

2-1-1992

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A physician, reflecting on the early days of his medical training, recounts a relationship with a patient suffering from a rare form of bone cancer. He recalls the following:

In the hospital, it was the habit [of this patient] to roam the halls late at night after his wife and small children had gone to their lodging. I never asked him whether it was pain that kept him moving or perhaps loneliness and a simple desire for conversation. One night, having completed my work for the day, feeling too tired to read on my own, and facing no other prospect but to give in to sleep, I felt like talking.

On that night, and on other nights following, we discussed nothing in particular. Our conversation might turn to his aspirations at work...or to my thoughts about medicine. For a time he would talk about his plans for the future as though they were still foremost in his mind, but before long he would lapse into the past tense and grow sullen. I think that a part of him was looking for encouragement, but what little I knew of his condition made medical reassurance nearly impossible. I hid from his pain by focusing on the bright side of things. It was a kind of dishonesty, though at that early point in my medical training I did not recognize it as such. What we had was better than silence, but we never really talked.

One night, after I had been away for several days, I met him again in the semidark hallway near the nurses' station. He was asking a nurse to bring something to his room...For some reason, she proceeded to introduce the two of us — a rare event by hospital standards. Equally strange, neither he nor I spoke up to say that we already knew one another. I put out my hand to shake his, and he started to do the same; then it hit me: his arm was missing. It had been amputated as part of his treatment. I should have anticipated the amputation...but it came as a surprise to me. In the instant before my hand withdrew and I looked down, at a loss for what to say or do, I caught in his eyes a look of sorrow, perhaps even shame. I begged his pardon, but we did not speak further...We never met again. (Gunderman 15-16)

A week or so later, the patient dies, and the rapidity of the deterioration and the injustice of the illness creates a crisis for the physician. He feels that he has failed this patient, though not medically as this was not his patient. He senses that he has failed morally, although according to the principles and canons of biomedical ethics, he has done nothing 'wrong.' The physician is disturbed that nothing in his medical training or in his medical ethics prepared him, guided him, instructed him in how to attend to this man's pain and suffering.

As it did with this physician, suffering confronts us, compels us, and condemns us. It confronts us with shock that can upheave our unified, positive, progressive vision of our world, our lives, and our selves. It compels us to act—to alleviate it or to flee from it—in order to restore our sense of unity shattered by its eruption into our present. It condemns us—our fictions of unity, peace and invulnerability, our factual selfcenteredness and complicity in its creation and sustenance, our paralysis in its face and our evasion of responsibility.

Suffering similarly confronts theological theory, accusing it of being ephemeral and inadequate, assuming the role of a problematic, a contradiction, a paradox. It compels us to speak words that comfort and justify. It condemns all theorizing that posits a metastructure more important than the real and everyday or that posits a God who could cause or allow suffering, convicting it of complicity and generativity of conditions, of privileging an air-tight image of God that we have created over the chaos of those who suffer.

Suffering similarly convicts biomedical ethical theory. In confronting biomedical ethics, the physical and social suffering of patients rarely finds itself addressed adequately. The reality of this suffering condemns a biomedical ethics that privileges the construction of clean and clear formulaic principles aimed primarily at facilitating the decision-making of medical practitioners and that allies itself with a theoretical structure which cannot account for the suffering of patients — a suffering which is the *raison d'être* for medicine and the locus for much of the moral significance of medicine. As for this

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physician, the sufferings of patients compel us to look beyond biomedical ethics.

This essay, then, undertakes three tasks. Part one offers a construction of some of the philosophical commitments of biomedical ethics, arguing that these prevent it from adequately conceptualizing two crucial characteristics of patients: (1) the fact that they are suffering and (2) religious/moral interpretations patients give to their own suffering. In order to highlight this problem, part two describes some of the dynamics of suffering as drawn from narratives of patients and phenomenological analyses of suffering. Finally, part three reflects on one way in which the Christian tradition has incorporated these dimensions of sickness and suffering into its corporate life, namely the Rite of the Anointing of the Sick.

BIOMEDICAL ETHICS AND ITS THEORETICAL ALLIANCES

Biomedical ethics failed this physician, failed to give him the conceptual or moral tools with which to act or to understand his lack of actions. It failed to convict his actions as wrong, although he profoundly knew that he had behaved badly. What do we mean by 'biomedical ethics' in this context, and why do they often fail to provide the necessary guidance or illumination?

Biomedical ethics might profitably be understood as a 'discourse' in the Foucauldian sense. Arthur Frank defines discourses as "cognitive mappings of the body's possibilities and limitations, which bodies experience as already there for their self understanding...These mappings form the normative parameters of how the body can understand itself" (Frank 48). By situating themselves at the intersection of a number of discourses offered by societies, individuals formulate what Frank calls a 'code' by which we understand, and hence navigate, both the world and our identities. Biomedical ethics, then, insofar as it offers societal expectations of normative ideals of individual performance, might be understood to function in part as an agent of social regulation.

This might seem a strange categorization for those of us familiar with a biomedical ethic that speaks the language of principles, rights, autonomy, and decision-making. But the power of this description is evident in H. Tristram Engelhardt's *Foundations of Bioethics*. Engelhardt is the most articulate and forthright spokesperson for the majority position in biomedical ethics, namely 'pluralist biomedical ethics.'¹ Pluralist biomedical ethics see themselves as a "general attempt at secular ethics," derived from the "logic of pluralism," a logic which seeks to describe a neutral framework for the peaceable resolution of controversies. (Engelhardt 6, 11, 39)

To create this framework, pluralist biomedical ethics utilize normative anthropological and sociological dualisms that structure of the liberal philosophy of pluralist society. The taken for granted dichotomies of mind/body, reason/desire, public/private, lead Engelhardt to make

some bold claims. First of all, he posits the moral landscape as bifurcated into "two tiers" mirroring traditional distinctions between public and private. These "two tiers" of the moral life he names the "peaceable secular community" and "particular moral communities" (54). The "peaceable secular community" functions as a conceptual space in which public disputes are resolved by 'rational' (i.e., impartial, unprejudiced, anonymous, universal) arguments made by rational beings "anywhere in the cosmos" who have transcended the boundaries of their particular communities (10, 81, 105); ethical reasoning and moral judgments derive authority through correlations with procedures of this general standpoint and not from any particular content.

While the second tier, particular moral communities, is the locus of moral content and meaning, these communities rely on premises that, because of their particularity, "cannot be secured by [rational] argument," so that judgments of these communities cannot be validated as "rationally" authoritative (54). Particularities and affectivities, commitments nurtured within particular moral communities, which for our purposes means especially *religious* commitments and convictions, therefore, cannot be admitted as premises in rational moral arguments. While moral agents live their lives within particular, substantial, concrete communities, for moral purposes they must disembody themselves from these attachments if they wish to function in the public, moral domain.

Engelhardt also provides criteria for membership in the 'peaceable secular community,' criteria that are necessary insofar as "not all humans are equal...[as he says] persons not humans are special" (104). The criteria, namely, rationality, self-consciousness, and a sense of worthiness of blame and praise, define a being as an autonomous moral agent. A body—a human body—does not qualify one to be a moral agent; correlatively, bodies are not theoretically required for moral agency. Bodies tend to be practical correlatives of moral agents, but they have no moral or rational value or content.

This distinction between 'persons' and 'humans' greatly simplifies the task of biomedical ethics. Engelhardt argues that there are only two methods by which to resolve an ethical controversy: agreed-to procedures or force. The autonomy of the members of the 'peaceable secular community' constrains society and other persons from using 'unconsented-to' force against them. But 'non-persons,' who can make no claim to autonomy, are not protected from such force.

Thus, a contradiction becomes apparent. On the one hand, a primary object of pluralist biomedical ethics is 'bodies,' and the task is to authorize legitimate use of force against bodies—for example, who decides what is to be done with a particular (now incompetent) body; when do we stop sustaining a body; when do we let new-born but malformed bodies expire; should we kill bodies; whose

body will have access to health care? But this same human body does not count as a legitimate epistemological or even anthropological moral resource. Moral subjectivity is equated with rational mind, and 'knowledge' is available only of those things predicated as accessible to all minds; human embodiment, the locus of human illness and suffering and the site of the practice of medicine, are overlooked.²

THE SUFFERINGS OF PATIENTS

The patient's suffering and pain convict the physician of moral failing.³ If biomedical ethics were to attend to the embodied sufferings of patients, what might they discover?

If nothing else, they would discover that the sufferings of the sick differ widely. This fact alone renders suffering inaccessible to biomedical ethics (See Smith 261). Not only are different kinds of sufferings associated with different kinds of illnesses—emergency traumatic injury vs. chronic illness vs. terminal illness that moves rapidly vs. a life-threatening condition that persists for twenty years vs. illness that has intense social stigmas—but each individual body will be inscribed differently by the intersection of the cultural discourses of class, race, gender, age, religion, science and politics with the individual's personal history. The matrix comprised of these intersections of discourses, relationships, and histories, provides our ongoing identity, the code by which each individual deciphers and negotiates the world. In instances of suffering, this 'code' is broken.

In spite of this irreducible particularity, phenomenological and autobiographical accounts of suffering note three consistent dynamics. In the first dynamic, experiences of illness or pain often re-situate patients' *vis-a-vis* their bodies, re-ordering taken-for-granted relationships between "self" and "body." Experiences of illness serve as a reminder that "selves" depend on the integrity of bodies, that health and lives are radically contingent. In illness the body often moves from the background to the forefront of perception, and patients increasingly identify their selves with their bodies, a move which also unfortunately often encourages medical professionals to do the same. Some describe this aspect of patients' experiences as "essentially an ontological assault" in which the body becomes the enemy, interposing itself between "us and reality," standing "opposite the self," (Pellegrino/Thomasma 207-208) challenging a culturally instilled sense of the transcendence of self over body.

While this reorientation can be illuminating, more likely it can be alienating. Pain and illness can first effect alienation by counteracting "the human being's capacity to move out beyond the boundaries of his or her own body into the external, sharable world" (Scarry 13). Restrictive and dissociative, pain "chains down our thoughts," breaks connections between "body" and "world." In addition to impeding motion beyond personal boundaries, pain also

alters the nature of these boundaries: "It is the intense pain that destroys a person's self and world, a destruction experienced spatially as either the contraction of the universe down to the immediate vicinity of the body or as the body swelling to fill the entire universe" (Scarry 35). The body can become one's "world" as pain occupies more and more of one's consciousness and crowds out awareness of anything else. Alienation can also be effected by experiencing the body as the "enemy," the "agent of the agony."

Secondly, patients often experience a loss or usurpation of their "voice." Voice may literally be "lost" as a function of pain, or legitimate "voice" may be denied or repressed because it does not fit with normative medical or moral language. As Elaine Scarry notes, one characteristic of physical pain is that, for the most part, it is "inexpressible." While I can *tell you* of my pain, for example, there is no way for you to truly grasp its reality—either *that* it is real, or how real, how intense it is; your doubt of my pain cannot be decisively dispelled (4). This inexpressibility, this unsharability, can isolate patients from those close to them and prevent them from effectively communicating their distress to medical practitioners. Moreover, Scarry continues, "pain does not simply resist language, but [can] actively destroy it, bringing about an immediate reversion to a state anterior to language, to the sounds and cries a human being makes before language is learned" (Scarry 4). (An alternative suggestion is that these sounds actually *are* the language of pain.) It can achieve this effect because, physical pain resists objectification. Undoubtedly, this characteristic of pain underlies medicine's tendency to identify patients with their bodies: this identification is a first step in trying to "objectify" the pain, to give it the referent, the object, that it lacks. As Arthur Frank notes, illness can also result in "the loss of capacity to express through the body" (Frank 85).

But in many ways, the medical establishment furthers the patient's experience of loss of voice. As many have noted, when it comes to medicine, the patient is a "stranger in a strange land" (Engelhardt 256); medicine is foreign country filled with unfamiliar languages and customs. Kleinman, for example, perceptively comments on how medical facilities seem designed to be navigated only by those who are familiar with them. Often, patients' lack of knowledge of the language of medicine can intimidate them, leaving them speechless. When patients do "find" their voice, they often speak of the "lived experience" of their illness in non-scientific and often subjective "common-sense ways accessible to all lay persons in their social group" (Kleinman 4). But, all too often, in order to participate in the medical cure, patients must conform themselves to the world of medicine rather than vice versa, learning its language; their accounts of their own illness are translated into the language of the profession.

Kleinman notes that practitioners "have been taught to regard with *suspicion* patients' illness narratives and

causal beliefs" (17). Physicians often feel they have to sift out meaning from confused and messy narratives of patients, listening selectively "so that some aspects are carefully listened for and heard (sometimes when they are not spoken), while other things that are said—and even repeated—are literally not heard" (Kleinman 52, 16; Scarry 6-7). 'Subjective' experiences of patients' illnesses become 'objective' categorized diseases. Moreover, not only are patients' narratives at times suspect, but at times, as a result of the "inexpressibility" of their pain, patients' claims of illness or pain are doubted, if not explicitly denied, especially in the cases of chronically ill patients or in cases where the "explanatory framework" of medicine has not yet shifted to allow an illness into "reality." (Contemporary examples of this might include early sufferers of AIDS and chronic fatigue syndrome.) Alternatively, patients who reject a diagnosis of disease, or who do not conform to acceptable modes of dealing with a diagnosis, may be labelled as "in denial"; the physiological "interpretation" is given higher epistemic status than the patient's lived experiential interpretations. Patients, along with their voices, can be rendered inadequate, unhelpful, wrong, inactive, silenced.

But, just as a crucial characteristic of suffering is its ability to dissolve and destroy language, a first step toward dissolving and destroying suffering, then, is linguistic. As pain and suffering "resist objectification in language" and de-objectify the world, they can be only overcome by "forcing [them] into avenues of objectification," an objectification correlated with the body in which they reside. (Scarry 5, 6, 17; see also Soelle 70-72) We find this same notion of "objectification" in descriptions of "work." Work, an inextricably social process, is the vehicle through which we "objectify" ourselves, a multi-directional process through which the "self" is constituted and through which the self constitutes the "world." Dorothee Soelle employs this concept to suggest that "working on" suffering is best understood as "transforming the act of suffering into purposeful activity...nothing [she maintains] can be learned from suffering unless it is worked through" (126).

A fundamental shape that this work takes in the lives of the ill and suffering is that of creation of 'narratives.' As Kleinman notes, "the illness narrative is a story the patient tells, and significant others retell, to give coherence to the distinctive events and long-term course of the suffering" (49). Kleinman further affirms that not only does the story reflect the experience of illness, "but rather it contributes to the experience of symptoms and suffering" (49). Arthur Frank confirms this process, noting that "in illness, the body finds itself progressively unable to express itself in conventional codes. Sometimes, with the right kind of support, it creates a new code" (85).

It is noteworthy that Frank remarks, "with the right kind of support." The dynamics of suffering in illness all contribute to a sense of isolation and marginalization voiced by many who have been ill. Consequently, this process of narrative creation depends on the resources,

options and opportunities offered to the individual by the social situation. Often these prove insufficient. But importantly, those who initiate this narrative process need not be the victims of suffering themselves; in fact, often they cannot be. Thus Kleinman includes as a "core clinical task" what he calls "empathetic witnessing. That is the existential commitment to be with the sick person and to facilitate his or her building of an illness narrative that will make sense of and give value to the experience" (54; see also Scarry 6) This corporate dimension is indispensable in the dissolution of suffering, for the sufferer to move from the state of isolation caused by the destruction of her world, through expression and communication to solidarity through which change is possible. Thus, potential for deriving meaning from suffering lies not in some inherent quality suffering possesses, nor in the abilities of its victims. It lies rather in the resources offered by society and in the willingness of individuals to participate in this process, to enter into solidarity, to pay "attention" to those who suffer.

SUFFERING AND ILLNESS IN A LITURGICAL FRAMEWORK

Given the secular commitments of pluralist biomedical ethics described in section one, the Christian community might seem an unlikely place to turn to find resources to aid and inform our physician. But Christian tradition has, from its earliest beginnings, been significantly committed to attending those who suffer. This commitment has led to the development of practices which in their contemporary forms attend to many of the dynamics of suffering outlined above and thereby shape contemporary Christian relationships to suffering, both individual and communal. In this third section, I would like to focus on one practice in particular—liturgical rites of anointing and healing. For our purposes, I will draw on the Roman Catholic tradition's Sacrament of the Anointing of the Sick.

Before turning to the Rite, it is important to highlight the centrality of suffering and healing in Christian practice. Healing the sick was one of three primary activities associated by the Evangelists with Jesus' ministry, inextricably linked with his preaching and teaching. John Dominic Crossan, in a recent article, attends to this fact and suggests that Jesus' particular bodily practices (i.e., eating and healing) embodied his message and had radical religiopolitical ramifications. Crossan locates his argument within the matrix of anthropological claims that correlate regulation of bodily boundaries with regulation of social boundaries. Drawing on Mary Douglas, Peter Farb and George Armelagos, as well as Pierre Bourdieu and Caroline Walker Bynum, Crossan begins with the position that in Jesus' Jewish culture, who one ate with defined and identified one's location in the social matrix: "those decisions about what we eat, where we eat, when we eat, and above all, with whom we eat...form a miniature map of our social distinctions and hierarchies" (1195). It probably

would have been rare, we can imagine, to find a Jew eating with a Samaritan or a Pharisee with a tax collector. Furthermore, bodies who were sick, menstruating or dead were denoted as ritually "unclean" and would have been categorized as those one ought not touch, let alone eat with. Thus, food customs and illness customs provided clear social divisions, with some designations excluding people entirely.

Within this matrix, Crossan argues, Jesus' proclamation of the advent of the Kingdom of God contained a radical social challenge. Crossan maintains that Jesus' practices and message championed a radically egalitarian "reciprocity of open eating and open healing" (Crossan 1195). Thus we find Jesus scandalizing on-lookers by those he chooses to eat with (tax collectors and sinners, taking water from a Samaritan woman). Parables tell of the kinds of people he healed—lepers, the blind, the lame, a woman "with a flow of blood"—those understood within the culture to be blemished or unclean. And importantly, in these parables it is clear that Jesus often healed by touch, as Crossan notes:

[Jesus] healed the illness by refusing to accept the official quarantine, by refusing to stay separate from the sick person, by touching him [or her], and thereby confronting others with a challenge and a choice. By so doing, of course, he was making extremely subversive claims about who defined the community, who patrolled its boundaries, who controlled its entries and exits, who, in other words, was in charge." (1197)

Crossan implies that these two practices—open eating and open healing—were identifiable marks of what he calls the "Jesus movement." Those who had been healed were enjoined only to carry the message, and those who carried the message were charged to carry with them no other provisions but to trust that message and miracle would open the homes and hearths of those they healed. These two practices are embodied in the contemporary Church in the Eucharist and in the practice of ministry to the sick. While this is not the place to argue for a stronger liturgical and ecclesial understanding of the constitutive nature of the latter practice, I would like to suggest that Christian liturgies of healing, at least as represented in the Roman Catholic Rite, are both responsive to the existential situation of those who suffer and continue to embody the meaning that Jesus' healing practices suggest.

As can be seen from the text of its Introduction, the *Rite of Anointing and Pastoral Care of the Sick* responds to a number of the dynamics of the sufferings of patients noted in part two above. First of all, the Rite is fundamentally liturgical, reconfigured from its earlier privatized forms in light of the Second Vatican Council call to liturgical renewal. Properly liturgical actions embody and intend the Church as a whole, and the Introduction to the Rite stresses this corporate dimension:

Like the other sacraments, these too have a communal aspect, which should be brought out as much as possible when they are celebrated....The faithful should clearly understand the meaning of the anointing of the sick so that these sacraments may nourish, strengthen, and express faith. It is most important for the faithful in general, and above all for the sick, to be aided by participating in it, especially if it is to be carried out communally. ("Rite of Anointing" 191)

The communal context of the action emphasizes that, overagainst the social and cultural realities of isolation and marginalization that attend illness, the sick are not alone. The ecclesial community continues to understand them as included, and in fact, to be an integral part of the community: "If one member suffers in the body of Christ, which is the Church, all the members suffer with him" (I Corinthians 12:26). ("Rite of Anointing" 190) This bond is reinforced in the ritual actions of touch—the laying on of hands and the anointing.

In addition to communal support being integral to ameliorating the burdens of suffering, in part two Scarry, Kleinman, Soelle and others further suggested the importance of "working on" or "transforming the suffering into purposeful activity." The Rite of Anointing of the Sick as a liturgical act can be understood as 'work' in precisely this sense. On the one hand this dimension can be seen etymologically, as the Greek term 'leitourgia' is derived from the two terms 'leos' (people) and 'ergou' (work). 'Liturgy' is precisely 'work' done by all the people in the Body of Christ. Equally importantly, in the Rite, it is 'work' done by the the sick person. The sick person is not understood as passive and, in fact, is enjoined special duties and activities which give meaning to their suffering:

The sick in return offer a sign to the community: In the celebration of the sacrament they give witness to their promises at baptism to die and be buried with Christ. They tell the community that in their present suffering they are prepared to fill up in their flesh what is lacking in Christ's sufferings for the salvation of the world...The sick are assured that their suffering is not 'useless' but 'has meaning and value for their own salvation and the salvation of the world'....And the sick are *believed* to be and seen as productive members of the community, contributing to the welfare of all by associating themselves freely with Christ's passion and death....In the sacrament, the faith of the sick person gives us, the healthy, a sign—an embodiment—of the words of Paul to Timothy: 'You can depend on this: If we have died with him, we shall also live with him. If we hold out to the end, we shall also reign with him' (2 Tm 2:12). (*Study Text*, 20-21)

The sick are challenged not to isolate themselves from the community, not to withdraw in embarrassment or fear. They are called to continue acting as a part of the body of Christ, called to forge ahead in the face of their difficulties, modelling discipleship and so serving as "minister to the whole church in their illness"(*Study Text*,

41). In this way, "meaningless" suffering—of which suffering associated with illness is especially a case—is given a use, purpose, meaning.

Finally, we noted in part two that illness inflicts suffering partly by breaking apart a person's "code"—that set of discourses, relationships, and histories by which one understands and interprets one's world and identity. The Rite addresses this in two ways. On the one hand, most of those to whom this Rite reaches inhabit a 'code' derived partly from Christian formation and partly from secular culture. In instances of illness, especially in contemporary Western culture, part of the crisis of illness is created by presuppositions supplied by secular culture. For example, illness can pose a grave threat not only to psychological identity but also to physical security in a culture that values to the point of ideology the idea of individual autonomy. By preaching and living the gospel of a God who is essentially dependent and self-giving, the sacramental rite informs those who practice it with an alternative vision of the world.

On the other hand, as we noted above, Kleinman and others advocate that those involved with the sick encourage the creation of 'narratives.' While this is important, the Church, especially through the practice of the Rite of Anointing of the Sick, invites those who suffer to locate their narratives in an ongoing story, to learn anew the stories of others who have suffered and the interpretations they gave their experiences, to truly hear—possibly for the first time—what it means to worship a God whose relationship to humanity was revealed on a cross.

SACRAMENTS AND MEDICAL ETHICS?

It might be objected that all this is well and good, but it doesn't really aid us in the difficult task of making day-to-day decisions about which technologies to use, and when, and for how long. But the power of the simple dynamic involved in these liturgical rites is easy to underestimate when compared to the power exercised by biomedical technologies and interventions. Like Jesus' practices of open eating and open healing, Christian understandings of suffering, illness and healing embodied in the rites and liturgies of common worship challenge contemporary cultural understandings. The Church's 'discourses' challenge those of secular society. They refuse to locate a creature's value solely in its rationality, refusing to accept the designation 'enemy' for the realities of suffering and death, refusing to validate a posture that is closed to the world and fearful and ostracizing of those who are 'other.'

Those physicians and patients formed by ecclesial practices of Christian communities will find themselves navigating the world of medicine and biomedical ethics along a different path, for what they see as 'persons,' 'threats,' 'dilemmas,' and even 'the world' may differ significantly from their colleagues. For the physician whose story opened these reflections, the Sacrament of the

Anointing of the Sick might have supplied him with alternative understandings of sufferings and a disposition toward openness and vulnerability that would have enabled him to reach out to the patient with a touch that healed. As importantly, it might have opened him to the touch of the patient that would have left him with the hopeful memory of shared community in addition to the empty sorrow of aloneness. □

Notes

¹I would assert the case for three approaches to biomedical ethics: (1) pluralist—represented by Engelhardt, and the work of Beauchamp and Childress in *Principles*; (2) an ethics of medicine—represented by Leon Kass, as well as Pellegrino and Thomasma in *A Philosophical Basis*; and (3) Roman Catholic biomedical ethics—represented by Richard A. McCormick, S.J., Lisa Sowle Cahill and Charles E. Curran.

²It is important to emphasize here that I am distinguishing between medical ethics and medicine. Clearly medicine attends to bodies and the bodily in a significant manner, both conceptually and practically. My remarks are directed solely at medical ethics at this point.

³On the other hand, I do not distinguish too clearly between the notions of 'suffering' and 'pain.' The distinction, which is commonly employed, relates suffering to one's self and identity, while pain is understood primarily in bodily terms. Although it is now rather standard to make this distinction, and the distinction can be helpful within certain arguments, I would resist making it too clear-cut, as I am concerned that it might buy into a mind/body dualism that will only exacerbate the problems I am trying to address.

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