Doughty follows in the footsteps of Jessica Mitford (*The American Way of Death*, 1963) whose investigative journalism unearthed abuses in the funeral home industry. Unlike Mitford who

¹¹⁵ Caitlin Doughty, *Smoke Gets in Your Eyes and Other Lessons from the Crematory* (New York: W. W. Norton & Company, 2015), 28-30.

aimed her criticism solely on the excessive profiteering of an increasingly protectionist industry, Doughty examines the deleterious cultural consequences of outsourcing the care of the dead along with the philosophical implications of ritual degradation. Consider her description of “internet cremation,” the most high-tech form of “direct disposal” offered at the crematorium where she first trained:

If your father died in a local hospital, you could visit the Bayside Cremation website, type in the location of Dad’s body, print out some forms, sign them, fax them back to the number provided, and input your credit card number to the website. All of this without ever having to speak to a real person. In fact, you weren’t allowed to speak to a real person even if you wanted to: all questions had to be sent by e-mail to info@baysidecremation.com. Two weeks later, the doorbell would ring and the postman would hand over Dad’s ashes, shipped by registered mail, signature required. No funeral home, no sad faces, no need to see Dad’s body—total avoidance for the low, low price of \$799.99.¹¹⁶

Doughty mulls the various forms of estrangement that such an offering represents, along with the lack of love and care implied by the practice, and the consequences for expectation-setting with regard to one’s own death in a manner reminiscent of Erikson. To wit:

“[T]he world suggested in the imagery of universal technology and apt to be dramatized by the media can turn into a vision of a totally fabricated order to be planned according to strictly logical and technological principles—a vision dangerously oblivious of what we are emphasizing. . . . namely the dystonic and antipathic trends endangering the organismic existence and the communal order on which the ecology of psychic life depends. An art and science of the human mind. . . . must be informed by a developmental, or shall we say life-historical, orientation, as well as by a special historical self-awareness.¹¹⁷

Doughty’s *From Here to Eternity: Traveling the World to Find the Good Death* examines cross-cultural practices of caring for the dead which, when compared to typical American practices, emphasize “organismic existence” and “communal order” and often include ongoing rituals of remembrance of the dead. While the practices themselves range widely, she portrays the presence of loved ones with the body and their physical participation in caring for the corpse as facilitating real contact with their

¹¹⁶ Doughty, *Smoke Gets in Your Eyes*, 103.

¹¹⁷ Erik H. Erikson, *The Life Cycle Completed* (New York: Norton, 1997), 96.

own grief (and reflexively, with one's own love for the deceased), as well as a vitalizing contact with one's own death and freedom.

The dominant funeral customs in America involve, increasingly, cremations that are not witnessed, or the formally-prescribed “viewings” of bodies that have been prepared to deny both death and decay. As Doughty writes, “North Americans *practice* embalming, but we do not *believe* in embalming. It is not a ritual that brings us comfort; it is an additional \$900 charge on our funeral bills.”¹¹⁸ Embalming is a practice that began amid the social dislocation of the Civil War so that the bodies of soldiers could be returned to their families. It serves social dislocation still, giving time for families to gather from afar and to memorialize the deceased at a more mutually convenient time. It was the invention of embalming that “medicalized” death, Doughty argues; the technique promoted the professionalization of undertakers who were able to argue “that with their technical training they protected the public from disease, and through their art they created a final ‘memory picture’ for the family”—ignoring the fact that corpses had been laid out safely in people’s home for hundreds of years.¹¹⁹ Doughty describes the technique in frank detail; traditional morticians inflict a great deal of trauma on dead bodies, puncturing vital organs in order to fill them with toxic chemicals that would eventually leak into the groundwater (if not, perhaps, for the heavy, sealed, protective caskets and concrete or metal vaults that are *de rigueur* today). Increasingly, mourners do not even participate in interment, and instead leave the casket at the gravesite for gravediggers and their backhoes. While Doughty writes from a religiously agnostic but ecologically invested perspective, Christians may well ponder what their participation in these culturally-dominant death rituals affirms with respect to

¹¹⁸ Doughty, *Smoke Gets in Your Eyes*, 84.

¹¹⁹ Doughty, *Smoke Gets in Your Eyes*, 81.

their profession that they are creatures of the earth (“adamah”), their faith in the resurrection that triumphs over decay, and in love that is stronger than death.

Doughty works hard to dispel the misperception that the newly dead are “ticking time bomb[s] of highly hazardous deadness,” that must be swiftly removed to preserve public health—a superstition propagated by many in the allied professions and by the imperative to free up hospital beds.¹²⁰ She advocates unhurried time with the dead—not because the corpse requires it, but because the living do—time to witness the profound physical changes death brings (“[d]ead people look very, very dead”),¹²¹ and to achieve a genuine sense of grief and closure that comes from confrontation with the physical reality that that person has completed his or her history of freedom. This time with the corpse, apart from formal wakes in which intimates are often pressured to put on a good face to interact with the more distantly aggrieved, is an opportunity to reflect on the graces of embodied life and on the persons who bestowed love and life on us. Doughty advocates participation in death rites that inscribe physical actions within the void of loss.¹²² Her funeral home offers families the opportunity to help wash and shroud their loved one’s body; historically in America, this has been women’s work, and she reflects that women, many of whom are on the vanguard of death-midwifery, might lead us to become skilled again in the forms of competency that bear on our existential freedom.¹²³ She relates that on the Indonesian island of Java,

¹²⁰ Doughty, *Smoke Gets in Your Eyes*, 174.

¹²¹ Doughty, *Smoke Gets in Your Eyes*, 115.

¹²² Traditionally, the Japanese have practiced “kotsuage;” mourners are present for the cremation, but do not observe it directly. When the skeletal remains emerge from the crematory, close family members use chopsticks to layer the bones into an urn, beginning with the feet. Recently, the Japanese have begun to move toward American-style cremations, preferring to have the remains ground and scattered by employees of the crematory. Doughty asked the head monk at Daitokuin Ryōgoku Ryoen, Masuda jūshoku, what has changed. He replied: “There are feelings that come with the bones, responsibility for the soul. Bones are real...The people who scatter the ash are trying to forget.” Caitlin Doughty, *From Here to Eternity: Traveling the World to Find the Good Death* (New York: W. W. Norton and Company, 2017), 185-86.

¹²³ Caitlin Doughty, *Smoke Gets in Your Eyes and Other Lessons from the Crematory* (New York: W. W. Norton & Company, 2015), 172.

Close relatives of the deceased wash the body, holding the corpse on their laps, positioned so the living are soaked in the water as well. The idea of cradling the dead this way, according to anthropologist Clifford Geertz, 'is called being *tegel*—able to do something odious, abominable, and horrible without flinching, to stick it out despite an inward fear and revulsion.' The mourners perform this ritual to become *ikelas*, detached from the pain. Embracing and washing the corpse allows them to face their discomfort head-on...moving to a place where 'their hearts are already free.'¹²⁴

Such acts of caring for the dead are forms of risking the self in love; while such acts of self-risking love ought not be limited to the dead, they may be understood as practices of dying with Christ that lead to a paradoxical self-possession. Doughty describes the “confident, stable feeling” that comes from facing one’s fears in this way, along with the forms of competence that have spread in conjunction with similar practices.¹²⁵ In Crestone, Colorado, volunteers from the Crestone End of Life Project, which operates a mobile, open-air funeral pyre, help families to prepare the bodies of their loved ones for their “do-it-yourself” cremations. The volunteers told Doughty that increasingly, “families have started to tell them, ‘Oh, thanks for coming but it’s okay, we can take it from here.’”¹²⁶

CODA

The early chapters of this dissertation established that the medicalization of death is a totalizing endeavor, easily acquiesced to in a pluralistic and fragmented society. Consideration of mature autonomy in the face of “biopsychosociospiritual” management would need to be equally comprehensive, and intentionally pursued. For those who claim a Christian identity, I have claimed

¹²⁴ Caitlin Doughty, *From Here to Eternity: Traveling the World to Find the Good Death* (New York: W. W. Norton and Company, 2017), 175.

¹²⁵ Doughty, *From Here to Eternity*, 175. Daniel Sulmasy and I argued that St. Francis’ kissing the leper functioned in this way, as a liminal moment in his spiritual biography: a self-risking action that set him on the path of increasing inner freedom. Cf. “Spiritual Preparation for Death,” in Lydia Dugdale, ed., *Dying in the Twenty-First Century: Toward a New Ethical Framework for the Art of Dying Well* (Cambridge, MA: The MIT Press, 2015), 90-91, 97-98.

¹²⁶ Doughty, *From Here to Eternity*, 134.

that “mature autonomy” can nevertheless be characterized rather succinctly: autonomy consists not in being “a law unto oneself,” but rather in making the “law of love”—love of God and neighbor—one’s own. I argued that Browning, by forwarding the characterology of the generative, and finally, well-integrated person, extends the possibility of a self-confirming autonomy that is contextualized within a particular history and sociality. His works highlight the significance of the particular ecological niches in which an individual’s autonomy may be activated and exercised, while his fundamental practical theology demonstrates that individual freedom becomes empty, incoherent, or self-defeating when exercised apart from communities that embody practical wisdom. Mature autonomy involves choice and decision; the rational faculties must be deployed in order for one to choose in accordance with his or her preferred sources of authority. Congregational processes of critical practical theology can help persons to gain clarity, distance, and freedom with respect to the socio-historical demands that press upon them, to correlate decisions about medical care, and to embody communal practices that are expressive of their considered identities. Such practices may well involve the retrenchment of prevailing institutions and the cultivation of practices that structure intergenerational life in such a way as to bring dying and death more fully within the community of faith, as well as to foster the primal trust that is activated in early childhood by loving relationships, and which also supports existential freedom at the end of life.

I have argued that the medicalization of death became a way of managing existential terror—the dread that medical management itself exacerbated by holding out the promise of ‘more time’ in which persons could postpone consideration of their mortality, and by crowding out communal practices for preparing for death within life. In contrast to heteronomous management, Rahner’s works testified to a profound spiritual autonomy nurtured through prayerful decision in which equanimity may be practiced and in which ‘*indiferença*,’ or ‘unattachment to particular things’

becomes the basic structure of the spiritual life, freeing the individual to receive individual directives from God, and to offer his or her unique history of freedom back to God in trusting surrender. Rahner's writings radicalize the concept of autonomous choice by insisting that through fundamental decisions, one posits one's self—who he or she has become in time. One may “die with Christ” throughout life by “taking up one's cross”—practicing patience sustained by faith amidst disappointments, experiences of frailty, sickness, and suffering—but also by “risking the self” in acts of neighbor love and moral decision where one's transcendental human freedom makes contact with the “categorially given” reality of “an inner-worldly Thou.”¹²⁷ While one's acts of neighbor love and self-risk should extend outside of the congregation or basic community, and include the reformation of social and political structures, I have suggested that vital basic communities could foster the ability to die a truly “human” death if they creatively seek to overcome the fragmentation of modern society by fostering “genuine living contact [between human beings],” “relationships of confidence and trust,” and “real opportunities for genuine mutual reliance”¹²⁸—the vital basic community, oriented around common prayer, the reading and studying of scripture, and the self-risking practices of neighbor love such as those that I related from Gawande and Doughty could truly replace the *modus vivendi* of medicalization with a freeing and responsible way of living and dying.

While Browning's works demonstrated the role of the congregation and community in the formation of one's own stable identity as well as the realization of one's own freedom amid the powers and principalities that bear down on us within our social milieu, mature autonomy must inevitably redound to the self: to paraphrase Rahner, “although you have to die, how will you do it?”

¹²⁷ Karl Rahner, *The Practice of Faith* (New York: Crossroad, 1983), 134.

¹²⁸ Rahner, *The Practice of Faith*, 170.

The loneliness of old age, the deaths of loved ones, and physical degeneration can be partially assuaged in community, but one must ultimately dispose of oneself in freedom and in trusting faith, after all the “props” of one’s life have fallen away. While a bleak nursing home might be fittingly compared to an asylum, Rahner’s works suggest that the maturely autonomous person might inhabit even it as a monastery—a place of stretching oneself out upon the world in generative prayer and of prayerfully entrusting one’s history of freedom to holy mystery, if one has practiced the patience of “dying with Christ” throughout life’s inevitable disappointments, and practiced the freedom of risking one’s stable identity in love of the neighbor. I have offered some possibilities for participating in practices that may deepen one’s capacity to posit oneself existentially, whether through participating in reformed practices of caring for the dead, or rearranging one’s life and living circumstances in openness to the needs of the neighbor (such as pursuing liturgically-driven intergenerational co-housing which could organically assume most of the functions of hospice and chaplaincy)—yet a free and creative love could take many forms; the maturely autonomous person must make the law of love their own.

EPILOGUE

This dissertation was a defense of autonomy in relation to death, the significance of which I believe was correctly, although incompletely, intuited by the biomedical autonomy movement of the 1960s. I partially ratified the intuitions of the biomedical conception of autonomy, which I take to have included a defense of personal inviolability and authenticity, as well as a vindication of individuality as worthy of respect. However, in this work of constructive Christian ethics, I moved to take seriously the *moral life* of the *patient*. I raised up ‘autonomy’ as a moral good, the pursuit of

which is justified by the “legitimate existentialism” located in the Christian witness that both affirms the inalienable responsibility of an individual before God, as well as the freedom for which Christ has set us free (Galatians 5:1). Scripture portrays the human as responsible for all his life before the One who looks beneath the surface and reads the heart. While I worked with an understanding of autonomy that fused freedom and responsibility, each of which are, in principle, unlimited, I also strove to take seriously the psychological and socio-political forces that bear down on us and help or hinder individuals in achieving an autonomous consummation of their lives.

This dissertation contributes to scholarly literature on medicalization: to wit, when do medical interventions become socially (and spiritually) iatrogenic, harming the capacities of individuals and communities to meet life cycle events with their own autonomous resources? It engages the philosophy of medicine to task about appropriate limits to medicine; yet it is also cognizant that we live in a moment of intense cultural division and pluralism, and understands that autonomous (here, deeply free and responsible) control over one’s life is difficult to synthesize under conditions of plurality, social change, and technological innovation, which have led many to despair.

Through dialectical engagement with Don Browning and Karl Rahner, I posited a synthetically exegeted understanding of “mature autonomy” that includes both widening care, “a grand-generativity” which I held to be normative for the individual who ought to mature morally through the life cycle, along with the increasing capacity to commit oneself existentially—to enjoy progressively greater freedom of spirit, freedom from attachments, and the freedom to posit *oneself*—who one has become in time—in an increasingly integrated way. In characterizing autonomy thusly, I moved away from conceiving of autonomy in terms of “consumeristic” choice and the presumptive moral neutrality of “choosing one’s choice.” I argued that autonomy is about who one

is becoming and the capacity to posit oneself with integrity, and indicated that free choices dealing with the concrete situations of life, including medical decision-making, are important sites at which this autonomy is expressed, and may even constitute “fundamental options.”

It is my hope that this work will serve as a significant contribution to scholarship in the fields of theological medical ethics, practical theology, and pastoral care. I hope that Christian clergy, ethicists, and interested laypersons might be led to consider how their congregations might more robustly serve as communities of moral discourse and discernment, to seek ways of combatting ritual degradation, and to reclaim death as a revelatory nodal point within their life together. I anticipate that this work might profitably lead congregations—even “vital basic communities”—to seek retrenchment of the technological and cultural forces that thwart persons’ capacities for deep freedom and responsibility within a milieu characterized by many different and legitimate sources of authority.

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