The Linacre Quarterly

Volume 34 | Number 3 Article 10

August 1967

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I am grateful for the opportunity to address myself to a company of medical men. My father and three brothers all elected your branch of the professions. When we enter family conversations, I soon find the discussion centering on their interests. I am not unused to the company of doctors, but I seldom get the floor!

Doctors and clergymen have a great deal to say to one another, but we rarely find occasion to express it. In the last twenty-five years I have visited a patient a day—yet I have had less than one discussion a year with a patient's physician. Our ministries are complementary, but we do not discuss the relationship.

When we confer so seldom, our harmonious joint ministries require a great deal of mutual trust, and some understanding of the particularity of service and viewpoint. The physician whom I do not see is my esteemed fellow laborer. He commands the resources of the tremendous advances in scientific knowledge. He is dependable and properly prepared. If he is not, his own profession works to eliminate or reform him. He has knowledge and diagnostic powers which I make no attempt to equal, nor even to second guess. If his patient complains against him, I would listen sympathetically, but I would ordinarily be inclined to wait patiently until I discovered the legitimate motive for the doctor's action.

The rabbi, priest, and pastor, covet in turn your support and understanding. Our work is not as clearly defined as at least a portion of yours seems to be. If one distinguish the practice of science from the expression of an art, we must lean more heavily toward the artistic side. I call a science that field of knowledge which is so regular in its recurrence, that it can be drawn or described in a classroom, and afterwards recognized in life. You look at a patient and say, "Aha! I recognize those symptoms."

Art, by comparison, deals with seldom-if-ever repeated configurations. The infinitely varied human personality with its spiritual needs calls for a substantial measure of art in that person who works to heal it. I find myself hesitating to describe any type of problem or type of ministry for the terminally ill, because after I have outlined my categories, none of the particular cases I recall exactly fit them!

TO KNOW THE TRUTH

A central problem deals with knowing the truth. How clearly should the terminally ill patient be informed of his condition? Sometimes this has been phrased: "Should we lie, or tell him the truth"? I think it is fairer to ask, "How much of the truth should be told"?

We are both confronted with such questions. I consider that the primary responsibility of telling falls

to you because the knowledge is scientific and can be most accurately relayed by one who knows the exact nature of it.

The answer to the question, "How much truth should be told"? cannot be given abstractly. In each case a separate judgment must be made, similar to that made by the surgeon when he judges whether or not a patient can undergo surgery. In this case, it will not be a decision of whether the organism has the capacity for surgery without entering shock, but of whether a personality has the resources to know truth without psychic shock.

Some people live honest courageous lives. They regularly face difficulties squarely. They approach death with spiritual resources, and they want to know the truth so that they can be as intelligent and as responsible as possible in their last days or hours. Such a person may look you squarely in the eye, and ask rather frankly about his condition, and you will be able to answer frankly.

Other persons simply cannot face threatening truth. They live in a society where all that is related to death is removed from ordinary life. "Living" goes on in homes, shops, stores. "Dying" is separated from these places, and goes on in isolated compartments, like hospital rooms. Even there, additional curtains are drawn, and doors are closed as death approaches. We depend upon funeral directors to give the lie to death with mortal remains which appear not to be dead at all. Although you may be committed not to encouraging anyone in such an unreal approach to life's limits, you cannot on the other hand hope to shock them into becoming totally different pers s with one startling announcemen their own approaching demise.

Tell them gently as muc s you think they can endure. Th some- times are aware of their ov limits and hesitate to ask what t y fear to learn.

You have one further obli ion in telling the truth to your pati t. You must not simply tell it, y must communicate it. This means at you must move the meaning fr your mind to his so that when i rrives it looks something like it d when it left your brain!

I would compare some p ents I have served to a man walkin round with a dozen pigeons perche on his shoulders and head, all read o take flight at the slightest pro cation. Each pigeon represents a "v id un- controlled thought about alth." You report on his health ar inad- vertently use a medical t m he doesn't understand. Three igeons go aloft. You make some emark about a consultation, and th e more birds fan the air. It doesn't tak much to get all twelve flying at once!

You may need to ask the patient to relate back to you what you have told him about his illness to discover the distortions that have already taken place. If you have time, probe his psyche a bit: "Do your symptoms cause you to have anxiety about any particular illness"?

I take seriously what a patient tells me about his illness. I do not consider that it is the final scientific analysis, but it does represent either how he understands his own illness, or else what he wants me to know about it. Under ordinary circumstances, I consider this partial knowledge advantageous. My interest is not in the science, but in the patient's understanding of himself and his predicament. The exceptions are when the person is scheduled for surgery, or is critically ill. In these instances, some member of the family should so inform the clergyman.

TYPES OF NON-SCIENTIFIC MINISTRIES

Other problem areas of the terminally ill are best understood if one approaches them by considering four kinds of non-scientific ministry. I term them non-scientific since the kind of knowledge which comes from carefully controlled experiments yields little light for them. They could also be called "personal ministries." I separate them into *confessional, affectional, ritual and meaningful.*

The *confessional ministry* is not simply that of letting a dying person confess some horrible sin. Many persons have no such horrible guilt upon their conscience, and it becomes a sort of manipulation to make them produce one! Nevertheless, there is nothing more private than the inner thoughts of each individual. Hidden thoughts yearn for sharing if the circumstance arrives where it is safe to share. Many people have something they want to talk over with someone before time runs out.

The confessional ministry could be called the ministry of sensitive listening. The clergyman is ordinarily thought of as the ideal recipient of such confidences, but they may be given to any person who gains the deep trust of the critically ill. You as a doctor may receive such confessions of hopes unfulfilled, of shame untold, of mystery unsolved, of timidity unexpressed. For that moment you become a holy minister offering a holy service to a person whose confidence you are bound to respect.

The *affectional ministry* is asked for by the patient when he requests that his spouse "just sit in the same room." We die one by one, and it is natural to ask for assurances of love and evidences of concern. This is sometimes what the patient really requests when he asks, "Can I go home"? Home may not be sanitary, but the sound of familiar voices, the ministrations of one's own family, and even familiar pictures on one's own bedroom wall have sustaining power.

I do not argue for home or hospital as if one were blessed and the other condemned. I urge when possible, opportunity for an affectional ministry, not only brought indirectly by a postman who delivers cards, or the the florist with the plant, but the presence of relatives beside the bed, and the visit of old friends. When a patient tells his doctor radiantly, "My pastor called today"! he may not only refer to the religious solace thus received, but also to the fact that the pastor represents the care, prayer, and concern of an entire congregation. His presence in the room says, "To us, (meaning the congregation) you are very valuable."

Doctors perform affectional ministries. You know that sometimes a point is passed where medical strategies mean little. Yet you go in and chat with the patient. Such visits may "take more out of you" than diagnosing and prescribing. They are a genuine service.

By *ritual ministry,* I refer to the various kinds of religious services which rabbis, priests, and pastors bring to the ill: our prayers, Bible readings, communion, and anointing. A meaningful ritual is an oft-repeated practice that speaks in a poetic symbolic way of a genuine power discovered and known in the midst of life. Protestant, Catholic, and Jewish ritual express the faith that this unseen Power makes life rich and valuable despite threats of every kind.

Persons who may be unable to bring themselves to speak of the seriousness of their condition, can partake of a ritual which admits finitude but sets over against it a larger trust. Frequently, the only reference to death I make during a visit is by means of the scriptures read or the prayers offered. Persons who cannot find words to speak of their fear are enabled to overcome it with the help of ritual.

Ritual help in crisis is most available and helpful to those who have used it often before. It is received according to a particular tradition. Critically ill persons want "their pastor," "their priest," or "their rabbi" and they want him to use the accustomed service forms.

Finally, there is the *ministry of meaning.* To a surgeon, each operation may be somewhat like others of the same grouping. But to the patient, *his* operation is a uniquely meaningful experience. And the possibilities of the meaning of a single operation range on a wide continuum, from tedium to excitement, and from dread to secret delight.

Even so, the experience of dying is capable of multiple meani s. It may be one of the great an high moments of living. If a perso eally desires to drink life fully, and o live it richly, he may wish not c ly to know the moment of birth, of lling in love, of true friendship, of tead-fastness under attack, of com eting an important assignment, bu also, and perhaps most of all, tc know those final, finishing moment alled dying.

For those of us in the Ch stian faith, the very symbol of th cross reminds us of the possibility t t the moment of death may be expe nced with tranquility and triumph The clergyman may offer a mean ng to the experience of dying which nakes possible heroism and courag born of faith. It stands as a mark gainst us that many persons prefer ot to "die" (to live through the fi l experiences consciously, kno ingly, and trustingly) but to "cop out." Man, who alone has capacity mong God's creatures to be alert to h s own future, also has the capacity o descend with help of drugs and sedatives to the level where the future approaches darkly and unseen. Many persons so depart.

Yet where any individual struggles heroically (with full knowledge of his predicament) either to survive (whether or not successful) or with resignation to approach death serenely, we witness a moral power that has potential to enrich the experience of many others. It is sorely needed in our virtue-timid age.

These are central problems and central ministries to the terminally ill. The ministries of confession and affection you physicians frequently perform. Those of ritual and meaning are largely our duty. You can assist us in the latter by never simply precluding the possibility that this patient may be the very one who has the religious faith requisite to enable him to die with a dignity possible only for faithful men. Be alert for that one who can accept the termination of his bodily strength, culminate his responsibilities with care, bid a conscious farewell with attendant blessings to his close associates, and lay down his life even as God requires it of him. Hide from him no fact. Offer him no crutch.

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