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What's Love Got to Do With It? Situating a Theological Virtue in the Practice of Medicine

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> "And yet, to say the truth, reason and love keep little company together nowadays. The more the pity that some honest neighbors will not make them friends."
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> Bottom, *A Midsummer Night's Dream*, III.i

I SOMETIMES TELL the pediatric residents and medical students with whom I work, "You have to love your patients, even those you can't bring yourself to like." I should say it more often, but it has a disorienting effect on a team of professionals not used to hearing the word "love" in the same conversation as "non-gap metabolic acidosis" or "metachromatic leukodystrophy." Doctors are, after all, champions of instrumental reason, and the profession's well-policed boundaries encourage us to exile subjective matters, like love or theological conviction, to the exotic jungles of "the private realm."[1]

People expect many things from a physician, among them ready access, an understanding ear, and technological mastery over cir-

[1] The private/public distinction is one of the current default cultural assumptions in which I was well catechized during my youth and early adulthood through sources both public and private, including formal education, the news and entertainment industries, and the field that calls itself "bioethics." Reason, presumably, has a role on both sides of this divide, while love is kept on house arrest in a private estate. With age and growing skepticism, I've come to share Bottom's lament.

cumstance, but no one seriously expects love from his or her doctor. Such talk threatens professional norms: to seek love from a physician seems a category error at best, and in a practice as inescapably embodied as medicine, a doctor who reciprocated a patient's request for love without terminating the professional relationship would jeopardize his or her license.[2]

The traditional stance in medicine is detachment, and its most eloquent champion was Sir William Osler, whose 1889 farewell address to the University of Philadelphia, "Aequanimitas,"[3] celebrates stoic calm as an essential mental virtue of the physician. Many aspects of doctor-patient relations have changed since Osler's day, but there are still good reasons for doctors to be cautious when considering whether or not to treat those they love. The standard argument is that effacing otherwise distinct professional boundaries leaves little room for objectivity. There is some merit to that, though the term "objectivity," judging by its use, has come to mean something like the emotionless application of scientific power to the patient's condition.

But there's more behind the physician's studied dispassion than concern for proper application of power. As scientist and novelist C.P. Snow once observed, "Somehow one's dreadfully vulnerable through those one loves."[4] Medicine is already quite vulnerable and intimate as it is. Strangers come to me, sharing stories and fears they've told to few or none, trustingly bearing their souls and bodies in the hope that I will make them better, or at least ease their minds. A young doctor learns to guard the heart against so steady an assault, though she may risk emotional paralysis in so doing. Yet doctors—most of them at least—truly care about their patients, and if their concern is almost never as visible as a nurse's, it's just as real and durable. The face of every child who died in my presence still haunts me, some now decades after the fact.

There's no doubt that contemporary health care has a pervasively transactional nature: a patient braves an ocean of paperwork in search of assistance with a problem, professionals provide highly specialized and technical remedies, and an impersonal bureaucracy sees to it that money ends up in the right pockets. On the other hand, patients disclose deep secrets and allow themselves to be touched in the most intimate ways, so much so that the patient's vulnerable encounter with a doctor, nurse, or therapist might easily be confused with

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[2] I write this essay in my own voice about matters with which I'm familiar. I hope my observations are applicable to nurses, therapists, and the many professions gathered under the term "health care," but I don't presume to speak for others.

[3] William Osler, "Aequanimitas," in *Aequanimitas*, 3rd edition (New York: McGraw Hill, 1932).

[4] C.P. Snow, *The Masters* (New York: Charles Scribner, 1951), 6.

love. Something tells us the resemblance is merely superficial, however, and most accounts of the therapeutic encounter name it an alliance, a partnership, or a relationship, scrupulously avoiding the L-word.

So much depends, of course, on what's meant by "love."[5] Physicians spend years acquiring specialized vocabulary to properly frame their observations and intentions, but show little care when speaking of whole continents of human experience still uncolonized by medicine's power. A doctor who doesn't acknowledge that his questions are intrusive and his therapies painful is not to be trusted. We do well to follow our ancient predecessors who, despite crude tools, laughable theories, and dismal cure rates, nevertheless treated words as speech-acts with power, substance, and consequence. If words do no work, they are idle, and if language is used poorly, we squander its power. Any form of human endeavor, including medicine and ethics, is undermined when language is eviscerated by abstraction and sentimentality, divorcing words from embodied experience. Careless and cynical misuses of the word "love" have corrupted a life necessity into a diffused and useless absence, as if a person dying of thirst were shown a pot of water, only to be forced to watch it boil away on a stove.

In the hospital, "love" is an acceptable term when safely confined to presentations on "medical humanism," (as opposed, it would seem, to "medical science") and then only if consumer-friendly and enervated, without a robust description of love in practice. Theology, however, provides some tools with which to make a start, however small, on the difficult—but, I believe, necessary—project of relocating love within the practice of medicine. I use these tools to suggest that the difficulty health care professionals have in talking about love stems from a fundamental modern mistake about the nature of health. I argue that health is always held in common, not individually, and that what now passes for medical ethics inappropriately values the individual over the community, the intellect—and particularly the will—over the body, and instrumental power over friendship. Finally, I offer suggestions how Christians in an otherwise indifferent health care system might restore and sustain practices of love.

[5] For a handy map of this linguistic minefield, with excursions into German, French, Latin, Greek, and Russian, see Josef Pieper, "Love," in *Faith, Hope, Lov*e (San Francisco: Ignatius Press, 1997), 145-162.

A Case Presentation: Jasmine

Jasmine[6] used to come to my office in a custom wheelchair, fitted with head supports, padding to keep her back straight and prevent pressure ulcers, and a rabbit's warren of interconnected bins in which her mother stored items necessary for excursions. Jasmine was old enough for junior high, though she rarely attended her "severe-to-profound" special education class in the public school because she was so susceptible to viral illnesses acquired from her classmates. A simple cold might worsen her seizures or progress to pneumonia, landing her in the hospital for days.

Her objective intellectual abilities were perhaps those of an infant or toddler, the result of what her medical history described imprecisely as "cerebral palsy." A look at a CT of her head, however, was frightening. I'm familiar enough with brain images to search them for familiar structures, the way one looks for coastlines or borders on a map. When the expected contours aren't there, one looks for distortions, missing pieces, or other signs of disease. But Jasmine's CT wasn't merely distorted. It revealed a black central emptiness where a normal brain ought to be and a thin white rim of cerebral cortex just beneath the skull, looking less like a jumbled map than the gaseous remnant of an exploded star. I could not reconcile the image on the viewer with the living, breathing child next to me in her chair. Jasmine had enough brain function for essential bodily tasks—breathing, normal heart rate, and digestion—but she would never stand, never walk, never speak.

Yet Jasmine smiled and offered a rough sort of laugh at the sound of my "hello" when her mother wheeled her into the exam room. She beamed when her mother spoke to me of events since their last visit. Jasmine had varying moods—some days somber and withdrawn, others happy, even playful when I stooped to examine her. I have no way of knowing, of course, what Jasmine understood—in the way most people would use the word—in these encounters. Perhaps she was reacting to familiar voices speaking in pleasing tones. Perhaps her smiles and laughs were nothing more than epiphenomena of involuntary responses to sound, the reflexive release of neurotransmitters across what cerebral cortex Jasmine still had. If so, Jasmine's mother and I mistakenly read great significance into her movements, sounds, and moods.

Or perhaps not. In fact, the tidal flow of neurotransmitters is not far from what neuroreductionists, like philosopher Daniel Dennett,

[6] In accordance with the Health Insurance Portability and Accountability Act of 1996, and more importantly, to respect the dignity of my sister in Christ, I have changed her name.

claim to be the entirety of consciousness and all its fruits, from an awareness of a full bladder to the writing of *The Origin of Species*. This "nothing more than chemistry" claim about consciousness is but the latest step in a half-millennium march to simplify the West's concept of the person, first from hylomorphic union to an imperial mind trapped in a machine called "body;" then a reduction of mind to will, and from will to chemicals perpetuating certain sequences of DNA. Those who agree with this last formulation are then able to explain away all manner of things—such as altruism, the notion of free will, art, literature, and music—as clever mental (i.e. neurochemical) deceptions keeping us and our closest relatives alive long enough to duplicate our genes.[7]

In Dennett's approach, the mind is reduced to "nothing more than chemistry," and number theory or novel-writing to "nothing more than byproducts" of hormonally-driven mate-finding strategies. One might imagine that this approach would foster solidarity between the Dennetts and the Jasmines of the world. To the contrary, neuroreductionists conspicuously bracket from critique their own, highly constrained forms of reasoning and the choosing capacity of the will. The result is to privilege one form of rationality, an autonomy indistinguishable from that produced by consumer capitalism, and an assortment of rights, the provenance and ontological status of which are habitually breezed over as with a con man passing suspect banknotes. Theologian Thomas Reynolds implicates this pattern of thought in what he calls the cult of normalcy:

> A stress on the rational also tends to favor the mind over the body. And the consequence is an instrumental view of human bodies. That is, it treats the body as a tool to be used and harnessed according to rationally calculated ends. Coupled with the consumer-oriented ma-

[7] Altruism, which under more traditional names was once a virtue, becomes problematic in the 19th century. Comte, who invented the word, clearly had a higher appreciation of self-sacrifice for others than his near contemporary, Nietzsche. For early Darwinists, however, altruism was a theoretical difficulty, explained away by some Neo-Darwinians in the 1960s with Hamilton's rule and the Price equation, which account for apparent selflessness through an unconscious calculus of individual cost and group relatedness. George Robert Price, the population geneticist for whom the equation is named, was often troubled by the social and personal implications of his work. Late in his life, he adopted an idiosyncratic Christianity based on his reading of the New Testament, though he soon abandoned Bible study for direct service to the homeless in North London. He finally committed suicide by slicing his carotid artery with a pair of nail scissors. While extreme caution is necessary when identifying motives for *any* suicide, friends attributed Price's self-engineered death to his despondency over the material conditions of the homeless he served.

> terialism that dominates North American culture, this can be particularly damaging for the way we think about disability[8]

My argument is not with neuroscience or evolution as such, both of which offer new and helpful insights theologians are only beginning to digest. I am nevertheless skeptical of claims that all human behavior reduces to "nothing more than" veiled strategies for competitive advantage. I share with essayist and critic Marilynne Robinson a deep suspicion toward the attitude that "we do not know our own minds, our own motives, our own desires. And—an important corollary—certain well-qualified others *do* know them."[9] The history of science is filled with great intellects engaging in often unconscious self-deception, fitting data into circular justifications of an *idée fixe*. It may be that Dennett's failure to deconstruct his own arguments with what he calls the "universal acid" of Darwinian evolution is not special pleading. But he's got a lot of explaining to do.[10]

Despite Jasmine's apparent lack of intentional action or symbolic communication, much less any signs of self-awareness, there's an interiority to her I recognize as analogous to mine. Neuroreductionists will scoff at my assertion as doubly deluded, but I've spent enough time in Jasmine's presence to intuit an interior world.

In any case, I knew from experience and the opinions of trustworthy specialists that Jasmine had likely reached the peak of her intellectual powers, and that decline and premature death would not be long in coming. I started what properly became an ongoing conversation with her mother about end of life care, how aggressive she wanted us to be should Jasmine's breathing fail or her heart stop beating. Our discussions were preliminary and inconclusive, invitations to reflect on matters Jasmine's mother would rather not imagine, but would eventually loom large.

Yet talking about what would come didn't distract us from the business at hand: caring as best we could for Jasmine, keeping her as healthy as possible. In that, Jasmine's mother was far more diligent

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[8] Thomas Reynolds, *Vulnerable Communion: A Theology of Disability and Hospitality* (Grand Rapids: Brazos Press, 2008), 88.

[9] Marilynne Robinson, *Absence of Mind: The Dispelling of Inwardness from the Modern Myth of the Self* (New Haven: Yale University Press, 2010), 59. While Robinson's entire book is wonderful reading, her chapter, "The Strange History of Altruism," is particularly pertinent to my argument here.

[10] A universal acid should, by definition, dissolve not only every container, but also every supporting structure as well: the floor, the foundation, and the earth beneath it. As Alvin Plantinga observes, "[O]nce I come to doubt the reliability of my own cognitive faculties, I can't properly try to allay that doubt by producing an *argument,* for in doing so I rely on the very faculties I am doubting." Alvin Plantinga, *Warrant and Proper Function* (New York: Oxford University Press, 1993), 234.

than I. Jasmine always arrived in the office with her hair done, her face shining, her diaper unsoiled. The useless muscles in her arms and legs were stiff and contracted, but not as bad as they would have been had her mother not been so faithful with her daily therapy. The white binder in which Jasmine's mother kept meticulous records of her medical visits and home care would make an accountant professionally envious. No doubt all this attention prolonged Jasmine's life. But at times, while I was writing my note after an office visit or leaving the hospital during one of her recurring admissions, I silently wondered to what end were we so diligently working. What did we hope to accomplish? What was the point of Jasmine's life, much less that of devoting more time and scarce, expensive resources toward her living longer?

I'm old enough now to know that a physician who denies having such thoughts is either more saintly or less forthcoming than I. Questions of futility come with the territory that medicine's technological power carves out of the desert of bodily decline. At least one reason, however, that my musings about futility never went any farther is that I truly cared about Jasmine. Serving as Jasmine's pediatrician was more than a task; it was a privilege and a delight. Furthermore, Jasmine's mother cared more deeply than I can imagine. She didn't idolize her daughter or fashion her into the sole focus of her life as some parents of so-called special needs children do. She didn't blind herself to the consequences of the treatment choices she made for Jasmine. What she did so obviously and well was love her. That, perhaps, was reason enough for me to keep at it.

Reason Enough?

But a parent's love for a child can't be the reason I care for many of my other patients. Robert, awaiting placement in a foster home, is as much my concern as Jasmine. So is Tyree, whose severe traumatic brain injury came at the hands of his crack-addicted mother's boyfriend. Tyree looks almost normal, if one ignores the appalling divot in his skull, but his limbs are already stiffening, his joints will soon twist at odd angles, and his boyish cuteness is rapidly fading. Few doctors get to choose their patients. By entering the next exam room, physicians tacitly consent to treat whoever waits there. If I were a pediatrician only to the demonstrably loved ("Every child a wanted child"), mine would be a very strange practice. What sort of love counts? How and to whom must it be displayed? Are these the questions a physician should ask before entering an exam room?

Explicit emotional investment (to use, for now, a modern and inadequate rendering of the word "love") of one individual for another, even that of a parent, is an unsteady foundation upon which to build

an ethic of health care, leading rather quickly to conclusions Catholic moral teaching condemns. It is, after all, the cornerstone of pro-choice logic—that, before birth, "viability," implantation, or some other transitional milestone, the fetus (who cannot yet express preferences) only has value insofar as another—in this case its more or less expectant mother—chooses to value it. I don't mean to downplay the harsh economic and social realities that may drive such valuations. I do wish to remind readers that the factor determining whether a primary care provider refers a woman for prenatal care or an abortion clinic is, in most cases, preference—maternal, paternal, or grandparental.

In this sense, the end of medicine becomes the fulfillment—to the extent that fulfillment is practically and financially possible—of the choosing agent's desires. The patient is reduced to an intellect and will encased within an all-too-often defective biological machine, while the physician becomes little more than a combination concierge and mechanic. If we were to follow this line of ethical reasoning, Peter Singer has done us a favor, demonstrating the logical inconsistency in marking a child's acquisition of agency, and therefore of inherent human value, even as late as birth. Though Singer is treated by some as a dangerous thinker on the fringes of acceptability, his preference utilitarianism, which construes the end of human life as the aggregate consequences of choices and actions that cause pleasure rather than pain, is increasingly mainstream.[11] Indeed, philosophical, political, and medical support for infanticide has been growing in the so-called developed world for forty years.[12] What

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[11] Hans Reinders makes an argument that parallels Thomas Reynolds' critique cited above. He locates the forces that alienate the disabled within liberal society, "because its moral community is constituted by 'persons' and these, in turn, are constituted by the powers of reason and free will. This conception of the person is particularly problematic with respect to the inclusion of severely mentally disabled citizens, since on the liberal view only persons in the sense of rational moral agents can be recipients of equal concern and respect." Hans Reinders, *The Future of the Disabled in Liberal Society: An Ethical Analysis* (Notre Dame: University of Notre Dame Press, 2000), 15-16. Martha Nussbaum attempts, with mixed results, to make a liberal case for justice toward the mentally disabled within a Rawlsian framework in her *Frontiers of Justice: Disability, Nationality, Species Membership* (Cambridge: Harvard Unviersity Press, 2006).

[12] See Michael Tooley, "Abortion and Infanticide," in *Rights and Wrongs of Abortion*, eds. Marshall Cohen, Thomas Nagel, and Thomas Scanlon (Princeton: Princeton University Press, 1974), 57. For a recent framing of the argument, see Alberto Giublini and Francesca Minerva, "After-birth abortion: why should the baby live?" *Journal of Medical Ethics,* (February 23, 2012): http://jme.bmj.com/content/early/-2012/02/22/medethics-2011-100411.full. Physicians in the Netherlands actively euthanize—rather than withdraw supportive care while continuing to offer pain control and comfort therapy—severely ill newborns. See Eduard Verhagen, M.D., J.D.,

makes Singer appear so dangerous and radical is the systematic way in which he deprives secular reasoning of attractive elements of moral theology and offers a purely naturalistic account of humanity.[13]

Since infants lack what Singer considers the essentials of personhood—rationality, autonomy, and self-consciousness—killing a newborn, for those who wish to be as consistent as Singer, is not the same as killing a person, and therefore should be permissible, particularly when the infant is handicapped. Singer agrees there should be "very strict conditions on permissible infanticide, but these conditions might owe more to the effects of infanticide on others than to the intrinsic wrongness of killing an infant."[14]

What gives Singer's reasoning its terrible fascination for readers in the economically "developed" global North is its appeal to culturally accepted forms of personal agency. While Singer harshly critiques individuals in the global North who choose to spend money on luxuries rather than make relatively small sacrifices to aid able-bodied persons in dire poverty, he nevertheless offers a bourgeois understanding of the person as an autonomous, choosing, rights-bearing individual, a standard severely disabled persons can rarely attain.[15] In the economically "developed" global North, the technocratic deficiencies of the disabled are usually managed through insti-

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and Pieter J.J. Sauer, M.D., Ph.D., "The Groningen Protocol — Euthanasia in Severely Ill Newborns," *New England Journal of Medicine* 352 (2005): 959-962. The latter example is an instance where technology, cost, compassion and control collide to make hard cases, which in turn make bad law. For a thoughtful consideration of these matters, see Charles Camosy, *Too Expensive to Treat?: Finitude, Tragedy, and the Neonatal ICU* (Grand Rapids: Wm. B. Eerdmans Publishing Co., 2010).

[13] See, for example, Kevin Toolis, "The Most Dangerous Man in the World," *The Guardian,* Friday, July 5, 1999 (Weekend section, p. 52); and Michael Specter, "The Dangerous Philospher," *The New Yorker* (September 6, 1999): 46-55. While some secular ethicists understandably wish to bracket the implications of Singer's relentless consistency from their own thought, Christians—who are charged by Christ to love their enemies—are mistaken if they believe Singer is too "out there" to be taken seriously. If Singer were merely an interesting atheist, like Slavoj Žižek, that's reason enough for Christians to wrestle with his ideas, many of which we will reject. Christian moral theologians and ethicists avoid profitable engagement with Singer's thought at their peril, as many of their late nineteenth and twentieth century predecessors failed to engage Nietzsche. Catholic theologian Charles Camosy begins such an engagement in *Peter Singer and Christian Ethics: Beyond Polarization* (Cambridge: Cambridge University Press, 2012).

[14] Peter Singer, *Practical Ethics*, 2nd edition (Cambridge: Cambridge University Press, 1993), 173.

[15] For Singer's views on personal responsibility, global assistance, and opportunity cost, see "Famine, Affluence, and Morality," *Philosophy and Public Affairs* 1, no. 1 (Spring 1972): 229-243, and *The Life You Can Save: How to Do Your Part to End World Poverty* (New York: Random House, 2009).

tutionalization and social marginalization, powered by the mixed motives of professionalized liberal orders: compassion and control. In so-called developing countries, where communal interdependence is not so thoroughly disrupted and freedom more often means shared consent rather than individual choice, disabled persons may still find a public place in the social order.[16]

Furthermore, there are children like Tyree, even more limited in consciousness than Jasmine, for whom I care even in the absence of loving, involved parents. If you polled most physicians why they, too, would continue such care, there would be much gesturing toward professional responsibility, the duty of a physician, and Hippocrates. Nowadays, however, many physicians treat the Hippocratic Oath—with its invocation of Apollo, prohibitions against abortion, euthanasia, and "cutting for stone," and promises to teach the children of one's medical professors for free—as irrelevant to modern medical practice as bloodletting or phrenology.

While Kant would protest, late modernity treats "duty" as a construct in evolution, changing over time. At the graduation ceremonies at my secular medical school, our class passed over Hippocrates to read a revised version of the Declaration of Geneva, originally composed in the wake of World War II, after atrocities committed by Nazi physicians came to light. But what had been revised—in this case, deleted—in the nearly four decades between its composition and my graduation is telling. My class pledged, as the original text read, to have "the utmost respect for human life." Conspicuously absent in our recitation, however, was the phrase that once immediately followed: "from the time of its conception."[17] What was essential to physicians in the wake of Nazi experimentation became superfluous a quarter century later.

Health in Communion

If neither maternal preference nor mutable concepts of duty suffice, then why should I—save for medico-legal implications of perceived patient abandonment—be concerned with the health of patients like Jasmine? I suspect this is unanswerable without first asking a far more fundamental question: What are the ends and purposes of the practice of medicine?

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[16] See Amos Yong, *Theology and Down Syndrome: Reimagining Disability in Late Modernity* (Waco: Baylor University Press, 2007), 127-140.

[17] *Declaration of Geneva* (1948). Adopted by the General Assembly of World Medical Association at Geneva Switzerland, September 1948, and revised in 1968. There have been several more revisions since, eliminating an earlier instance of the word "life," and adding references to disability, sexual orientation, human rights, and civil liberties.

An end belongs to a thing, practice, or art in itself; to separate the two destroys the latter. My language here would be suspect in a secular academic hospital, but I believe it relatively noncontroversial to say the end of medicine is the restoration and maintenance of that which we call health, and to separate health from medicine makes the practice unintelligible.[18] Purposes, in contrast, are intentions; they belong not to things, but to agents. My purpose in practicing medicine might range from wealth, social status, and control to human flourishing or the compassionate relief of suffering. As long as my purpose does not contradict the end of medicine—that is, health—I don't compromise the integrity of the practice.

But what does it mean to speak of health in Jasmine's case? Like the word "love," "health" has been beaten to airy thinness by trivializing overuse and vacuous abstraction. According to the World Health Organization, for example, health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity,"[19] but I'm not sure how relevant those abstractions are to someone as "limited" as Jasmine. Even noting that health is etymologically akin to the English words "whole" and "holy" seems, at first, to miss the mark. What would wholeness mean for Jasmine, whose limbs are materially intact but nonfunctional, whose forebrain is an attenuated shell, who communicates in grunts and moans?

But this is to think of health in terms of the isolated individual. For Christians, at least, the "wholeness" signified by "health" must never be imagined so small, because a Christian does not exist except in relation—first to God, and then to all creatures. Writer and farmer, Wendell Berry, makes this very point with concision:

> I believe that divine love, incarnate and indwelling in the world, summons the world always toward wholeness, which ultimately is reconciliation and atonement with God…. I believe that the community—in the fullest sense: a place and all its creatures—is the smallest unit of health and that to speak of the health of an isolated individual is a contradiction in terms. [20]

The Christian's foundational relationships are with the Trinitarian God through the person of Christ, and the people Christ gathers

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[18] See Francis Slade "Ends and Purposes," in *Final Causality in Nature and Human Affairs,* ed. Robert Hessing (Washington DC: Catholic University of America Press, 1997), 83; Robert Sokolowski, "What is Natural Law? Human Purposes and Natural Ends," *The Thomist* 68 (2004): 507-29.

[19] From the Preamble to the Constitution of the World Health Organization, adopted in New York, June, 1946.

[20] Wendell Berry, *Another Turn of the Crank* (Washington, D.C.: Counterpoint, 1995), 89-90.

to himself as a body. It cannot be overemphasized that the body Christ gathers is liturgical, constituted by and disciplined through communal worship and communal moral practice. Liturgy—from the Greek *leitourgia*, or people's work, as opposed to the private *ourgia*, from which we get the word "orgy"—is, in Alexander Schmemann's words, "an action by which a group of people become something corporately which they had not been as a mere collection of individuals." [21] At the center of Christian life is—and has been since the birth of the church—a people gathered by Christ.

The beginning of Christian life is baptism, a liturgical, sacramental movement from estranged isolation into the body Christ gathers to himself, where "If one member suffers, all suffer together."[22] The implications of uniting a bewildering diversity—Jews and Greeks, slaves and freepersons, men and women[23]—in one gathered body were challenging and invigorating to Paul and his contemporaries. Living our way into this mystery today, in health care no less than other social and political minefields, should be no less so.

When a Christian is alienated through suffering and illness, she is reunited (one might say, "re-membered") with the gathered body by prayer and communal anointing, as commanded in the Letter of James.[24] Rather than following the modern practice of confining the sufferer to controlled marginal spaces like hospitals and nursing homes, the Christian community is instructed to surround the patient (the word patient comes from the Latin, *patere*, "to suffer") and mark her with oil.[25] While oil was commonly used in the ancient Mediterranean world as a medicinal agent (see Luke 10:34), its Jewish liturgical uses included the commissioning of priests, kings, and prophets. Through this ritual practice, then, sick persons are honored and reclaimed "as productive members of the community, contributing to the welfare of all by associating themselves freely with Christ's passion and death."[26]

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[21] Alexander Schmemann, *For the Life of the World: Sacraments and Orthodoxy* (Crestwood: St. Vladimir's Seminary Press, 1988), 25.

[22] 1 Cor 12:26a.

[23] 1 Cor 12:13, Gal 3:28, Col 3:11, Eph 4:3-6.

[24] Jas 5:13-15.

[25] I am indebted to M. Therese Lysaught for this insight. See her "Patient Suffering and the Anointing of the Sick," anthologized in *On Moral Medicine,* 2nd edition, eds. Stephen E Lammers and Allen Verhey (Grand Rapids: Wm. B. Eerdmans Publishing Co., 1998).

[26] National Council of Catholic Bishops, *Study Text 2: Pastoral Care of the Sick and Dying* (Washington, D.C.: Office of Publishing Services, USCC, 1984), 20. Note that the Hebrew *Mashiach,* from which we get the word "messiah," and the Greek "Christos," mean "anointed."

At the center of Christian liturgical life is the Eucharist, described in an early but easily recognized form in Chapter 11 of Paul's First Letter to the Corinthians. The words of institution Paul uses are virtually identical, in Greek, to Jesus' words in Luke 22:19-20. Paul goes on to say that some of the Corinthians are eating and drinking unworthily, by "not discerning the body." This unworthiness arises from not meeting the real needs of people: their hunger and thirst. Some of the Corinthians gather to eat and drink all they want, while others receive nothing at all. In so doing, the powerful eat and drink condemnation upon themselves, weakening their physical bodies and the gathered body of the church.[27] For Paul, health, wholeness, and holiness exist only in community.

I don't mean to suggest that Paul understands liturgy or church to be primarily about physical health; rather, liturgical practice and discourse form a Christian understanding of the wholeness that is health. Neither am I implying that the Christian should be concerned only with the wholeness of his or her immediate community. The stories, practices, and commitments of the gathered body form our behavior towards the totality of creation.

Likewise, the gathered body is formed in its understanding of the physical body in union with, not in opposition to, spirit and mind, or as Scripture sometimes has it, spirit and soul.[28] Liturgy and sacrament engage not just beliefs but physical bodies submerged in water, smeared with scented oil, and fed with bread and wine become Christ's body and blood. If a sacrament is an outward sign of an inward grace instituted by Christ, that grace is signified on the human body.

The passages from Paul cited above also show how misdirected is any attempt to read Paul as a Platonic dualist, opposing the physical body to spirit or soul. Paul does contrast spirit (*pneuma*) and flesh (*sarx*), using the latter term to signify the human tendency to serve itself and its own interests rather than others. Flesh is that part of us, as creatures, alienated from God, a sign of our mortal need of redeeming grace. On the other hand, Paul uses the physical body (*soma*) as a symbol of the church[29] and the locus of our creaturely relationship with and service to others, as in the passage from 1 Corinthians 11 cited above. Paul writes of body, spirit, and soul as a unity, awaiting the coming of Christ.[30]

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[27] Paul's use of first century conceptions of the body in this regard receive a fascinating treatment by Dale Martin in *The Corinthian Body* (New Haven: Yale University Press, 1995).

[28] See, for example, Heb 4:12.

[29] Rom 12, 1 Cor 12, Eph 4.

[30] 1 Thess 5:23.

As a Jew schooled in Torah, how could Paul think otherwise? He knew, for example, Genesis 2:7, "then the LORD God formed man of dust from the ground, and breathed into his nostrils the breath of life; and man became a living being." Lost on us is the Hebrew word-play between *'adam* (man) and *ha-adamah* (dirt, dust, or ground) that emphasizes the inescapable materiality of the human person. To this dirt, God adds his breath—the word means "spirit" in both Greek (*pneuma*) and Hebrew (*ruach*). Finally, the Hebrew word rendered above as "living being," (*nephesh*) is just as easily rendered "soul." Over many centuries, "soul" has increasingly given way in Western thought to "mind," but my point is the same: what God has joined, neither Plato nor Descartes should put asunder. Consider all this next time you recite the Apostles' Creed and profess aloud, alongside your gathered brothers and sisters, belief in the resurrection of the body. Perhaps you may even ponder what this could mean, in the scope of God's mercy, for you and for Jasmine.[31]

A perfect church would fully embody this sacramental and liturgical formation, but ours is not now nor has it ever been a perfect church. The liturgical Christian traditions are as guilty as anyone else in choosing individualism over community, or mind over body. It's ironic, then, that Wendell Berry, who lives in dynamic tension with the non-liturgical but Scripture-steeped Baptist tradition, summarizes my argument far more eloquently than I:

> The grace that is the health of creatures can only be held in common. In healing the scattered members come together. In health the flesh is graced, the holy enters the world.[32]

If Berry is right—and I believe he is—then the health and wholeness that is the end of medicine gathers and encompasses Jasmine, me, and all my community's creatures in ways for which medical science has no language. To live a healthy life myself, I can't do so in isolation. I can't be healthy without Jasmine.

SITUATING LOVE

In 1 Corinthians 11-13, Paul moves, more or less seamlessly, from liturgy to the gathered, interdependent body to the virtue of love.

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[31] For one thing, what body would Jasmine inhabit and still be Jasmine, if not her current, disabled body? Even Jesus' resurrected body bore the wounds of his suffering (John 20:27). Theologian John Swinton recalls hearing Angela, a deaf woman, describe a dream in which she met Jesus: "Jesus was everything I hoped he would be… and his signing was amazing!" in Stanley Hauerwas and Jean Vanier, *Living Gently in a Violent World: The Prophetic Witness of Weakness* (Downers Grove: InterVarsity Press, 2008), 13.

[32] Wendell Berry, *What are People For?* (New York: North Point Press, 1990), 9.

Following that lead, we turn at last to love's place in a Christian understanding of health. Early in his extended essay on love, Josef Pieper writes, "loving something or someone means finding him or it *probus,* the Latin word for 'good.' It is a way of turning to him or it and saying, 'It's good that you exist. It's good that you are in this world!'"[33] Berry and Pieper help remind me, were I to forget, that it's good for Jasmine to be alive and that love may be an ideal purpose, for Christians at least, to serve the end of medicine.

This is not vitalism, a way of absolutizing a single biological life at the expense of all other goods or a community's legitimate needs. Neither is it a disguised version of that pious chestnut, "God has a plan for her," which, though no doubt true in some way, threatens to turn Jasmine into God's plaything, a means by which the Divine manipulates history. Rather, I understand Jasmine's physical presence to be good in the same way that God looks upon all creation and names it good.

I must add here that the *response* of some "normal" people, including me, to Jasmine's disabilities (much more so than the disabilities themselves) points to something grossly deformed in at least one part of creation: myself. No doubt I would see Jasmine very differently were I not alienated from God through sin, but she is so visibly "other," a stranger to the world I prefer to inhabit, with its easy mobility, technological freedoms, and intellectual pursuits.[34]

It's not only Jasmine's weakness, her inability to convey complex preferences—to make her will known—that makes me uneasy. Her disability is a vivid reminder that my own status as a thinking, choosing individual is temporary and contingent. There will come a time when I will be as limited in my thoughts and choices as she is now. Jasmine, in reminding me of my body's inescapable contingency, is an affront to the life I live in my head. It's my misplaced desire for a life without limits that warps how I see her, the way distant galaxies serve as gravitational lenses, distorting and bending the light from still farther objects behind them.[35] Because I desire individual

[33] Pieper, *Faith, Hope, Love*, 163-4.

[34] Nor are these struggles peculiar to late modernity. Consider the word "cretin," now used in medicine—and rarely at that—to describe victims of severe congenital hypothyroidism, though once employed more generally to designate children with severe intellectual deficits. Though the etymology is contested, it's most likely taken from eighteenth century Swiss patois, in which *crestin*, akin to the French *chretien*, "Christian," signified a human creature as opposed to a brute. In a mountainous region where dietary iodine was scarce, the term was a linguistic reminder that the intellectually and physically disabled were persons.

[35] For an exploration of the dangers in Faustian limitlessness, see "Faustian Economics," in Wendell Berry, *What Matters: Economics for a Renewed Commonwealth* (Berkeley: Counterpoint, 2010), 41-53. Regarding the reciprocal relationship be-

strength more than our common weakness, I see Jasmine as the alienated world sees her, "a shame or a provocation," and her "problems as burdens to be removed or resolved as quickly as possible," instead of as a "living icon… of the crucified Son."[36] If I fail to see Jasmine's humanity in her limitedness, I reject Christ.[37] Jasmine's condition twists her limbs and spine in what must be painful deformities, but the weight of my wrongly ordered desires in turn deforms me into a twisted self.[38]

But, as John 3:16 reminds us, alienated creation is precisely that which God so loved that he sent his only Son. That which God loves retains some of that which God, in creating, saw as good. As with the liturgical practice of anointing, a physician, nurse, or therapist, by the act of caring for a patient like Jasmine, affirms the goodness that that particular person is in the world. Furthermore, Jasmine's suffering presence is the tacit center around which a community—Jasmine's family along with her doctors, nurses, and therapists—is constituted. How the care-giver receives Jasmine's presence is crucial. The patient calls the doctor or nurse to pursue the end of medicine through the habit of caring presence.

Indeed, one may apprehend doctor and patient as friends in the ways analogous to Artistole's taxonomy of a particular form of love—friendship (*philia*)—in the *Nicomachean Ethics*, as relationships of pleasure, advantage, and virtue.[39] I enjoy Jasmine's company, and judging from her squeals and smiles, she enjoys mine. We are, I hope, working towards a common end, that of mutual health in communal wholeness. Finally, I apply, as best I can, my medical skills to help her towards that form of excellence most proper to Jasmine. She, in turn, by her vulnerable presence, encourages me to practice my art in service to the vulnerable. She teaches me to will her good for her own sake—because it's good that Jasmine is in the world—and not to maximize her or my pleasurable experiences or to pursue an abstract duty.

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tween seeing and desire, I could point to Michel Foucault and Rene Girard, but I leave that to others more qualified to mine their work.

[36] John Paul II, "Message of John Paul II on the Occasion of the International Symposium on the Dignity and Rights of the Mentally Disabled Person," http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/january/documents/hf_jpii_spe_20040108_handicap-mentale_en.html.

[37] See Stanley Hauerwas, "Christian humanism is determined by the Father's sending the Son to be one of us. So humanism must always begin with Jesus' humanity. When that isn't the case, in a world of speed and placelessness, compassion becomes a way to say that certain people would be better off dead" (Hauerwas and Vanier, *Living Gently in A Violent World,* 53).

[38] The phrase from the Augustinian tradition is *incurvatus in se*.

[39] *Nicomachean Ethics*, Bks. VIII and IX.

Aristotle acknowledges friendship (*philia)* as a form of love, but he would not consider my relationship with Jasmine friendship, given the stark inequalities of power and ability between us.[40] I disagree, though I concede our friendship might, in fact, be more apparent if it were more obviously reciprocal, as it is with my patients who aren't so disabled. As a pediatrician, I'm used to patients with whom I can't converse—infants both sick and well—but I'm willing to concede my evolutionary advantageous inclination toward finding babies cute. They will also likely grow up to be "productive members of society," perhaps more obviously so than I. But, in valuing my infant patients according to their potential, as adults, to get and spend, I once again abandon Jasmine. As Lennard Davis, an author and adult son of deaf parents, observes, "Value is tied to the ability to earn money: if one's body is productive, it is not disabled."[41]

It seems easier, after all, for Jasmine to befriend me than vice versa. She does not appear to be put off by my temporary abilities and power as I am by her disability and weakness. She is, in many ways, the other, the perfect stranger, challenging me to welcome her in the Christian practice of hospitality. Whether in spite or because of my broader array of choices, I am less free to love. Jasmine is a test case, the encounter that reveals how I respond to everyone.[42]

Heart and Mind

If I write of love for Jasmine—who can't tell me what she wants, much less what she wants to be when she grows up—what does that love look like? It certainly isn't an intellectual exercise, at least in the sense in which the doctors use the word "intellect." Love ultimately entails a sustained choice, but it is not primarily an act of will, and love is nothing if not emotional and embodied. Perhaps the best word for its center is the Orthodox usage of the Greek word, *nous*: "the eye of the heart,"[43] or "the intellective faculty of the heart."[44] The

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[40] In *Rhetoric,* Bk. II, ch. 4, Aristotle describes *philia* as "wanting for someone what one thinks good, for his sake and not for one's own, and being inclined, so far as one can, to do such things for him."

[41] Lennard Davis, *Enforcing Normalcy: Disability, Deafness, and the Body* (London: Verso, 1995), 131.

[42] Along with St. Augustine, I'm comfortable accepting this test as coming from God: "It is written, '*The Lord your God is testing you in order to know if you love him*' (Deuteronomy 13:3). The phrase 'in order to know' means 'in order to enable you to know,' because how strong one's love is is hidden from oneself unless it becomes known even to one's own self by God's testing it" (*Quaestionum in Heptateuchum*, 57; PL 34, 563).

[43] This formulation is taken from the Fourth Century *Marcarian Homilies.*

[44] This is from contemporary Orthodox Bishop Kallistos Ware, who says further, "Nous, in particular, is a very difficult word to translate. If you just say 'mind', that is

Orthodox poet, Scott Cairns, calls to mind the unity of spirit and materiality in the Hebrew *nephesh* ("soul") when he refers to *nous* as "that queer, cool confluence of breath/and blood."[45] To center one's engagement with God and the Other in the *nous* requires the Christian to reacquaint mind and heart—to make reason and love friends—overcoming something like what T. S. Eliot named the "dissociation of sensibility."[46] It is the fateful Western estrangement of reason and affection, that leaves us, poor banished children of Descartes, careening back and forth between polarities that were once a unity.

This dissociation plagued us long before the Enlightenment—in Platonic and Gnostic dualisms, for example—but it is now particularly acute in applied sciences, including medicine, where technology's power and socially conditioned individual desires encourage individuals to value the results promised by instrumental reason over the messiness of affection, friendship, or any of the varieties of love. Affectionless power is most harmful to the voiceless and marginalized.[47] Physicians like to imagine that bioethics has lately tamed the beasts which self-described progressive medical scientists unleashed—of which forced eugenic sterilization and the Tuskegee syphilis experiments are only the best known—but disembodied bourgeois principles (like autonomy or its emasculated and neglected cousin, justice) remain conspicuously silent about the welfare of communities, especially those for whom the control power of applied science is structurally unavailable.

Among the tragedies of contemporary medical education is that many students have a keen interest in pairing affection with specialized knowledge. Medical curricula, however, cultivate the latter while

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far too vague. In our translation of the *Philokalia*, we, with some hesitations, opted for the word intellect, emphasizing that it does not mean primarily the rational faculties. The nous is the spiritual vision that we all possess, though many of us have not discovered it. The nous implies a direct, intuitive appreciation of truth, where we apprehend the truth not simply as the conclusion of a reasoned argument, but we simply see that something is so. The nous is cultivated certainly through study, through training our faculties, but also it is developed through prayer, through fasting, through the whole range of the Christian life. This is what we need to develop most of all as Orthodox, something higher than the reasoning brain and deeper than the emotions." Kallistos Ware, "Becoming Orthodox: Thoughts on Personhood, the *Philokalia*, and the Jesus Prayer," *Road to Emmaus,* 10 (Summer 2002): 49.

[45] Scott Cairns, "Adventures in New Testament Greek: *Nous*" from *Philokalia: New and Selected Poems* (Lincoln: Zoo Press, 2002).

[46] See T.S. Eliot, "The Metaphysical Poets" (1921) in *The Selected Prose of T.S. Eliot* (New York: Harcourt Brace Jovanovich, 1975), 64.

[47] It is harmful to not only economically, physically, or politically marginalized humans, but all living creatures external to the standard calculus of cost and benefit, such as nonhuman animals, ecosystems, and the soil.

ignoring the former, conveying the clear message that the affections are, at best, marginally relevant to medical practice. I've sat alongside interns and residents anguishing over their own Jasmines, weeping over patients who do poorly, and emotionally flogging themselves for providing imperfect care in an imperfect system. In these vulnerable moments, we, their mentors, may offer consoling words and perhaps even model our own practice of compassion, but we're soon enough back to business: the efficient and effective application of medical science.

By overemphasizing the practical intellect and neglecting the affective we leave young physicians friendless, confused, and unguided. This cognitive-affective dissonance resembles what Peter Singer wrestled with as his own mother slowly succumbed to Alzheimer disease. Even when her declining intellectual faculties slipped below those which Singer proposes as the absolute baseline for personhood, he provided her with private nursing care, money he elsewhere argues should be used to help those in poverty who still meet his criteria for assistance. As he later explained to a journalist who asked how he could justify such an exception to his otherwise relentlessly consistent philosophy, "I think this has made me see how the issues of someone with these kinds of problems are really very difficult… Perhaps it is more difficult than I thought before, because it is different when it's your mother."[48]

I am not suggesting this episode proves Singer a hypocrite. Rather, I believe he recognized a dead-end—revealed when neglected affection collided with pragmatic reason. Such dead ends are hidden in medical education as well. Calls for better data on the clinician's experience generally do little more than quantify our failures, and "humanistic" attempts to correct the imbalance, while laudable, rarely relieve or eliminate the emotional burdens. Even when medicine, as currently practiced, attempts to engage the affections, approaches almost always take the form of problem-solving or curricular add-ons, perpetuating the delusion that all things, even love, are subject to control via instrumental reason.[49]

My plea is not to overthrow medical science, or to go back to some imagined past where all was well. There never was such a time. Even if there were, how would one turn back the clock? Medical reason is not what it was when I entered the field more than two decades ago, much less when Sir William Osler advocated stoic *aequanimitas*

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[48] From Michael Specter, "The Dangerous Philosopher."

[49] See Jeffrey Bishop's discussion of this in *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (Notre Dame: University of Notre Dame Press, 2011), 19-23.

as medicine's essential mental virtue. If love and reason can still be made friends, and if doctors can befriend their patients in a technocratic profession for which friendship is, at best, a private, peripheral concern, it will be something new, never before seen.[50] Those Christians in the profession willing to shoulder the task will be making this up as we go along, improvising on themes given us by our tradition, thoughtfully accepting what the profession offers without being determined by it, creatively adapting what our tradition offers to the circumstances at hand.[51] I am too limited a person to tell you the destination, but I can gesture in the direction I think we must go.

Love in Practice

If you've read this far hoping to discover my theological "fix" for the problems identified, I'm sorry to disappoint. As I've written elsewhere, a Christian takeover of—or alternative establishment to—the medical-industrial complex is neither likely nor desirable.[52] Rather, I propose that liturgically formed and theologically informed Christians thoughtfully and lovingly embody the convictions and practices of our tradition.

That means, first and foremost, that they are part of a worshipping community, people who sustain one another in the difficult practices of the gathered body. I suggest starting with the Eucharist. Notice who comes forward for communion: the healthy and the ill, the weak and the strong, dear friends and those I can't quite bring myself to like, who wouldn't have been invited had I been in charge of the guest list. It's good that each one is here, because Christ—not you, not I—calls his people together. And in coming together at the Eucharist, we all become part of one body—Christ's.

This will also require persons with considerable skills in and understanding of two very different worlds: medicine and the church. Reintroducing love in practice to the world of instrumental reason need not be a harsh and dreadful thing, but we should not imagine it will come without effort and cost. Love is patient, sometimes at the cost of efficiency. Those who follow the way of love will find or make time in their schedules for patients in need. If such habits displease the boss or jeopardize one's productivity bonus, what takes priority? I have a family and other important financial responsibilities, so the answer is rarely straightforward.

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[50] We do have, in the form of L'Arche and other communities of friendship, examples to learn from and follow.

[51] See Samuel Wells, *Improvisation: The Drama of Christian Ethics* (Grand Rapids: Baker Publishing, 2004).

[52] Joel Shuman and Brian Volck, *Reclaiming the Body: Christians and the Faithful Use of Modern Medicine* (Grand Rapids: Brazos Press, 2006), 9.

Love is kind, often at the expense of being nice. Medicine is full of difficult judgments about what behaviors are healthier than others, about which courses of action are more likely to achieve a desired end. If love requires me to speak for the marginalized or tell an unfashionable truth to a patient or colleague, will I do so, or will I "make nice?" What if my job is at stake?

Love bears all things, and that makes one vulnerable. To what degree can I be vulnerably present to my patients without compromising clinical judgment? How will I know?

Love, as we have seen, must be embodied, reacquainting the mind with the heart. Matthew 25 makes clear that we are judged to the degree we embody such love in practices to an array of persons we may not be inclined to like: strangers and prisoners; the sick, hungry, and needy. What might medicine look like if Christians recovered the basic practice of hospitality, of extending a loving welcome to the stranger? "Hospitality," "hospice," and "hospital" seem, at first glance, an unlikely trio, though all derive from the Latin *hospes*, which can mean both "guest" and "host," an ambiguity still present in some modern Romance languages. The Byzantine historical counterpart to the hospice was the more elaborate institution of the xenon, from the Greek *xenos,* which can mean "guest," "host," "stranger," and "foreigner." Etymologically, then, xenophobia may mean as much fear of being host as it does fear of strangers.

Welcoming the stranger in the disabled Other is the foundational practice of the L'Arche communities, pairing able-bodied assistants with intellectually impaired friends. These long-term friendships assume the goodness of all community members. This could be mere warmed-over bourgeois liberal piety if not for a second assumption: that the impaired person has much to teach the able-bodied assistant about patience and love. As L'Arche founder Jean Vanier writes:

> Through my contact with… my many, many… teachers among the people with disabilities, I have in some small way learned to inhabit my body and to see it not just as a channel for therapy but as a way of revealing my heart and being in communion with others.[53]

And he elsewhere observes:

> The heart of L'Arche is to say to people, "I am glad you exist." And the proof that we are glad that they exist is that we stay with them a long time. We are together, we can have fun together. "I am glad you exist," is translated into physical presence.[54]

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[53] Jean Vanier, *Becoming Human* (Toronto: Anansi Press Limited, 1998), 98-9.
[54] Hauerwas and Vanier, *Living Gently in a Violent World*, 69.

L'Arche communities explicitly acknowledge that they cannot care for all impaired persons. L'Arche never intended to fix a problem; it serves as a sign, a witness to a world that confines the profoundly impaired to marginal places where they can be controlled and cared for. That's reason enough for modern medicine to reject L'Arche or to dismiss it as a quaint and ineffective oddity. It is naïve, if not dangerous, to assume the L'Arche model can or should be readily incorporated into medical practice as it currently is.

The history of the hospice movement is instructive. Dame Cicely Saunders' original intent was to create communities of hospitality providing total care for the total suffering of pilgrims on their way to death. Over the course of several decades, however, her vision became something rather different: the field of palliative care. As physician and ethicist Jeffrey Bishop narrates the tale, the forces of instrumental reason (including, but not limited to, regulators and third party payers) turned an embodiment of hospitality into a bureaucratically governed, highly individualistic enterprise for managing death.[55] While embodied love and loving persons—Christians and non-Christians—are common in palliative care, the hospice movement's theological motivations have, for the most part, been quarantined on the safe side of the public-private border.

Christians in health care should not expect the medical-managerial system to embrace hospitality. Rather, we must embody it ourselves, welcoming *all* strangers as guests—that is, as Christ.[56] The health care system will require us to follow its legitimate rules, to see more patients than we can truly attend to, to document and bill, but we may still greet our patients with joy, speak to them with dignity, touch them with the same reverence as when we receive the Body of Christ in our hands or on our tongue. To welcome not only Jasmine as Christ, but also the rude, helplessly needy family in the next exam room, requires not a change in the medical system, but a transformation in me. So I must start there, loving even the patients I can't bring myself to like, and attend to what questions arise, what practices call.

That is, I think, what theological reflection by liturgically-formed communities can offer to human endeavors such as health care: better questions to ask of our everyday experience and practices, ques-

[55] See Bishop, *The Anticipatory Corpse*, 253-78.
[56] *Rule of St. Benedict*, ed. Timothy Fry (New York: Vintage, 1998), 51-3; Matt 25:35.

tions that will, in turn, shape how we go on.[57] I can't define all the questions such practices will elicit, but let me offer two for starters:

> 1. If every patient is a guest to be received as Christ, ought not the focus of medical ethics be *whom we welcome* and *how* rather than devoting so much energy to the quandaries of the privileged—those dilemmas arising when medical power (typically in the form of high technology, high-cost therapies) collides with patient autonomy (almost always understood as the choices of isolated, rights-bearing individuals)?
>
> 2. If our relationship to the patient is one of embodied friendship in community, how does this relativize the physician's allegiance to the reigning queen of disembodied bioethical principles: autonomy? Are the discourses of autonomy (centered in the will) and dignity (centered in the embodied affections) truly incommensurate?[58]

Asking these and other questions may lead you to work toward changing things after all. If so, I wish you well. My deep hope, however, is that, whatever you do, you do as a Christian, disciplined by the practices of the gathered community and schooled by the best of teachers: the suffering embodiment of Christ who arrives in the distressing disguise of the patient.[59]

Real Presences

Three years ago, I left the outpatient practice where I first met Jasmine for a position as an inpatient physician, teaching residents and students at a major academic pediatric medical center. My duties there are full of new challenges and opportunities to pose new ques-

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[57] I am differentiating here between liturgical *theologia prima* and the reflective discourse of *theologia secunda,* which many in the West have come to understand as the exclusive meaning of the term "theology." We do not know how to think about our relationship to God and the Other unless we are first aware of our absolute dependence on God's grace, an awareness arising from our practice of communal supplication. I am relying, therefore, on Prosper of Aquitaine's profound insight, *ut legem credendi lex statuat supplicandi,* from his *Capitula Coelestini 8*.

[58] Some contemporary bioethicists think so. See Ruth Macklin, "Dignity is a Useless Concept," *British Medical Journal* 327 (December 20, 2003): 1419-20, and Steven Pinker, "The Stupidity of Dignity: Conservative bioethics' latest, most dangerous ploy," *The New Republic,* May 28, 2008. These articles differ in tone and substance. Macklin's is higher on both counts, while Pinker's disgust at the materiality of the human body makes his already condescending argument comical. Similarities in the articles, though, include privileging the disembodied autonomous will and fearing that talk of dignity is an illegitimate religious—and specifically Catholic—ploy to restrict individual choice and medical progress.

[59] The allusion is to Mother Teresa's frequent reminder that Jesus comes to us in the distressing disguise of the poor and homeless.

tions, but I deeply miss meeting with, talking to, and enjoying the company of many of the families that called me their pediatrician. I still have the lifeblood of a physician's practice: direct patient contact and unmediated encounters with families in difficulty, but that comes in isolated moments—a few rushed days in the hospital—rather than in conversations taken up time and again over months or years. Sometimes I wonder if I made the wrong choice in leaving primary care.

I still see Jasmine from time to time. I ran into her outside the hospital cafeteria not long ago. Her mother was wheeling her to a waiting van after an appointment with a pediatric subspecialist, and to my surprise and joy, Jasmine beamed at the sound my voice. Her mother and I asked one another, with genuine interest, how things were, and we spent what little time we had together in catching up. What I most clearly remember, however, is a sense—immeasurable by any tool of medical science—of being in the presence of dear and knowing friends. It was good that we were there, the three of us, together. It was a holy moment (not the sort of language I use at hospital committee meetings, mind you, but it is precisely the right word). It was an encounter of souls. It was also an encounter that changed me, that invited me to attend, as I had not before, to the holiness present in touching my patients, in hearing their stories, in sharing their grief and fear. On occasion since, when I find myself perfunctorily examining the tenth child admitted that week to my service with an asthma exacerbation, or when I catch myself eyeing the door as a mother vents her anger and frustration at life in general and a dysfunctional medical system in particular, I remember Jasmine's smile, calling me to be present.

Present to what? Present to the wounded and needy persons before me. Present to the worshipping community that sustains me in my work. Present to the many teachers, only some of whom sign their names with an "MD," from whom I learned the knowledge and skills necessary to practice my art. Present to the Christ hidden in my patients and, even more surprisingly, in me—the Christ who speaks through Jasmine's smile and countless other channels of grace, reminding me that here, too, is Christ, asking to be welcomed, waiting to be loved.

It unveils the other virtues, informs them, and makes their practice easier. It points out the truth behind the surface, and the connection among things. Without wisdom, we donâ€™t really know what we are doing.Â The disposition for joy is something that can be consciously cultivated. It is often the result of good vitality in the body, peace of mind, and an attitude of appreciation. It is also a natural consequence of a deep meditation practice, and the letting go of clinging. Examples: Feeling good as a result of the positive states you have cultivated in your body (health), mind (peace), and heart (gratitude). Without joy we are unhappy, cranky, gloomy, pessimistic, bored, neurotic. Love and the lover must be continuous themselves, but are the naturalized, and natural, across space and time in order to demonstrate concepts of male authorial contemplation.6 In that they and their love remain true. Ironically, this case, far from being natural or a priori, love the importance of calculability in literary only takes place via the media technologies that romantic truth is most evident in its desire to distribute its idea. By insisting on the agency of appear incalculable. In other words, truth, love, machines and the cultural quality of love, Kittler the subject, and even nar Critic Reviews for What's Love Got To Do With It? All Critics (53) | Top Critics (20) | Fresh (51) | Rotten (2). Complete with the rock star wigs, superhero body and slightly timid but ever so deliberate snarl in her speech, Bassett embodied the icon during her slow and steady rise to fame, and her tumultuous marriage September 8, 2017 | Full Reviewâ€¦ Candice Frederick. Reel Talk Online.Â It's an astonishing movie, first because despite the pathology of the relationship, it's not only about victimization; it's a celebration of spirit, both religious and human, about a woman who finally found the guts (and the faith) to say "No more." July 29, 2013 | Rating: 3.5/4 | Full Reviewâ€¦ Stephen Hunter. Baltimore Sun. View All Critic Reviews (53). Audience Reviews for What's Love Got To Do With It?