Can the communion of saints help the search for justice in dying well (enough), “in Abraham’s arms, where Lazarus is poor no longer”?

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How can we practice dying in community? What communal practices nourish positive acts that make dying well (enough)—more than prudent caution in avoiding causing death (killing)? What part of our common ecclesial life as Catholics enables us to accompany dying persons as a gracious return to God? We are twice haunted: most first world deaths result from foreseen end-stage illnesses; mortality is less feared than burdensomeness for caregivers from vulnerable dependence. Of those who die in the hospital, many deaths result from decisions to withhold and withdraw treatments. From ten kinds of desolation about dying, ten parallel consolations are discerned in hopes and outcomes-based best practices.

Keywords: Fears of dying, Hopes for dying well (enough), Best practices improving dying, Cultural memory, Communion of saints, Community of faith

INTRODUCTION

Part A. Death as Biomedical Eventuality and Accompanied Adventure

How can we practice dying in community? What positive communal acts comprise dying well (enough)—beyond prudent caution in avoiding causing death (killing)?¹ What part of our common ecclesial life as Catholics enables us to accompany dying persons as a gracious return to God?

For example, how might we nourish resilient generosity to give ourselves back to God? What do our hearts say? “He alone is sufficient for the heart who made

it” (Newman 2007).² Things we love tell us who we are (Aquinas 1975b, 74–77; White 2002, 103–115; Kreeft 2009, 183).³ An exciting story within each of us reveals a colossal hope-filled arc—evoking not feared loss but promised intimacy—revealing how our created longings become redeemed hungers as wonderfully accompanied among those we eagerly join amidst the Community of Saints (United States Conference of Catholic Bishops, hereafter USCCB 1986, nn. 1, 13, 363).⁴

But we are twice haunted: most first-world deaths result from foreseen end-stage illnesses; mortality is less feared than burdensomeness for caregivers of vulnerable dependents. What biomedical realities and religious truths demonstrably make

dying a better experience—by retrieving practical skills historically called *Ars Moriendi*, or those arts of dying well (enough)? Anticipatory burdensome decline awakens deep mistrust in ten desolations—consoled by ten practical hopes.

At the funeral rites, especially at the celebration of the Eucharistic sacrifice, the Christian Community affirms and expresses the union of the Church on earth with the Church in heaven in the one great communion of saints.... The funeral liturgy mirrored the journey of human life, the Christian pilgrimage to the heavenly Jerusalem. (USCCB 1985/1998, Order of Christian Funerals, 5 n. 13; 15 n. 42)

In Paradisum (USCCB 1985/1998, n. 176).⁵

In paradisum deducant te Angeli: in tuo adventu suscipiant te Martyres, et perducant te in civitatem sanctam Ierusalem	May Angels lead you into paradise; may the Martyrs receive you at your coming and lead you to the holy city of Jerusalem
Chorus Angelorum te suscipiat, et cum Lazaro quondam paupere aeternam habeas requiem	May a choir of Angels receive you, and with Lazarus, who once was poor, may you have eternal rest

Three questions frame this inquiry. From ten kinds of desolation about dying, ten parallel consolations are discerned in hope, and outcomes-based best practices are discussed. A concluding chart reviews the answers.

1. What is a snapshot of contemporary fears of dying?
2. What hopes—for dying well (enough)—come from the Communion of Saints according to that compendium of Catholic beliefs for the community of faith called the *Catechism of the Catholic Church* (hereafter cited as CCC)?

3. What best practices improve dying in community—or make it more just—“In Abraham’s arms...where Lazarus is poor no longer”?

Concise answers here are detailed elsewhere (Buckley and Feldt 2012). Historically, Jesuit voices of justice have culturally re-invented dying in three ways; with spiritual traditions, as a composition of place, and with discernment about self-donation into God.

In Jesuit traditions, we neither come from nor return to God without God’s gracious help—that demonstrably improves dying.

Spiritual traditions from St. Ignatius include meditations, prayers, mental exercises, and directed self-review. We meet Jesus in Gospel stories through reflection, in St. Ignatius’s *Spiritual Exercises*, on sin, the life of Jesus, the Passion of Jesus, and the Resurrection of Jesus, that shapes our reflections on the world, human psychology, and our relationship to God (Ignatius 1992). Disciplined reflection converts narrative stories into directed spiritual dramas of guided divine encounters. One’s role in the divine purposes in the world is determined through prayer and composition of place, examination of points, called analysis, and dialogue with God, called colloquies—in conversations among retreatant, guide, and God (Martz 1962, 27–32; Barthes 1976).

In relation to dying—composition of place (*compositio loci*) is an imaginative construal in which we place ourselves in a biblical passage by inventing responses to being addressed by God and Jesus using our different—especially visual—senses (e.g., Ignatius 1992, exercise 47). By mentally adopting a place as a locale in this pilgrimage of the senses, we are re-located in our encounter with Christ—imaginative tools (poetics) disclose our deepest desires and resistances to divine purposes in meeting Christ (Standaert 2007, 14, 16). Sixteenth-century Jesuit Jerome Nadal

constructed Gospel stories with woodblock images. A geometric perspective displays three-dimensional objects in two dimensions—and renders distance as sequential time—hence the reader is drawn into specific, sensual locales of human drama for meditation (composition of place). Nadal's vivid portrayals of the two stories of Lazarus in the New Testament of miraculous raising (Jn 11) and judgment (Lk 16) invite us to dramatically encounter Jesus who cares for us in our own death and resurrection ("Jesus wept") (Nadal 1595, plates 26, 74–78, 81, 84).

From what can such meditative poetry rescue dying and caregivers? Biblio-therapy remains an unproven cure; yet among incurables, healing of memories, expectations, and anticipation counts as no small gain. Our feared frameworks desperately need reconstruction from foreseen death—ways of decline that risk prolonged burdensomeness for our beloved. Locating ourselves by recalling the expressive drama of Jesus' encounter with Lazarus and his care-giving sisters heals our past memories with anticipated accompaniment. Imaginatively connected visual settings—linkages rhetorically termed *loci* ("locations")—were also called a "memory palace" as popularized by the sixteenth-century Jesuit Matteo Ricci (Spence 1985).

St. Ignatius's diverse heritage shapes end-of-life decision making with "discernment" that has multiple meanings with regard to good dying. Discernment not only distinguishes between good and evil spirits within a self as an ethic of character (lower and higher satisfactions)—it also reaches toward wholesome care for other persons (flourishing in aesthetic categories) and union with God (mysticism).

Dying well includes deliberate choices rooted in Ignatius's "Discernment of Spirits" (Ignatius 1992, 135, 165–189, 313–336). What Canadian Jesuit Bernard Lonergan said of his own work and of the German Karl Rahner's work is similarly

true for American John Kavanaugh: each originated in discernment. Lonergan's book *Insight* retrieved twentieth-century sources for how our intellects function in discernment (Lonergan 1980; Siebenrock 2007). Ignatius's second week of exercises includes "The Two Standards"—also termed kingdoms. These shape John Kavanaugh's discernment of how consumer culture forms choices for living and dying as illustrated in his chart "The Commodity Form and the Personal Form" (Kavanaugh 2006, 124–126).

Much of Rahner's complex method of theology—and his theology of death—originate in Ignatius's rules for the discernment of spirits for the second thematic week of an Ignatian retreat (Rahner 1964, 1965, 1982).

Why does Rahner argue that the help we owe the dying is freedom to embrace death as an act of religiously ultimate meaning (e.g., in an existential way)? It is because everything must serve as a free opportunity for self-donation into God as Mystery—that can happen prior to imminent death (Rahner 1975/1981). Rahner's understanding of how we discern human and religious freedom of the sick decisively influences his own claims about persons who are dying. Here, Rahner unites classic religious views about incarnation with redemption. Dying—like living—is an opportunity for self-disposal into God that God aids and accompanies in Jesus Christ and others. God's saving self-disclosure in Jesus Christ graciously helps each dying person to choreograph six complex kinds of free, embodied self-awareness that reach out or transcend, including ultimate self-disposal into God, spontaneous desires, autonomy, a world that serves freedoms, a world of natural purposes, and authenticity (Buckley 1994, I: 178).

Ignatian voices have shaped dying into a communal performance. Dying is discerned as good—or better—when one deliberately

strives (has a preferential option) against internalized impoverishment (Arrupe 1977, 381) in accompanied self-disposition (Fitzgerald 2006; Nadal 1595) into Mystery (Rahner 1975/1981) with rights to pain management (Hollenbach 1979). Thus, we discern how care is proportionate for a death of one's own (McCormick 1997). This involves prudent action and character (Keenan 1993) in participatory struggles (Daens in John XXIII 1961: n. 236; Grande in Romero 1985, 22; Brackley 2005) through rituals of communal meaning (Sicard 1975) in solidarity against fearsome isolation vigilant for private divinization (Bresnahan 1995).

Dying becomes good by encouraging generous self-giving to God with Christ. We do not miserably relinquish our individual mortal lives—but are encouraged to dispose ourselves into God with generous accompaniment from our Communion of Saints. Dying well is more than what we passively tolerate—but a performance in which we actively participate by imaginative self-donation. Nadal's woodcuts remind us: dying and caregivers are not invited to simply passively repose in God's presence, rather to actively dispose ourselves as composed in place, accompanied by Jesus.

Care is neither merely a domestic duty nor a professional obligation—but shared ministry for all the baptized who “believe what they read, teach what they believe, and practice what they teach” (1 Pt 2: 5–9; CCC 1547; USCCB 2003).

Part B. Shift Conversation from Causing Death to Performing Dying

Why did lectionary prayers shift by 1981 from 1969's “for a happy death” to “for the Grace of a happy death”? (USCCB 1969/2002).⁶ Adapted pleas bespeak evolving needs: people now die differently. The Gospels are clear: Jesus foresaw, predicted,

and performed his own death as a passage, not merely a passive death event. His invitation to follow and imitate him is no simple demand to emulate his dying.

Prior ages featured pre-modern deaths by pestilence and famine, then receding pandemics until the mid-eighteenth century, followed by degenerative and man-made diseases in early twentieth-century first and second worlds. Causes of death shape our experiences of dying as cultural performances—whether from heart disease, stroke, cancer, or chronic obstructive pulmonary disease (COPD). Earlier assumptions about causes of death (mortalities) also constructed dying processes as imaginatively performed dramas (poetics). After the fourteenth-century Bubonic (black death) pandemic, deathbed struggles between angels and demons popular during subsequent *Ars Moriendi* ritual traditions shaped fears of post-mortal judgment as a gateway to eternal rest.

Thus, our fourth epidemiological transition of delayed degenerative diseases has provoked three responses from the late twentieth and early twenty-first centuries (Vallin 2007, 384–386). Changes in the public health debate whether a good death enables or requires decriminalization, legalization, or regulation of assisted death.

First, beliefs about accompaniment and abandonment shape dying processes for subjects in central Europe in contrast to making way for the death events of agents in Anglo-American cultures (Ricoeur 2006a, 347; Buckley 1994).

Second, new kinds of dying from end-stage illnesses with foreseen outcomes fragment portions of *Ars Moriendi* traditions and re-invent others in novel forms. Is that care best which accompanies dying by family and caregivers, or simply relinquishes inappropriate treatment? Differently weighted alternatives are not false dilemmas (International Theological Commission, hereafter ITC, 2012).

Third, some central and northern European cultures of socialized health care have legalized assisted suicide by procedurally restricting access that determines who is eligible to receive it and perform it under specific guidelines; e.g., Netherlands, Belgium, and Switzerland. Other European nations instead debate decriminalization of assisted suicide—that is, discretionary prosecutions are confined to procedural violations of specific laws (e.g., Germany, France, and United Kingdom). In these contexts of legalization-decriminalization debates, key texts are the only ecumenically Christian-Catholic church documents in the world on assisted suicide. German Catholic and Evangelical-Reformed bishops, French pastors, and Paul Ricoeur argue that we should not assist death but accompany the dying (Ricoeur 2006b; German Bishops 1975–2010; French Bishops 1991). In contrast, American accounts take place in legal contexts of legalization-decriminalization debates that additionally include regulation of self-termination. Here, specific documents recurrently recommend we desist intrusive overtreatment as its own form of the ministry of Jesus' compassion (Catholic Church, USCCB 2009; Episcopal Diocese of Washington DC 1997; Presbyterian Church 1995; United Church of Christ 2011; Evangelical Lutheran Church of America 1992, 1999).

PART I: AMERICAN WAYS OF DYING: TEN FEARS OF MEANINGLESS, LONELY DYING

Even people who want to go to heaven don't want to die to get there. (Jobs 2005)

What makes many uneasy about dying? Clinical data recurrently reports at least ten reasonable fears about dying alone—as desolations: (1) a new purgatory of

prolonged dying by inappropriate treatments; includes (2) desisted treatment as feared abandonment; (3) end-stage decline and dependency related to institutionalization with (4) poorly managed pain and (5) feared incapacity from end-of-life depression because (6) advance directives do not guarantee improved care for the incapacitated. (7) Inadequate continuity of care includes (8) burdensome costs, and (9) feared caregiver compassion fatigue with (10) misplaced trust in prayer as bad medicine because of negative private cultural beliefs in individual spiritual well-being and religious practices.

In contrast, the Communion of Saints invite us to consider ten reasonable hopes which accompany dying and death—as consolations based on different kinds of justice. Our restlessness about eternal rest encounters (1) a lifelong entreaty to God's friendship with communal support that nourishes a response (2) encouraging generous self-donation from “composed places” accompanied by Jesus (3) returning to our origin after an exciting common pilgrimage. (4) The dying experience compassionate pain management (5) and are sustained in passionate commitments to overcome indifference. (6) Communities nurture well-founded hopes that recalibrate care after the end of cure for reconciliatory healing (7) amidst our anticipatory memory of constant accompaniment. (8) Impoverished fears invite us to hear again—our preferential option—that good news (9) which joins us to the prayer of Jesus in the “hour of our death” in the “arms of Abraham” (Lk 16:22). (10) Our prayer enacts (performs) accompanied trust with Lazarus, “no longer poor.”

Ordinary language about death and dying reveals key assumptions. Metaphors help us understand (cognitively) and respond (affectively) by enacting (“performing”) our experiences of dying. Is dying well best understood as befriending death

(Nouwen 2009; Bernadine 1998, 127) or as pilgrim fellowship (Ratzinger 1996, 2005, 129 n. 4), as accompanied presence (Fitzgerald 2006), as self-giving into Mystery (Rahner 1975/1981), or as enabling some kind of trait of character among the dying—whether patience (John Paul II in Walter 2011), obedience (Jonathan Daniels in Walter 2011), love (Bowman in Walter 2011), healing (Sulmasy 2010) or living toward a good death (Tolstoy in Walter 2011) (Walter 2011)?

Between 1945 and 1989—amidst an emerging surplus of cures, our death anguish became medicalized, as most American English metaphors for death and dying emphasized negative passive characteristics—especially how individuals become an “anticipatory physical corpse” as spatially oriented property (Bishop 2011). Common expressions reflect shifts from cardiopulmonary to brain-centered criteria for death. Terms refer to physiological effects of death (she expired, heart failed), as movement (she slipped away or dropped dead), sleep (the long sleep), loss (lost life), surrender (relinquished life), or “light gone out” (extinguished), personifications (hand of death), and eschatological expressions (last gasp, untimely end) (Bultinck 1998, 59).

Contemporary Purgatory of Inappropriate Treatment by Franchised Dying

Preventable suffering can be reduced among supervised dying persons. Fears of over- and under-treatment in dying are micro-pictures influenced by macro-structures. In 1963, investigative journalist Jessica Mittford published a now famous disclosure of ways in which the funeral industry manipulated bereavement for economic gain (Mittford 1963/1998). Parallels are telling: “demand-based” economies of health care

at the end of life in the United States interpret dying in competitively medicalized contexts. Half of the world’s population now lives in cities; some 82 percent of Americans live near an urban area with acute care facilities. North America contains 4.5 percent of the world’s population yet 30 percent of the world’s hospitals. About 2.4 million die in the USA each year, yet some 80 percent of Americans today believe technology can always rescue them (Callahan 2008, 30–32).

It is routine—but shortsighted—to lionize or villainize technology for medicalizing dying. Both neglect how urbanization concentrates efficiencies for markets; these enable and constrain resource macro-allocation (rationing), micro-allocation (access), and what end-of-life care counts as cost-effective—which is to say, reimbursable by third party payers. It is the franchising of dying by reimbursement that influences uneven referrals. Healthcare professionals additionally become employee-providers; patients simultaneously become clients, and clinical practice becomes litigation averse—which frustrates rather than enhances good dying and death. In American common law, palliative sedation for a terminal condition has emerged from a twentieth-century medical model requiring permission for an acute intervention.

Yet, an ethos of discrete treatment interventions reveals why decisions are not well coordinated to manage end-stage pain. Counter-claims about a “healthcare system” reduce wellness to efficiently re-imbursed. Critics charge that the overwhelming influence (“hegemony”) of re-imburement bureaucracies are disorganized patchwork quilts privileging franchised wealth-care for billably ill.

What challenges dying well? Individual stories (narratives) do not always reflect wider trends. Some dying in the United States is enviable and world-class—yet

why do so many persons experience dying in hospitals as hostile to effective pain relief? We already know how more individuals might experience hospices that are hospitable to good dying with key “best practices.” These include defining treatment goals, learning to die well, and accepting dependence at the end of life among clinicians, family caregivers, and wise patient choices (Byock 1997, 2012).

Complex answers are practical rather than unattainable. We know what does not work. Some hospitalized dying exposes patients to treatments that include avoidable medical errors (iatrogenic events), are medically ineffective or burdensome (futile), or are inappropriate to disease outcomes (over-utilize health services). Demonstrably futile treatments and over-treatments dehumanize dying by disconnecting it from care-giving communities. They depersonalize care by treating principally the body and ignoring spiritual needs. They individualize dying by focusing on personal choice rather than shared decision making and risk consumerizing dying by making patients into clients whose dying processes are coverable benefits—with pre-death technology targeting billable events—that are not actually necessary to change outcomes (Buckley and Feldt 2012, VII).

Originally designed as a care approach for cancer patients, patients can meet hospice criteria if they have a six-month life expectancy with other end-stage diseases (congestive heart failure, COPD, Parkinson’s disease, and dementia) (Rogers 2009, 4–8; Prince-Paul 2009, 13–17). Hospice care can occur in many different places, in the patient’s home (if she has a caregiver), in an assisted living or nursing home, or in a hospice facility. However, dramatic regional variations in hospice referrals show a reluctance to relinquish end-stage aggressive treatments by patients, caregivers, and health care. One

out of six Americans (some fifty million) are uninsured. Nearly one hundred thousand deaths each year are due to underinsurance—that, in 2010, equals three times the number of auto fatalities and four times the number of HIV/AIDS related deaths (Navarro 2003, 56–62).

Desisted Treatment Is (Mis)-perceived as Abandonment

Franchised dying routinizes access to referral into presumed treatments. However, shifting patient conditions and medical technologies renegotiate boundaries between expected care and discretionary treatments. Two questions are key: who decides and how? A patient or valid proxy should decide based on well-informed advice. One threshold is “futile treatment.” For example, is nutrition and hydration always basic, required care like feeding or sometimes a treatment like medicine subject to judgments of benefit and burden?

From 1987 to 1994, Catholic officials debated and eventually adopted prudential policies (called *tutorist*) which argued that vulnerably incapacitated persons should be presumed to receive medically assisted feeding as ordinary care—unless such care was “insufficiently beneficial or excessively burdensome” (USCCB 2009, 29). Withholding or withdrawing such care was not abandonment—but acknowledgement that “the duty to preserve life is not absolute” (USCCB 2009, n. 58).

For the first time in history, most people in the developed world—perhaps 70 to 80 percent, face death at a comparatively predictable time, later in life from diseases with long, generally foreseen deteriorative declines. Among the most recently available comparative national data—for 2010 in the USA and central Europe—heart disease, cancer, stroke, and COPD are among the

top five causes of death (CDC 2013, 13, 58; German Helmholtz Association 2010). Of those who die in the hospital, many deaths result from decisions to withhold or withdraw treatment by patient informed consent or designated surrogate(s) (Melhado and Byers 2011, 16–28). Yet, such desisted treatments can be (mis-) perceived by patients and caregivers as abandonment—especially when a DNR is misinterpreted as relinquishing care (Sulmasy and Snyder 2010, 1946–1947). There is not only uneven compliance but also wide interpretation of documented DNR orders for inpatients. The quality of care plans for interpreting boundaries of life-sustaining treatments in end-of-life care do not adequately distinguish issues of intubation, blood pressure therapy, ANH, antibiotics, dialysis, spiritual needs, and adjustments of sedatives/analgesics (Sulmasy, Sood, and Ury 2004, 1573–1578).

End-stage Decline and Dependency Are Exemplified by Institutionalized Deaths

On the day they die, half of the people know where they are. Although most persons want to die at home surrounded by loved ones, chances remain slim: most Americans (60 percent) actually die in the hospital, and 20 percent of these die in intensive care units (ICU)—whereas another 20–25 percent die in nursing homes (Lusardi, Jodka, and Stambovsky 2011, 46–57). Deaths in institutions and ICU are not reported as “good” by family caregivers (Teno et al. 2005, 1905–11).

Pain Remains Poorly Managed

Few believe the dying must suffer unto death, yet undertreated pain generally and especially at the end of life remains widespread (Hamel and DuBose 1996). This is due to practical rather than unfeasible

barriers such as patient misplaced fears of addiction, exaggerated caregiver concerns about lethal risks from competent opioid use, cultures of provider under-prescriptions, and fears of regulator sanctions (Smith et al. 2010, 563–569). Only perhaps 10 percent of pain cannot be relieved by appropriate measures (Ingham, Portenoy, and Mohamudally 2009, 203–222). If physicians and hospitals can provide the world’s most advanced treatment, why is the experience of pain in the dying so poorly addressed (Teno et al. 2007, 120–125)? In industrialized societies like the USA, the most preventable suffering occurs among supervised dying. Owing to the unpredictable nature of dying among particular patients, nearly eight out of every ten hospital deaths occur without a palliative care consultation or formal pain management plan (Pan et al. 2001; Smits, Furetti, and Vladeck 2002). Between 26 and 50 percent of patients are reported to have pain that was undertreated at the end of life—including more than 70 percent of all Medicare decedents (Fineberg et al. 2006; Imhof and Kaskie 2008, 908). A third of people enrolled in hospice report pain at the last hospice care visit before death (Institute of Medicine 2011).

In clinical terms, suffering is a subjective appropriation and interpretation of a grammar of affliction. It distinguishes pain as a stimulus response from traumatic events, specific injuries, resulting disabilities, morally and legally blameworthy harm, objective diseases (epidemiologies) that are chronic, acute, and terminal, including subjectively perceived sickness and illness and challenges to mental wellness (Cassell 1999).

End-of-life Depression Neither Inevitable nor Incapacitating

Many older adults and dying patients experience depression in unique ways that

impact end-of-life decisions, but need not completely incapacitate (National Institute of Mental Health 2011). Depression is not automatically equated with legal incompetence nor decisional incapacity. Clinical (unipolar) depression is neither a normal nor inevitable part of the dying process; not all mood-related disorders are depression. Yet, depression remains both widely un(der)treated and demonstrably capable of effective treatment; approximately 80 percent of persons with depressive disorders go untreated while 80 to 90 percent of those treated find relief (Werth 2004, 627–629). Un(der)treated depression “is the most commonly identified reason that leads patients to seek hastened death,” with a prevalence of depression among terminal patients at 20 to 50 percent (Rosenblatt and Block 2001, 320–325). Among those choosing physician-assisted death in Oregon, some data show co-morbid depression is under-diagnosed, and under-referred for psychiatric evaluations (contrast Leven and Parker 2011 with Dore 2011).

Advance Directives Help Does Not Guarantee Improved Care for Decisionally Incapacitated

For those unable to make decisions, some advance directives improve certain kinds of care (White et al. 2007, 34–40). Key questions remain: who decides (patients and valid proxies) and how? No instrument is perfect. Different audiences and jurisdictions interpret each tool in diverse ways. Several tools demonstrably improved predecessors. Living wills (1969) offered helpful planning—like property disposal—but remain limited by clinical vagueness. Advanced directives (1990) are good at delegating real-time decisions about specific treatment decisions but limited by changing conditions and technologies.

Pre-commitments and values histories (1988+) help caregivers with future goals, but are limited when prior autonomous decisions must be re-calibrated for evolving patient well-being (e.g., POLST, MOLST, Five Wishes) (Brugger et al. 2013). Some argue that current tools and their usage can be improved—others point to a range of limits; for example, there is patient under-usage (only 5–25 percent have directives), patient under-compliance (most want “leeway”), and patient non-adherence due to proxy bias (one-third make errors), language inadequacies, new situations, and misguided ambitions to micromanage death (Buckley and Feldt 2012, II).

Who Cares? Fragmented Care Is Inadequate

Many dying persons and caregivers experience frustrations among fragmented, specialized healthcare providers, and institutions. Reasons are complicated by diverse needs, technologized health care, complex third-party payment systems, and different experiences of pain and palliation (Dartmouth Atlas).

Because understandings of care are widespread in professional and popular literature, but have cultural origins in central Europe, it helps to concisely review key meanings regarding Reich’s research into a western fourfold “myth of care” including traits, affects, interactions, and interventions. Historical meanings of care include (1) care as affect: trouble, grief, modern anxiety, or contemporary anguish, etymologically derived from the German words *kar/carü*. (2) Care as solicitude names concern for people, discourses, groups of practices such as institutions and organizations. (3) Care can also refer to care-filled, responsible, specific attention to precise competencies or exact skills. (4)

Caring about concerns a particular person and her growth (Reich 2004; Jecker and Reich 2004; Fry 2004)—explored in Gilligan's critique of Kohlberg's androcentrism (Gilligan, 1982).

Different economies express care. Socialized medicine in central European command economies features caregiver paternalism ("doctor knows best"). This includes general care (called *Sorge*), social services (*Fürsorge*), and pastoral care (*Seelsorge*). These each position healthcare professionals as part of (integrated) state services for the needy—with overlapping private and sometimes religious sectors (Sulmasy 2005). North American health care includes traits, affects, interactions, and interventions but has emerged in demand-based healthcare economies with evolving third-party payment systems largely based on employee insurance—and patient-rights movements focused on informed consent narrowed down to decisional capacity that includes shared decision making amidst mobile kinship networks (Faden, Beauchamp, and King 1986).

Gendered Elder Care-Giving Inequitably Burdens Women

Gendered elder-caregiving poses inequitable risks. Debates about healthcare reform have opened up complex discussions about who has access and who pays—as well as the realization that good dying exceeds sheer economic interpretations of cost, price, expense, and value. However, a perception by fragile dying patients of being a genuine burden demonstrates inequities caused by amenable dysfunctions. Sociological data report four ways that eldercare is "gendered" in binary role relations in central Europe and North America: working women provide socially under-

supported care for older women who are themselves increasingly intensive users of under-resourced care services (Holstein and Mitzen 2001; President's Council on Bioethics 2005). More are aging, and costs are rising; every day, seven thousand new Americans join Medicare; a baby boomer couple who reach retirement and have paid \$114,000 in Medicare payroll taxes will typically require medical care costs exceeding \$350,000 (Nordqvist 2011).

Dying Exhausts Caregivers with Compassion Fatigue

Dying incapacitates patients: empathic care-giving risks incapacitating caregivers. Illness and dying all too often convert beloved families into sometimes ill-prepared caregivers always on call (Levine 2004). Is sharing human vulnerability (care-giving generativity) a threat or basic value for humans and communities? The loss of self in compassion fatigue (coined by Joinson 1992 (116–121) for risks of professional caregivers) is different from the emotional exhaustion of burnout, symptoms similar to post-traumatic stress disorder and cognitive changes from vicarious trauma (Bush 2009).

What are social laboratories of assisted death telling us (Oregon, Washington, Montana, and Vermont)? End-stage cancer (morbidity) accounts for four out of five Oregonians who have chosen lethal self-administration since 1997. Most cancer patients do not have cognitive impairments faced by other end-stage illnesses. In these groups, autonomy aspirations and perceptions of burdensomeness outweigh pain management issues, although some 85 percent die in hospice and virtually all are insured (Oregon State Website).

What Improves Dying: Individual Spiritual Quests or Group Religious Practices?

Is prayer medicine? Different spiritual quests and religious practices improve and worsen dying. Some experience a return to God as divine “other” negatively as emptiness (apophatic), and others as fullness (cataphatic). Do these experiences presume we—or God—are beings with property or responsive to appreciative self-donation (Marion 1991, 2002; Honneth 1996)? Catholic traditions offer prayer in many kinds (CCC n. 2700ff) and forms (CCC n. 2626ff)—as well as varieties of spiritualities, mysticisms, religious and secular ways of life and dying; Augustinian, Benedictine, Carmelite, Cistercian, Dominican, Franciscan, and Ignatian—to name merely a few (McGinn 2006, Lamm 2013).

Dying well comes in different ways: from trust in cosmic order where God is in control (Pevy, Jones, and Yarber 2009); prayers (Balboni et al. 2011); accompanied friendship (Fitzgerald 2006); guilt and shame (Satterly 2001); anger with God (Exline et al. 2011); hope in afterlife (Dezutter et al. 2009); and belief in miraculous cure (Sulmasy 2006a, b, c). Pope John Paul II’s 1984 letter—in part VI called “The Gospel of Suffering”—explains how suffering can enable inner conversion (John Paul II 1984).

At the end of life, how is spiritual well-being measured differently in stories, social functions, and symbolic connections (Buckley and Feldt 2012, XVI)? Hundreds of scholarly research articles have interpreted and applied “spirituality” according to dozens of “assessment” criteria (Gijsbert et al. 2011, 852–863).

Three questions recur: existential meanings, social functions, and symbolic interconnections. What answers do we hear from dying persons and caregivers? (1) Why is pancreatic cancer ending my

life? For both religious and nonreligious persons, some find that the biggest challenge posed by their dying is personal existential meaning. Narratives or stories interpret experience (phenomenology) that yields coping attitudes and behaviors (e.g., avoiding punishment images or anger-blame to God).

(2) For some, the main challenge of dying is a surrounding culture perceived as foreign (secular); viz., Will heart surgery cure my doubts about God’s love? Social practices of confessional belonging influence a willingness to seek support, use prayer and aggressive end-of-life treatments.

(3) For some the chief religious challenge of dying in pluralist cultures is diversity—hence the challenges become: how does my dying connect me socially and naturally; viz., How can my incurable cancer make a more just, sustainable, and humane world? Different cultural and professional competencies re-interpret our embodied identities within larger social and natural frameworks with different kinds of structuralisms.

Key assumptions rely on widely debated terms; viz., When is a person dying; facing imminent death or end-stage illness, terminally ill, or expecting to die, those for whom treatments are ineffective, too burdensome or too costly called futile? What does improvement mean and for whom?

PART II: TEN CATHOLIC STYLES OF DYING “IN ABRAHAM’S ARMS”

“We have all known the long loneliness and we have learned that the only solution is love and that love comes with community.... We are to be pruned as the vine is pruned so it can bear fruit.” Dorothy Day on Peter Maurin’s death (Day 1952, 273–280).

“[Rosa] Come, we are going for our people....” Edith Stein to her sister on

their arrest and deportation to Auschwitz (Hamans 2010, 68).

I have often been threatened with death.... If they kill me, I shall arise in the Salvadoran people. If the threats come to be fulfilled, from this moment I offer my blood to God for the redemption and resurrection of El Salvador (Romero 1985, 50–51).

Father Henri Nouwen, a friend of mine for more than twenty-five years paid me visit.... he talked about the importance of looking upon death as a friend rather than an enemy (Bernadine 1998, 127; Nouwen 2009, xi).

What does it mean to “give oneself up,” “lay down one’s life” or “be pruned”—or personify death as “friend”?

Nourished Against the “New Loneliness” by an “Abundant Harvest of Good”

Hospitalized dying subdues nature yet places us in a crowded world at risk to new forms of lonely anonymity (Paul VI 1971, n. 10). We are not alone but “beings with”; capable of enjoying that abundant harvest of good from the community of faith and Communion of Saints (Vatican Council II 1965b, n. 40). Every covenant and promise in our sacred texts is between a community and God—not only individuals (Ratzinger 1999).

Answers to “Who are we?” come in part from reviewing “Of what communities are we a member?” Who or what is the Communion of Saints? Those who contrast discontinuities with human communities in the world (as “secular”) choose the language of “communion” and “pilgrim fellowship” (Gustafson 2004; Ratzinger 1996, 2005, 129n4). Others affirm connections to larger communities as “People of God” and “companions” (Johnson 1999, 2003). Masters of suspicion warn

against self-projections (Marx, Nietzsche, and Freud in Ricoeur 1977, 33). Others caution against excess religious enthusiasms that glorify refuge in supposedly secure religious identity against others: these institutionalize communion type ecclesiologies (clericalizing, juridicizing, and triumphalizing) or divinize invisible biological metaphors (Body of Christ, Mystical Communion, CCC nn. 946–952; Dulles 1974/2002, 47–48).

Based on the understanding of God revealed by Jesus and the Holy Spirit (Trinity), the Communion of Saints refers to four items (CCC nn. 946–952; 960–1):

1. a universal call to be close to God in Christ (Vatican Council II 1965b, n. 40) especially among the community of faith on earth (CCC, n. 771). The Communion of Saints also refers to the
2. spiritual union among members of the Church, dead and
3. living (Apostles Creed).
4. It also refers to a consensus across many Christian traditions about
 - 4.1 what is holy (*sancta* including faith, sacraments, goods, charisms, and charity, CCC n. 960) and
 - 4.2 who are holy (*sancti*—pilgrims, purified, and glorified, n. 961).

Historic and ongoing disagreement continues among different Christian traditions about two items. First, in what kind of categories do we understand those who have gone before us—and are now with God? Secondly, how do these predecessors relate to us (as companions) and Jesus Christ, the Father, and the Holy Spirit (as mediators of God’s salvation)? The *Catechism* uses both meanings (CCC nn. 956–958). An egalitarian model understands our relationships with saints as companions and friends. A patriarchal model frames certain privileged dead into positions of hierarchical patronage. Liturgical changes at Vatican II encourage a

return to the paschal mystery with saints as friends and fellow disciples of Jesus—and with Mary as a way to learn the truth about Jesus (Dulles 2006, 24–29). Respectful veneration of (physically) dead persons who direct us to God incarnate is not adoration (CCC 2132). Invocation of the communion of saints is not evocation of spirits called “spiritualism” (CCC n. 958; ITC 1992, n. 7.2). As Augustine insisted, no lionization of the dead should lead to marginalization of the needs of the living (Beatrice 1999, 161–162).

BEST PRACTICES: “Pray Always” Connects Us to the Communion of Saints

Why “pray always” (1 Th 5: 16–17)? Prayer is gift, promise, and communion (CCC nn. 2558–2559). Our prayer does not first speak but listens: we are “hearers of a Word” spoken to us, not alone—nor on a fated bleak journey of urbanized demise in postmodern annihilation—but as befriended among those who have gone before us who bear us up as companions along a pilgrimage. “Pray always” shifts language from that of anxiety about a solitary afflicted journey to graciously accompanied self-disposition on a gifted itinerary. We (re)turn to God with others (1 Th 5:17; CCC nn. 2633, 2742; Evangelicals and Catholics Together 2003). The ERDs (USCCB 2009) recommend “appropriate” decisions some fourteen times—in contexts of religiously based discernment. German pastors state: “We owe the sick not help to die, but help in dying” (German Bishops 1975 in 1975/2010).⁷

Equip Saints with an “Optimism of the Redeemed” (Schönborn 1993)

Faith offers an “optimism of the redeemed”—not boosterism for the

confident (Ratzinger 1993, 469–484). Trust comes not from what we tell ourselves but what we have been told by another (e.g., “Do not let your hearts be troubled”) (Jn 14:17). Effective catechesis proclaims shared living in our community of faith that helps good dying among a Communion of Saints. The whole concern of catechesis is a love of Christ that nourishes our own (CCC n. 25). German pastors are clear that suffering is not personal punishment of abandonment, but solidarity with Jesus that begins in life (German Bishops 1996 in 1975/2010).

Dying persons can experience redemption, liberation, and salvation—in culturally embodied catechesis. This happens with post-catechetical education into mystical beliefs called mystagogy. Jesuit guides help us encounter Jesus in Jesus’ coming (incarnation), life (ministry), dying (passion), death-resurrection-ascension (paschal mystery), and their impact (redemption). While our individual faith is a personal surrender-assent to a prior word of God in revelation, our beliefs are expressed in credal, confessional, communal, and cultural statements that no one seriously simply equates (Dulles 1985).

Thus catechesis is embodied truth that is performed—as event, process, and content. It is a vital part of the ministry of the Word—connected to the Eucharist. And this Eucharist is a memorial of the paschal mystery (Irwin 2005, 122–145). Liturgy, sacraments, prayer, and morality (CCC n. 13) attest to how God is near, Christ has gone before us, and the saints accompany us in last truths (eschatology) of death (CCC n. 1020–1060), judgment (n. 677), heaven (n. 1024), and hell (n. 1035).

Catechesis consists not of memorized formulas or pejorative indoctrination. Rather—it means embodied training in justice through speaking, hearing, and proclaiming—a culturally vital interchange, literally “to sound down” (into the ears) (CCC n. 5).

To understand catechesis in terms of different kinds of justice, many adapt a reflective method adopted by Vatican II called “see-judge-act.” Pope John XXIII first used the approach in his 1961 encyclical *Mater et Magistra* based on recommendations of Cardinal Joseph Cardijn’s pastoral work with student and workers’ movements—influenced by Jesuit Adolf Daens (John XXIII 1961, n. 236). Effective catechesis is a grace-filled event, process, and content of justice that emancipates both women and men in societies and churches (Schussler Fiorenza 1994, 53–80). Catechesis suggests dying persons—with their unique “liberty as children of God”—experience redemption, salvation, and liberation through Christ in cultures as already communally underway, inviting their contribution to a shared destiny (CCC n. 1741).

Understandings of “redemption” presuppose cultural interpretations of “political economy.” Earlier meanings of redemption—influenced by Paul—focused on God and Jesus and our participation in becoming “at-one” with God through Jesus’ “atonement”—understood variously as moral change, ransom, satisfaction through just restitution or penal substitution, or God’s just governance of the world (Burns 1975, 285–304; CCC nn. 601–615; Finlan 2005, 2007).⁸

Anticipation changes dying and caregivers: redemption is less an individually achieved task than a received mystery involving the Trinity and our world. God self-communicates as a relation (Trinity) who reveals redemption (called “economy”) through the Communion of Saints by justice experienced in our cultures (CCC nn. 54–73, 232–237). Liturgy, prayer, and growth in holiness come to dying and caregivers as sanctification—through culture and the Communion of Saints—that redeems our dying and the world—it does not merely repeat his death.

In 1948, enculturation was synonymous with socialization. By 1965, Vatican II described relationships between faith and culture. Catechetical documents beginning in 1979 began to describe a dual process between Christian religions and cultures called enculturation. Cardinal Ratzinger (1988 in 2009, 1993) and later Pope Benedict (2006) framed the issue as one universal truth in the plurality of cultures called interculturalism (Follo 2010).

The *Catechism* as content is now being reflectively applied as acts and processes across cultures. Evangelization is connected to the different elements of the life and message of Jesus Christ—it means bringing the Good News of Jesus into every human situation—through cultural formation.

The experience of dying improves as a religious act. Good dying—as a practical mystagogy of accompanied self-donation—is enhanced by different understandings of charity (between persons) and justice (among persons). Dying is a comparatively better experience when it reflects considerations of justice as equality (informed consent and decisional capacity), need (depression, compassion fatigue, pain management), merit (futility, brain death), productivity-contribution (end-of-life costs), justly sharing burdens of dysfunctions, and justice as fairness (cultural competencies) (Buckley and Feldt 2012).⁹

BEST PRACTICE: Shift from Good Friday Passion Relinquishment to Easter Paschal Solidarity

Why is it important to re-imagine our dying from emphasizing simply sacrificial relinquishment to accompanied self-donation? The argument shifts from desisted treatment for embodied property to self-donation for accompanied living and dying.

Pastoral practices and philosophical shifts change public debates. In comparative

anthropology, sacrifice—especially of self—is a central feature among diverse cultures. This is illustrated in Jesus, the Gospels, and Christian traditions of martyrs and saints (Bell 1997, 98–115). Sacrifice is an important feature of our religious tradition and personal experience—but it is not the final word. As Pope Benedict reminded us, the centrality of the Cross must not reduce love to bitterness, nor forget the Resurrection (Benedict XVI 2006).¹⁰ Catholic traditions have historically prized different forms of sacrifice for their roles in character development called sanctification—but have not always equally recognized how Jesus’ sacrifice and Resurrection transforms our own. The road to Calvary is not never-ending (Bradley 2005, 148).

Our Church offers us pastoral guidance. Close scrutiny of four decades of the only ecumenical texts in the world about assisted death from central Europe demonstrate a masterful re-interpretation of “paschal mystery” from a “Good Friday” to “Easter Sunday” paradigm. Although the term “paschal mystery” appears only twelve times among four of sixteen conciliar texts, central European pastors who write about end-of-life reasoning, nowhere cite texts of Jesus’ passion.¹¹ Instead, in their public arguments about accompanied dying, they only use texts from funeral liturgies with Easter images from scripture. What this means is that an earlier model of “personally afflictive identification with the literal suffering of Jesus’ physical passion” was popular in fifteenth- and sixteenth-century *Ars Moriendi* traditions following times of acute pandemic deaths with anxieties about individual post-mortal judgment. Tormented deathbed desolations brought consolations from ritual protocols by “virtual clergy” displayed in woodblocks of *Ars Moriendi*. Yet these contrast with Nadal’s consolations in Jesus’ company.

The current “Order of Christian Funerals” revised after Vatican II in the 1970s

and then again in 1989 in English translation, emphasizes “the paschal mystery” of Jesus’ life, passion, death, resurrection, and ascension (USCCB 1985/1998, nn. 1, 2, 8, 9 etc.). Prayers teach us to trust in the transformative accompaniment of the saints: this impacts what we remember, expect, and anticipate about a good dying. The Trinitarian and relational basis of the communion of saints enables us to hear and pray the *Prayer of the Hour of Jesus* (CCC n. 2746ff). In the fellowship of the Trinity, Jesus gives himself back to God the Father (CCC nn. 232, 248, 264, 1010, 2746).

What are practical implications of this shift from passion to paschal mystery? At a funeral we hear and sing consolation images (epideictic rhetoric) that construct meaning: “May Angels lead you into paradise... into the arms of Abraham... with Lazarus who is no longer poor...” This prayer dramatically involves the person. It composes us as confidently among the Communion of Saints. The invocative discourse of ritual petition for and about one who is now deceased in the past becomes (e)vocatively addressed doubly to the presently deceased for a currently bereaved audience with a consoling past memory in anticipation of a future shared expectation at the moment (Sicard 1988, 238; Walker 2000, 4–17, 277). Politics connects with poetics in catharsis, reversal, plot, and character (Aristotle 1998, 13; Lysik 2004, 2, 397; Irwin 2002). Human life is a social drama—not a solo virtuosi performance—that does not pander to a private wish for individual post-mortal resuscitation, re-animation, or re-incarnation.

Shift from Location of Death to Destination in God among the Saints

The question shifts: from where I die to among whom shall I conclude one life and

begin another. “In half an hour, I’ll know more than you do” were the poignantly joking but spiritually telling last spoken words of martyred Jesuit Alfred Delp to his prison chaplain before being executed by Nazis (Delp 2004, xvii). Dachau’s clergy remembered themselves among “martyrs” and “Saints” from *In Paradisum* (Bernard 2007, 35). Such sentiments disclose not bitter resentment but generous anticipation. Domestic language of familiarity brings comfort—whether dying “at home,” or as a “resident” of a “nursing home” rather than merely a “patient-client” in a “hospice/hospital facility”—challenged by negative indifference, apathy, sloth, and incapacitating “impasivity” regarding deep commitments—amplified when care is reduced to watching TV (CCC nn. 1866, 1869, 2094).

BEST PRACTICE: Destiny as Adventure

For Christians, our origin is our destiny (*exitus et reditus*)—and this invites us to return the gift of ourselves as creation (CCC n. 358), embodied life (n. 366), re-unified in the resurrection in Christ (nn. 997–999) as dust returns to earth (n. 1007) (Chenu 1963, 304–322).¹² The return to God as our origin is a pilgrimage of purification and justice among the Communion of Saints. This is no solitary venture but a collaborative adventure against modernity’s “low grade confusion...about our loves” (Brackley 2005).

From Painful Journeys to Accompanied Pilgrimages of Pain Relief

Dying persons have different kinds of rights to effective pain relief. A tradition with a savior both crucified and raised has historically offered numerous ways to

interpret pain—but misery is not its final word.

Adequate pain relief is a question of social justice not merely personal fortune or privilege. Contrary to implied passive etymologies, pain is neither simply “punishment” (*poena*, Latin; and Greek, *ποινή*)—much less magical or tritely educative—nor is a “patient” merely “one who suffers, endures” (Latin, *patiens*). Descriptions of pain have shifted from pain as a merely passive perception that is received like “touch” to a functionally active and emotional construction that is cultural and embodied (Aydede 2009). Amenable suffering in dying and death is no longer patient with religious meanings that simply valorize misery. Wider dramatic narratives explore alternatives such as how the “Mystery of Holy Saturday” examines different ways Jesus “healed” those he encountered (von Balthasar 1990).

Who is responsible for effective pain relief? Jesuit voices discern why persons have different kinds of rights to effective pain management if not relief, that are grounded in traditions of common law, Christianity, Judaism, and Islam (Hollenbach 1979; Jonsen and Toulmin 1988; Buckley et al. 2012; Buckley and Feldt 2012). Arguments in favor of better pain management appeal to personal and social costs (utilitarianism, Institute of Medicine 2011), duties (health-care professionals, Bernat 2008), and five kinds of rights: a basic human right (Brennan and Cousins 2004; International Association for the Study of Pain 2004; Human Rights Watch 2009), a civil liberty (California Pain Patient’s Bill of Rights 1997), a civil right (Pettus 2011), a risk of criminal homicide (Syme 2009), and a civil duty (Tucker 2004).

Without promising a cure, Christianity encourages—like the Hippocratic tradition—that healing from befriended accompaniment as part of well-managed pain (Hauerwas, 1986).

Nor is genuine pain from death and loss a final word about each of us. Our shared destiny is a purifying pilgrimage of arrival not merely departure. Maria Shriver's 2008 poetic paraphrase of John F. Kennedy Jr.'s after-death poignant departure in the image of a small boat disappearing over the horizon—also described his welcome in tear-filled greetings as a destined arrival among friends—paraphrasing Henry Van Dyke, recalling Donne and Cicero (Shriver 2008; Donne 2012, 200; Cicero 1980, 26–27).

BEST PRACTICES: Death as Door to Communion, Not a Gate for the Soul

A shift from “place” as location of death to locale of care amidst one's beloved enables one to perform self-disposition/donation and be nourished for a journey with Christ and the Church (CCC nn. 1020, 2691). We practically assist one another to overcome preventable suffering and effective pain relief; a Communion of Saints welcome a “body” not a corpse. “Then death is considered as a door leading to communion after death with Christ, and not as freeing the soul from a body that burdened it”—nor as a gate for the immortal life of a solitary soul (ITC 1992, 6.2; Phan 1984, 511).

Five Common Yearnings Enable Profound Commitments Beyond Merely Guarding Decisional Capacity

Why might prudence not be enough to improve our dying? Catholic teachings tell an enthralling story about five common yearnings in a real world with a shared destiny. These form practical wisdom called natural law—with assumptions about how humans live and die in this real world, our destiny, God, common life, and practical moral reasoning. Jesuit

traditions discern how fabrics of God's grace enable generous responses to architectures of assistance forthcoming amidst frameworks from the community of faith and the Communion of Saints.

From the fourth century to the beginning of the twentieth century, many Catholics understood their personal growth in three stages: as beginners (who do good and avoid evil by confessing sin and amending life), to proficient (seeking spiritual growth through works of mercy), to the perfect (seeking contemplative, mystical union with God) (Keenan and Harrington 2005, 25–26). In moral theology, a basic practical insight of natural law is to do good and avoid evil. In dying, negative prohibitions (proscriptions) teach us to avoid evil (protecting the vulnerable from unjust assault), and positive instructions (prescriptions) encourage pursuit of the good (generous self-giving). Ascetical theology encourages development of human growth in character (called sanctification) enabling good dispositions (virtues rather than vices) nourished by self-involving communal identities (ascriptions). Various forms of mystical theology emphasize how a self is unified with the divine. After the seventeenth century, efforts to re-connect or bridge the first stage of moral theology with the second stage of ascetical spiritual theology, sometimes led to conformism of self-restraint, caution, and reluctance in prudence—rather than creative positive efforts (spiritual growth, divine union).

With respect to end-of-life decisions, Catholic historic reasonableness, rather than rationalism, favors appeals to basic truths (right reason, revealed truths, Christian love) and action guides or rules (e.g., the principle of double effect, permitted cooperation to avoid evil, toleration) that are in the ERDs. What we seek to prudently avoid (harming vulnerably dying)—is part of but distinct from what we seek

to earnestly commend, viz., generous self-donation into our ultimate destiny.

If we aim to know how to ultimately give ourselves to God in dying—where will we find advice? Some expect or request pastoral advice from the Church about how to avoid what is bad (harming the innocent) or enable what is good (self-dispose into God). The ERDs' practical advice is local, called (in canon law) "particular law" in some dioceses with healthcare services. But do the ERDs contain compelling evidence of public claims (rhetorics) that make them more than "rules for Catholics"?

These practical guidelines contain five reasonable assumptions or commonly shared yearnings—from a philosophical heritage of natural law—about human life and death in our actual world, our divine destiny, common life, and practical moral reasoning.

(1) Claims about what "ought" to be, rest on prior judgments about what "is" the case, some call "meta-ethical," viz., humans live purpose-filled lives in communities in the world with a destiny. From its Aristotelian-Thomistic roots, natural law argues that enough can be known (epistemological realism) about the nature of human flourishing (anthropological eudaimonism) as grounds for public argument about our actual world (cognitive realism called metaphysical realism)—based on Catholic threefold re-interpretations of eighteenth century thought (McCool 1977, 28).¹³ This includes pastoral sensitivity that recognizes human limits to what is culpably blameworthy (Murray 2005, 111).¹⁴

(2) Claims about who we are give three practical guides for our destiny. A supernatural goal is assumed as a given—and is sometimes additionally supported or "proof-texted" with beliefs from creeds and prayers (USCCB 2009 preamble; intro II, V). What is "sustainable" refers to some

understanding of a "whole system"; respect—not worship—of our creaturely embodied-ness sustains different goods as "common" (CCC nn. 2415–2418; Benedict XVI 2010).

A second forbids direct self-killing and a third endorses dying as good when deliberately performed as an accompanied act of self-disposal into ultimate destiny called God. Thus, a classic natural law argument from Aristotle and used by Aquinas, argues that self-killing violates self (preservation and appropriate self-love), the common good, and divine rights over life and death (Aristotle 1982; Aquinas 1975a; Porter 1995, 118). In 1989 German pastors reformulate this "trilogy of harm" argument—by exploring how a good death should not be assisted but accompanied with positive meanings for the self, others, and God (German Bishops 1989 in 1975/2010). Suicide and euthanasia are never morally acceptable, but German pastors follow Augustine, Martin Luther, and Karl Barth in arguing that not every act of self-destruction is morally culpable self-murder—hence suicide should be neither legalized, idealized, nor criminalized but medicalized as a cry for help (German Bishops 1989 in 1975/2010; Augustine 1981, 27; Luther, LIV, 27; Barth 1957/2004, 486/426).

Beliefs about our destiny explain why debates continue over how hastened death opposes responsibilities to self-preservation, others, or God. Some offer "natural law" defenses of hastened death in very narrow, exceptional circumstances where prolonged, medicalized dying directly threatens preservation of a "whole" self, or some common good or even risks ignoring truths about God's victory over death in Christ's resurrection (Cahill 1977, 47–63; Cahill 2005, 112–117; Farley 1995, 1–19; Küng and Jens 1996). Others eliminate or expand exceptional circumstances (Buckley and Feldt 2012, VI, IX, X).

(3) Claims about our shared destiny are part of shared responsibilities. A natural law method #3 justifies care for the needy with an argument about our communal rights and responsibilities as well as human dignity, then, in the ERDs, quotes proof-texts from the Bible to establish these points already made, based on these principles (e.g., Jesus' concern for the sick in Mt 8:1–4; Mk 1: 40–42 in USCCB 2009, general intro. and part II).

(4) Claims about our shared destinies and responsibilities are rooted in what God graciously enables. Natural law method #4 describes surrounding fabrics of natural and human communities as an enveloping ecology in which God sustains our participation. Here the Bible is quoted as divinely revealed law that, like the natural law, participates in the eternal law in the mind of God, which can be expressed in human positive law (Aquinas 1966; USCCB 2009, preamble, part I, part II). Contending claims among different laws are sidestepped.

(5) Claims about what God requires, are based on what God enables in grace that is discerned over time. Why aren't general principles enough (Don't kill! Seek God!)? Natural law method #5 uses procedures of casuistry to resolve particular cases of conscience—and advance moral understandings by creatively resolving conflicts that emerge about relevant facts, presumed obligations, or pertinent principles. Overweening caution commending simple obedience rarely exhausts God's graciously ongoing redemptive help. Moral knowledge advances according to how effectively we use conflict resolution to engage not avoid disputes with creative solutions.

Among others, Rahner criticized advice in the form of merely abstract ideas: he warned against such "universal essentialist ethics" for offering pastorally inadequate, merely general answers and abstract principles that could

not relieve one of responsibility for personal decisions before God which paid due heed to the teaching authority of the Church (Rahner 1975, 231).

It seems obvious: the more specific the advice—the greater room for honest disagreements. A particular applied decision (treat/withhold), involves specific moral choices (proportionate care) based on diverse (sometimes rival) moral principles (family obligations; professional duties) for situated moral agent(s) (e.g., dying, valid proxies, physicians, nurses) with time-based elements (sometimes urgent). Discrete practical judgments involve time and culturally bound precise factual assumptions—that evolve over time. These include criteria for death (cardio-pulmonary to whole brain death), understandings of pain—or futility (medically indicated, personally burdensome, inter-subjectively costly) (President's Council 2008, 91). Disagreements signal not wholesale skepticism—but reflect living traditions.

Given its importance for end-of-life decision making, what pastoral advice offers wise interpretations of the principle of double effect? For example, lethally risky pain suppression is permitted without the intention to hasten death based on a principle of double effect (USCCB 2009, 60–61). Some use double effect reasoning as justifying principles (Beauchamp and Childress 2008, 128, 160), whereas others use them to demarcate forbidden harms from permitted risks in professional–patient relations amidst biomedical goods (Sulmasy and Pellegrino 1999). Withholding and withdrawing futile treatment does not kill dying persons.

Thus, it is no surprise that there are contending interpretations of double effect criteria; what is evil intrinsically (acts, contexts, intentions)? What discriminates for whom? Whose foreseen good is distinct

from what kind of evil (patients, caregivers, healthcare professionals)?

To make matters more complex (or rich), each of these categories alternately functions as descriptions of circumstances, justifying principles, and exceptions to normative generalizations. Are current conceptual tools adaptive enough to promote practical gains in palliative sedation for end stage dying (e.g., Georgetown mantra, ERD principlism, Catholic double effect, ELCA¹⁵ situationism, Anglican-Methodist quadrilateralism, UCC¹⁶/Presbyterian exceptionalism)?

Hence, it is decisive for Christians and Catholics to know that not only are end-of-life decisions internally complex, but a legitimate—and necessary—plurality of opinions can clarify important issues. For example, the ethical method “principlism,” that focuses on specific guidelines (USCCB 2009, Part V, nn. 55–66), endorses discrete outcomes called decision-ism that forbid direct killing. However, to assess futility, wise practical judgments informed by experience help to adequately assess when a patient’s experience of a treatment’s burdensomeness might outweigh a physician’s appraisal of its medical effectiveness.

But end-of-life decision making can be enriched and nuanced—not necessarily fragmented or corroded by the legitimate range of historic and contemporary Catholic methods. Are end-of-life decisions best approached prudentially (Rahner and Keenan’s Jesuit probabilism, Keenan 1993, 300), professionally (Sulmasy and Pellegrino’s medical beneficence, 1999, 545–549), presumptively in light of ecclesial wisdom (Dominican probabiliorism in Ashley, deBlois, and O’Rourke 2006, 54–55), or by weighing “safe opinions” (Redemptorist *Æquiprobabilism* in Johnstone 1985, 58–70)? Might there be more options? For some, practical maxims function like exceptionless axioms promising geometric certitude

about end-of-life complexities. For others, common sense maxims are practical not theoretical principles, timely not timeless, presumptive not necessary for taxonomic guidance to improve judgments based on comparative experiences (Jonsen and Toulmin 1988, 21, 67, 258, 285).

By selecting model cases called paradigms—methods of casuistry advance our understanding. For example, at Vatican II and in the ERDs, there was a shift in understanding humans from human nature to human person (Vatican Council II 1965a, 3). This enabled refinement of several points—including why one may not simply “do any evil to achieve some good.” Earlier widely used categories distinguishing obligatory and discretionary treatment decisions relied on assumptions about available technology that were now rapidly changing in acute care settings (ordinary versus extra-ordinary) (Harvey 1988). New distinctions focused on the impact upon the whole person—not simply the body—as (dis)-proportionate (Congregation for the Doctrine of the Faith, hereafter, CDF 1980). Double effect reasoning about risky therapies also evolved: mid-twentieth century (papal) judgments about pain medicines weighed such usage as exceptional risks to the body and cautioned against side-effects (chiefly sedation) said to threaten consciousness among those imminently facing death (Pius XII 1957; Pius XII 1958). Later Catholic claims normalize end-of-life palliative care (CCC nn. 2276–2279; USCCB 2009, nn. 60–61). Remedies that alleviate and suppress pain focus upon the dying person—who should be able to prepare for death while conscious and receive social support “so that they can live with dignity until the time of natural death” (USCCB 2009, 60–61; O’Rourke, Kopfensteiner, and Hamel 2001). New factual circumstances shift from imminent death to appreciation for how effective

palliation improves dying: it is persons—not only bodies—who die.

BEST PRACTICES: From Avoiding Rational Suicide to Dying Reasonably Well Enough

Practical guidance for correct actions—such as the morality of human acts (CCC nn. 1762, 2273) forbids certain disposition over life (n. 2280). Practical guidance also offers a vision for how to die well enough by recommending how to best self-dispose into God (n. 2299). Thus decision-ism is not a mere checklist of procedures for assent to death events—nor dissent from killing—but part of gracious consent to accompanied shared destiny. The Communion of Saints suggests we do more than merely cautiously obey (negative) action guides (deontic rules or action guides such as “don’t kill”) but also develop traits of character or being (called aretaic or “virtue” ethics; viz., “generously self-donate into shared destiny”).

From Experiencing Care to Performing Healing

What improves care when cure is no more? The end of cure is not the end of healing (Sulmasy 2006a, 2006b, 2006c). Practical advice transforms experience into wisdom about how healing can care when cure is gone amidst suffering. Dying persons expect caregivers to address complex spiritual and religious needs (Fuller 2001; Ai and McCormick 2010). Care is more than an anonymously competent service exchanged for a fee. Some chaplaincy departments have been renamed from “Departments of Pastoral Care” to “Departments of Spiritual Care” (Hunter 2004). Some retrieve how positive religious symbols help dying well by trust in divine mercy and friendship (Fitzgerald 2006; Reinis 2007).

Is spirituality a measurable outcome or many measureable outcomes? In 1998, the Association of American Medical Colleges studied spirituality and medicine at medical schools (AAMC 1998). Nurses and social workers have done likewise—and the National Cancer Institute has published a “Study of Spirituality in Cancer Care” (NCI 2012). In the past century, care ethics has become professionalized in Anglo-American worlds of demand-based health care. Healthcare chaplaincy began in the 1920s; in 2002, a national association of clinical pastoral education listed 350 accredited training programs and 600 trained supervisors (Hunter 2004).

Yet why is there still “not widespread acceptance of a [single] standardized method to assess, plan, intervene and evaluate spiritual care in nursing” (Puchalski et al. 2009)? Plurality and diversity surprise few serious students of culture—different prayers, spiritualities, and mysticisms are facts of history noted in the *Catechism* (nn. 2626, 2700).¹⁷ Some demand-economies of health care individualize spiritual well-being with reigning models of consumer preference. Beginning with nursing criteria in 1978 and through 2009, more than 230 research articles have measured and applied “spirituality” according to more than two dozen assessment instruments (Gijssberts et al. 2011).

Should the end of life be characterized by caution or generosity? False dilemmas mistakenly rivalize what can be differently emphasized. The useful practical advice of the ERDs is welcome—frankly stating limits (no assisted suicide), demarcating permitted exceptions (double effect) from blameworthy harm (cooperation with evil) that helps the wise.

Is dying made better by (epistemological) certitude about what is avoided (“intrinsically evil murder”) or generosity in what is sought? Unlike Plato for whom ethics was a theoretical science, for Aristotle ethics was a practical part of the polis

that required sensitivity to variety, good habits, and applied prudence.

However, clarity is important about relations between negative and positive moral guidelines: positive acts neither commend nor defend direct death as disguised “goods.” Rahner is also clear: universal (even negative) norms neither simply apply nor completely exhaust positive, timely, existential opportunities for doing what is good (Rahner 1975, 224–225).

BEST PRACTICES: Why Care about Healing When Cure Is Gone?

Forgiveness is so important to Catholics—as a sacrament, it brings about what it signifies (CCC n. 1422ff) in restoring friendship and the Communion of Saints (CCC 1468–1469). Yet data give new practical advice. As noted, that loss of self in compassion fatigue is different from the emotional exhaustion of burnout, symptoms similar to post-traumatic stress disorder and cognitive changes from vicarious trauma (Bush 2009). Certain advice has stood the test of time of best practices regarding self-nurturance (diet, exercise, social support) and generativity (solve practical problems one day at a time). The professionalization of care ethics offers many resources for families and colleagues (Buckley and Feldt 2012, XVIII).

From Continuity of Care to Constant Accompaniment Amidst Threefold Self (Past-Present-Future)

Dying is ritualized in practices of accompaniment. When death is foreseen, dying and their caregivers simultaneously live with past memories, current expectations, and future anticipations—as threefold selves. Some quarter of a billion religiously plural Christian central Europeans and Americans alike perform cultural rituals in

over 100,000 diverse communities. These groups enact five styles of contemporary dying. Dying persons in these communities are socially divinely accompanied (1) with embodied integrated life that is divine property (1 Cor 6:19–20; Aquinas 1975a; 63–79; Kant 1775–1780, 154)¹⁸ in origin and destiny (Hankey 2002, 279–324). (2) Dying confers ethical inviolability not ontological innocence limiting interference (Aquinas 1975a, 63–79; Beauchamp et al. 2008, 304–308) (3) for those invited to ideals through purification of character into virtuosi models (Wojtyla 1981; John Paul II 1984, 1990)¹⁹ (4) as gracious trustees who share an optimism of the redeemed (Ratzinger 1993, 1988/2007, Catholic Church, CDF 2000) and (5) who procedurally relinquish disproportionate over-treatment (CDF 1980; USCCB 2009).

“I’m glad you ended it on Easter Sunday and not on Good Friday,” quipped Martin Scorsese’s parish priest, the Rev. Francis Principe to him about his 1976 movie *Taxi Driver* (Scorsese 2012, 29–30). Do styles of dying privilege individuals facing a dour Good Friday alone, rather than the communion of saints liberated by Easter Sunday? When moral theology is confined to avoiding evil—this leads to minimalism or moral narcissism. Two popes have written about dying well—and vitally reconnected embodied wholeness in moral theology with sanctification in ascetical and mystical theologies. To interpret suffering, Wojtyla, and later as Pope John Paul II, linked the paschal mystery to incarnation and embodiment; Ratzinger, now Pope Emeritus Benedict XVI, connected the paschal mystery in patristic terms to the Trinity, cross, and Eucharistic ecclesiology (Ratzinger, Boeve, and Mannion 2010, 68).

BEST PRACTICES: Land-Marking Memories, Expectations, Anticipations

Religious belonging and spiritual quests negotiate landmarks with various kinds of maps because we each live across time as a threefold self of anticipatory memory among others (beings-with). When cure is no longer, one correctly looks for signs of accompaniment in clinical, social, symbolic, and poetic forms—in prayer, ritual, and music.

From Resisting Burdensomeness to Bearing Each Other Up

Over a dozen different etymological meanings of “burden” from the twelfth century in English derive from “birth” (responsibilities “to be borne,” Oxford English Dictionary 1979, 1183). In other words, what we “take on” has roots in kinship but emphasizes how we are never alone—despite complications of kinship mobility.

BEST PRACTICES: Recalibrating Perceived Impoverishment as a Pilgrimage of Sustainable Vulnerability

From what do we wealthiest people in the world need emancipation? Perceived burdens occur amidst webs of cultural beliefs about how we are sustained. Correctly interpreting how we are “over-burdened” includes admitting care is never futile but frankly conceding—compassion can fatigue—even as mutual vulnerability sustains us.

Two kinds of autonomy invent two models of dignified death: one argues that the state should regulate that death as dignified which medicalizes autonomy by controlling the timing and manner of death events (Hedberg et al. 2009). A second argues that the state should widen

accessibility to palliative care that can be beneficent in enabling a dying person to be self-governing (autonomous). A person autonomously “self-governs” her dying when she experiences dying processes as “worthy” because “dignified” as a death of her own in solidarity as vulnerably accompanied—typically refusing self-termination (German Pastors 1975–2010; Buckley and Feldt 2012; XI).

Human vulnerability enables and constrains. We—in the first world—are rightful hearers of the Church’s renewed preferential option for the poor—first articulated by Jesuit voices—who ourselves need liberation from impoverishing burdens of interpreting dependencies as unacceptable, de-humanizing burdens (Arrupe 1966; Jesuit Superiors in LA 1990, 77–83; Gutierrez 1971, 132, 160; Pope 1993, 242–271; Twoney 2006, 321–368).

From Shame to the Arms of Abraham: Spiritual Well-being and Religious Quests

What novel hopes and fears derive from new kinds of end-stage dying? Spiritual well-being is not merely institutional any more than spiritual quests are simply personal. Unquiet about prolonged dying in our era of anticipated death faces new opportunities and challenges.

Why is it good news that we are accompanied?

Consider: How did German pastors solve a paschal mystery? Five strategies were used. They explicitly reject euthanasia programs in which Nazis criminally murdered tens of thousands. They oppose legalization of assisted suicide and insist dying be accompanied. They offer a series of arguments. First, they shifted background interpretive debates from incarnation and crucifixion to resurrection and redemption. Second they use a moral, called

“tropological,” reading of the Lazarus texts to disclose that it is not assisted death but accompanied dying that is just when humane. In German hands, Lazarus stories of miraculous raising (Jn 11) and judgment (Lk 16) are combined. They are now morally used (tropologically) to make claims that our destinies are shared in transformatively accountable ways. Third, the pastors adopted the public, constructive rhetoric of accompanied dying and re-wrote the *Catechism* (Germany) and laws (France) to qualify religious figures of speech (tropes) which appeared to endorse if not sanction inappropriate end-of-life treatment (“sanctity of life,” a “culture of death”). German pastors added a key phrase before the discontinuing of burdensome medical treatment that is not in any other *Catechism* translation: “Morality does not require therapy at any price” (n. 2278).²⁰

How did French discussions push back against inappropriate end-of-life treatments? Within one generation, one key concept (*l'acharnement thérapeutique*) shifts from endorsing “prolonging life” (Collins 1982), even “heroic treatment” (Corréard et al. 2007), to sinister “aggressive medical treatment” (John Paul II 1995, n. 65) even “therapeutic over eagerness,” “coercive,” therapeutic obstinacy “harassment” (Paul Ricoeur 2006; National Assembly of Québec 2012; Canadian Parliament 2009).²¹ For Ricoeur, it becomes philosophical over-reach and religious ignorance under-appreciative of Christological witness. By 2000, French law criminalizes this category as legally proscribed overtreatment (Terrenoire 2000).

Fourth, an imaginative shift from Good Friday passion to Easter Sunday paschal mystery led to a fifth series of best practices of accompanied dying that precluded assisted death. How did German pastors solve this paschal mystery? Nowhere citing texts of Jesus’ passion—central European pastors instead take their cues from those twelve citations in conciliar texts about the

paschal mystery. A symbolic sea change has happened. Just societies owe everyone a humanely accompanied death.

Against the legalization of assisted suicide, German Christians both debate its decriminalization but have developed a series of social practices of accompanied dying. Humane dying includes acts of ultimate self-disposal as (1) a death of one’s own (*eigenen Tod*), (2) by social *Sorge* (3) with ultimate self-disposal (*Verfügung*, perhaps religious). Thus (4) assistance becomes humanly worthwhile as appropriate help in dying (*Sterbehilfe*) not help to die (*Hilfe zum Sterben*), (5) permitting neither self-destruction (*Selbsttötung*) nor killing on request (*Tötung auf Verlangen*) for religious and philosophical (Kantian) reasons, (6) with requisite dispositions, structured social care (*Fürsorge*, *Seelsorge*), pain relief, and (7) ritualized trust in a shared future (German Bishops 1975–2010; Schockenhoff 1992, 108–126; Holthaus and Jahnke 2008).

BEST PRACTICES: Our Own Hour of Death Is His

How is the performance of dying made better by being a gifted participation? Our “Hour of Our Death” (CCC n. 1014) is personal but neither individual nor private; it is an accompanied, ecclesial event in which we are participants, not simply agents alongside Jesus’ anticipatory performance of his dying and rising. The “prayer of the hour of Jesus” fulfills the Our Father (CCC nn. 1014, 2746). Earlier liturgical traditions saw reception of the Eucharist as nourishment (*viaticum*) for a journey as Passover—passage in the hour of death in a family setting. Anointing physically healed a body (*salus*—health)—and Viaticum was a token for joining the communion of saints—recalling the coin placed in the mouth of the dead as

payment to the ferrier Charon (“Charon’s obol”) for passage over the river Styx in Greek antiquity (Paxton 1990/1996, 33, 202, 204). Viaticum came to be replaced by “extreme unction” for situations of imminent death. With prolonged dying, contemporary traditions re-locate the Eucharist as part of the Sacrament of the Sick (Sicard 1988).

Shifting from Ordeals of Purification to Opportunities for Donation

How can legitimate concerns about competent care be assisted (not replaced) by trust in accompaniment? Every pilgrimage has opportunities for different kinds of goods from the Communion of Saints to enable the conversion of cultural performances of dying as rituals enduring affliction (restoration through purification) into opportunities to perform self-donation (rituals of exchange, communion, and sacrifice, CCC nn. 946–962; Bell 1997, 94–135).

BEST PRACTICES: From Protective Loss to Resilient Gain

Funeral rituals sculpt grief with lament (Buckley and Feldt 2012, XVIII).

God’s drama for us is not a lonely venture (wandering *peripateia*) but land-marked adventure with accompanied return. Our deepest hungers do not lie.

“The funeral liturgy mirrored the journey of human life, the Christian pilgrimage to the heavenly Jerusalem” (USCCB 1985/1998, n. 42). A public argument claims just societies owe us an accompanied pain-free dying. Thus, it is important to shift behaviors, attitudes, and social institutions from protective bereavement (Kübler-Ross 1969) to accompanied resilience (Bonanno 2009). Kübler-Ross’s five stages of grieving as protective

bereavement in non-sequential stages offered denial, anger, bargaining, depression, and acceptance as nearly universal. Clinical psychologist George Bonanno’s research indicates how individuals have unique grieving processes that include elements of constructive resilience.

One received view of the Christian funeral liturgy and *In Paradisum* interprets the three structural stages of Christian life from home preparation of a body, to procession to the church, to commendation in burial (USCCB 1985/1998, n. 42; Bell 1997, 33–46). Rituals perform a pilgrimage through three liminal thresholds to reconciliation in larger wholes—whether iconic with the cosmos, or indexed to seasonal calendrical cycles or different societies. Understanding lament as poetic performance enriches discussions of Jewish elements in functional solidarity in sociology (e.g., Durkheim in Pickering 1994). New questions emerge: Do three thresholds accurately reflect complexities of contemporary life and death; are comparisons accurate between then and now or somewhere and everywhere?

In Paradisum texts historically pivot many ritual and cultural changes. “The Rite for the Commendation of the Dying has been revised within the post-conciliar liturgical reform of the rites of the sick, the dying and burial.” Textual sources of the current burial rite reach from current texts in 1983, as “adaptations of 1972 texts,” themselves a “revision” of Counter-Reformation texts from 1614—with roots from the seventh through ninth centuries (Donahue 2003, 9–10, 2001, 1). Behind textual changes in the rite are contextual changes and shifted fore-texts of understandings of death, dying, and the afterlife (Donahue 1999; Power 1996, 281–302).²²

The “Communion of Saints” has been expressed as a composition of place across a rich history by appealing to many senses. In our opening *In Paradisum*—rhetorical

devices orally–aurally use climax (*gradatio*) with namesakes (*eponym*) and repetition (*symploce*) for dramatic emphasis to associate the bosom of Abraham, holy city, and Jerusalem as Paradise. Origins of such links occur in early Christian homiletic and pastoral consolation traditions—including how Luke’s parable of judgment (Lk 16) is interpreted by controversialists Irenaeus and Tertullian to counterbalance divinely promised post-mortal existence in Abraham’s bosom—with provisional purification and judgment (purgatory or hell)—making cogent why embodied souls anticipate this as “just” (Irenaeus 2012, book 2 ch XXXIV.1; Tertullian 2013, 55). Based on biblical texts in Luke 16:22–23 (angels and bosom of Abraham) and 23:42–43 (kingdom = paradise), patristic homiletic traditions in Origen, Ambrose, Augustine, and Gregory of Tours connect visual images of the “bosom of Abraham,” “paradise,” and “Jerusalem” by poetically recalling oral ritual memory (Aristotle 1991; Origen 2009, 131–134; Bede 1960, VI, 23.43; Ambrose 2007, n. 12.53; Augustine 1890, 539–551, n. 4; Gregory of Tours 1988, 133–134).

From early third-century catacomb art to the present, Lazarus has been visually portrayed with accompanied, care-giving sisters Mary and Martha—no less than raised from the dead by Jesus—exemplifying a human condition of compromised subjectivity (Jensen 1995, 20–29; Esler and Piper 2006; Thomas 2008; Stevenson 2010). A fifth-century *Decretum Gelasianum* commended using patristic texts in liturgies—and elements of *In Paradisum* are expressed in the fifth-century spoken prayer at the time of death for St. Peter’s Church in Rome (*Vaticanus Reginensis* 316) (Franz 2002, 55). By the eighth century *In Paradisum* appears as a ritual guide for oral prayers at the house of a dying person and procession to church

called *Ordo Romanus* 49 (Sicard 1978, 215–220). By the tenth century this prayer is constructed as an oral–aural chanted responsorial at a Swiss monastery (*Hartker Antiphonary*, St. Gall Manuscript, 980–1000). Each phrase is a highly crafted artifact for acoustical memory (speaking, thinking, remembering) blending Latin prose (metered verses of short and long syllables), Greek literary funeral mourning (*consolatio-exhortatio*), and Byzantine ritual poetry. Each word has been deliberately chosen and carefully assembled into a poetic whole for anticipatory memory (Saulnier et al. 2001, 37). This chanted prayer becomes the origins of later and contemporary prayers of commendation for burial, *In Paradisum*.

Christians did not invent solace. Syriac mourning prayers adapt Jewish lamentations (Randhofer 2004, 37–38). Christian ritual origins of accompanied destiny link Jewish prayers of *Qaddish* (one kind of Jewish mourning prayer), *Sanctus* (with Hebrew words *Hosanna* and *Sabaoth*), *Pater Noster* (Our Father), and *In Paradisum* (Spinks 1991). Each contains a characteristic rabbinic invocative trilogy of “name,” (prestigious origins of divine names— saint-ancestors) “eternity” (kingdom-eternal rest), and “blessing” (plea against trial and evil, Paradise-Jerusalem) (Lenhardt 1999, 303–311; Weitzman 1993; 2001; Brown 2010, 276–322). Characteristic of the Aramaic (pre-) first-century AD *Qaddish*, these came to the Our Father via Matthew (6:9) and Luke (11:2), to the *Didache* and the antiphon *In Paradisum* by eastern Syriac rituals (Kirchhoff 1940; Kraemer 1999; Kabir 2001, 111–140; Ullendorff 2003, 122–124; Wandrey 2007, 269–88; Berger 2011, 40–41). Historically mutual defenestrations among Jews and Christians fail to obtund nimble poetic prisms tracing incandescence (Madigan and Levenson 2008; Bockmuehl and Stroumsa 2010).

We can take comfort. Like our destiny— our prayers, rituals, and sacred texts have origins in “Abraham’s arms” where “Lazarus is poor no longer.”

Dying and death: reasonable fears, well-founded hopes, best practices

Fear	Hope	Best practice
1. <i>Prolonged dying alone by inappropriate treatments</i>	<i>Harvest solidarity</i> in lifelong entreaties from the Trinity and Communion of Saints. Life does not end; <i>existence is transformed</i>	<i>Pray always</i> enacts a shared pilgrimage and discerns appropriate care
2. Pessimism of desisted treatment as <i>abandonment</i>	<i>Equip Saints</i> by “composition of place” with Jesus using the <i>event, process, and content</i> of catechesis as an “Optimism of the Redeemed” for good dying amidst our <i>community of faith</i> and our <i>Communion of Saints</i>	<i>Share transformation</i> in shift from Good Friday “passion” to Easter Sunday “paschal mystery” to judge when to withhold/withdraw (passion, death, resurrection, and ascension)
3. Institutionally <i>foreign location</i> of death events (hospitals)	<i>Awaken new familiarities</i> : Location and destination are a <i>re-turn home</i> among others	<i>Enact</i> our origin and destiny as ritual re-turns to God and the Communion of Saints—to anticipate and request hospice
4. <i>Poorly managed pain</i>	<i>Make compassion practically competent</i> for preventable suffering and effective pain relief	<i>Practical help with suffering</i> enables death as <i>pilgrimage through “door to communion</i> not gate for burdened body” to actively engage pain
5. <i>Incapacitating end-of-life depression</i>	Diagnose and treat co-morbid depressions to shift from guarding decisional capacity to <i>enabling profound commitments</i> of self-disposition into God	Clarify the forbidden (direct killing) and enhance promoted: generous self-disposal into shared destiny
6. <i>Advance directives do not guarantee improved care</i>	Shift from <i>cure to healing</i> . From disposition of self as embodied property in pre-commitments to self-dispositions for healing relationships	<i>Healing after cure</i> enables reconciliation that restores friendship and the communion of saints
7. <i>Fragmented continuity of care</i>	<i>Landmark and map accompaniment</i> for a threefold self—past-present-future of anticipatory memory among others to be alert to clinical, social, and symbolic	Five styles of contemporary dying are <i>socially divinely accompanied</i> (1) with embodied integrated life that is sacred or divine <i>property in origin and destiny</i> (2) which confers <i>ethical inviolability not ontological innocence</i> limiting interference (Aquinas 1975a) (3) invited to character ideals through <i>virtuosi purification</i> (Wojtyla 1981) (4) as gracious trustees who are <i>confidently redeemed</i> (Ratzinger 1993) and (5) who procedurally <i>relinquish disproportionate over-treatment</i> (Vatican/USCCB 2009)
8. <i>Burdening caregivers</i> with different kinds of costs	<i>Experience preferential option for the poor</i> to discern the sustainability of our vulnerability to <i>bear one another up</i>	In the intermeshed communion of saints, <i>care is never futile</i> but shared
9. Caregiver exhaustion from <i>compassion fatigue</i>	Just societies owe everyone a humane accompanied death, <i>in the arms of Abraham</i>	Our own “hour of death” participates in how Jesus foresaw his death to recognize how <i>compassion fatigues</i> , enables self-nurturance (diet, exercise, social support) and generativity (solve practical problems, one day at a time)
10. Misplaced trust in <i>prayer as bad medicine</i> because of negative private cultural beliefs in spiritual well-being and religious practices	Converting rituals enduring affliction (restoration through purification) into <i>opportunities to perform shared self-donation</i> (rituals of exchange, communion, and sacrifice)	<i>From protective bereavement</i> (Kübler-Ross 1969/1997) to <i>accompanied resilience</i> (Bonanno 2009) in “Abraham’s arms” where “Lazarus is poor no longer”

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ENDNOTES

1. For best practices of good clinicians, family caregivers, and wise patient choices, see works of Ira Byock (1997, 2012).
2. Newman's citation evokes Augustine's "because you have made us for yourself,

and our heart is restless until it rests in you." Augustine, 2009, 3; also see 22, 72, 92, 278.

3. The suggestion that our final end unifies an intellectual vision of the greatest good with a passionate delight reflects complex arguments of Aquinas's interpretations of Aristotle on the passions.
4. An approach to dying based on *gracious participation*, *generous donation*, and *appreciative memory* rather than *feared scarcity*, is rooted in principles of Catholic social teachings such as the dignity of the human person, the right of participation, the common good, and the universal destination of goods. By probing how people *participate* in ritualized memory, we ask what the symbolic economy of grace *actually* does for people and to people who participate in it—much as the US bishops' 1986 economics pastoral letter asked about economic participation updated in 1995 and 1996. The USCCB was formerly called the National Conference of Catholic Bishops. Some sociological traditions in demand economies construct ("problematize") aging and dying by constructing reflective self-appraisals of self-mastery that terrorize "scarce resource consumption models"; functionalists probe nursing care; conflict theories examine Social Security and symbolic interactionists map stigma and bias (Henslin 2010, 26–52).
5. *In Paradisum*, from USCCB 1985/1998, "Order of Christian Funerals," both verses conjoined; nn. 176, 294, 315, 347, 384, (n. 396, "Office of the Dead," version by Thomas Tallis, [1510–1585]); Angels... bosom of Abraham, text alone, nn. 174, 230, 292, 313, 333, 403.
6. *Rituals in Lectionary* 1969 E1970 "for a happy Death" (nn. 891–895) becomes retitled as "for the Grace of a Happy Death" by L1981/E1998–2002 (963–967 n. 31, No. 460). USCCB (1969/2002).
7. "Nicht Hilfe zum Sterben, sondern Hilfe im Sterben wir dem Kranken schuldig." German Bishops, 1975, in 1975/2010.
8. Finlan (2005), on Abelard, see 74; Irenaeus, 67; Christus Victor, 66; Anselm, 44, 71, 73; penal substitution, 8, 36, 38, 58.
9. See considerations of justice as *equality* (informed consent and decisional capacity in Chapter I), *need* (depression, I,

- compassion fatigue, IV, pain management, V), *merit* (futility, IX, brain death XIII), *productivity-contribution* (end-of-life costs, XV), justly *sharing burdens* of dysfunctions, and *justice as fairness* (cultural competencies, XVII) in Buckley and Feldt, 2012.
10. Compare n. 7 and n. 17 with understandings of the Cross at nn. 1, 10, 17, 19, 35, 38, 39 in Benedict XVI 2006.
 11. Compare German Bishops (1975/2010) with Vatican II (1964): nn. 5, 6, 61, 104, 106, 107, 109; (1965a): n. 22; (1966a): n. 15; (1966b): n. 8. See Kemper (1999): 46–51; Murphy (2000): 139–146; Franz (2002): 48–68; Torres Queiruga, Susin, and Sobrino (2006).
 12. The NeoPlatonic emanation and return (progression and conversion) is not a cosmic determinism or emanationism—but characterizes the structure of Aquinas's *Summa Theologiae*.
 13. It is not Aquinas—but the deductive Enlightenment rationalism of the German Christian Wolf (1679–1754) that structured this framework of neo-Thomist distinctions among ontology (being), cosmology, and psychology. McCool 1977 likewise makes plain the influence of earlier Spanish Jesuit Francisco Suarez (1548–1617).
 14. “The doctrine of natural law has no Roman Catholic presuppositions. Its only presupposition is threefold; that reality is intelligible; that reality grasped by the intelligence imposes on the will the obligation that it be obeyed in its demands for action or abstention. Even these statements are not properly ‘presuppositions,’ since they are susceptible of verification” (Murray 2005, 111).
 15. ELCA—Evangelical Lutheran Church in America.
 16. UCC—United Church of Christ.
 17. For example, see *Catechism of the Catholic Church*, Part 4: “Christian Prayer” and “Catholic Prayer Traditions for the Catechist,” <http://www.dioceseofjoliet.org/reo/currProject/AppendixL-PrayerTraditions.pdf>.
 18. Kant (1775–80), “God is our owner; we are His property.”
 19. A mystical theology of the soul's ascent through suffering to complete Christ's suffering on the Cross as personal education in perfection for union with God characterizes John Paul II's writings in 1948/1981, 1984, and 1990, although his 1984 essay added claims about redemption and his 1990 final writing adds more on the resurrection.
 20. “Die Moral verlangt keine Therapie um jeden Preis.” Whether or not this sentence explains, summarizes, or qualifies what follows, it is not in (original, or eventual) French, Latin, English, Italian, or Spanish editions of the *Catechism of the Catholic Church* at n. 2278.
 21. A sample of the variety of denotations in French literature of the 1990s and 2000 includes eagerness, overtreatment, futile, harassment, excessive, coercive, life-prolonging, at <http://www.linguee.fr/francais-anglais/traduction/acharnement+th%C9rapeutique.html>.
 22. Donahue—like Power and Ratzinger/Benedict XVI—explores how shifting ritual funeral language undervalues tribulation, dying, and penitence for sin, and effectively presumes immediate post-mortem resurrection. Abraham's bosom was an anticipatory locale (“Refrigerium interim”) of purification for the soul later articulated in doctrinal distinctions between particular and final judgment (Paxton 1990, 39, 62). Changing *causes* of dying or death (epidemiologies) and franchised dying re-calibrate understandings of embodiment, suffering, and memory in relation to death and dying. John Paul II cautions against over-identifications of suffering with sin that neglect responsibilities for palliation and risk under-valuing Christ's redemption or over-valuing human works—1984, n. 14ff, n. 25.

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