

ON MIRACLES AND MEDICINE: NEGOTIATING
RELIGIOUS VALUES AT THE END OF LIFE

By

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To my family and all the people I love.

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INTRODUCTION

To begin, a truism: the technological resources of contemporary western medicine have had a significant effect on the ways westerners have come to die. Both common sense and the academy agree that machines and chemicals with the ability to sustain or end human life have transformed dying and death. Specifically, health care practitioners have been trying to stave-off death for as long as humans have been ill—another truism. Therefore, the practices of healing and the experiences of dying have interwoven for as long as humans have been making meaning. When one is dying, or even seriously ill, in contemporary America, often one finds oneself in a hospital. But the American hospital is a complex corporation because, all things being equal, complicated people and intricate technologies constitute its rooms and halls. Patients, and their family members, hope their clinicians are not merely technicians, but healers. While technicians can fix a mechanical problem, healers can repair, anticipate, question, and care for us, despite our sour attitudes and constant complaints. The hospital has become a cathedral with real authority over bodily death, as it has the power to physiologically and psychologically heal.

The question, “How has the American hospital become the site of dying?” is important for a historically-minded bioethicist. As a clinical bioethicist in training, I often ask related question “How, and why, do values clash over the care of very-ill individuals?” The American hospital has become a place where values (and the systems that surround individual values) often conflict. The push toward patient’s rights has made American medicine more egalitarian; indeed, with the decline of explicit physician paternalism, value pluralism has become an unquestioned part of hospital culture. With this transition, however, the rights of individual patients have come to conflict with schemes of biomedical decision making and the distribution of communal goods.

For example, what happens when a surrogate decision maker (hereafter: “surrogate”) wants to continue ventilator support, aggressive chemotherapy, renal dialysis, or vasopressors when the health care team believes the patient cannot benefit from such therapies? What if the surrogate firmly believes these the hospital should provide these therapies because she steadfastly believes God will soon heal her loved-one? In this dissertation, I will address a subset of the many value-conflicts that occur in advanced American hospitals; I do so by analyzing the ways value systems grounded in Christian concepts and experiences encounter schemes of reasoning/deliberation that rely on non-theological medical concepts. A value system that places theological concepts at the center, interprets past events, present conditions, and future possibilities in a different manner than the non-theological value systems clinicians employ.

Orienting Questions and Objectives

Two questions orient this dissertation, “What do patients (or their loved-ones) mean when they appeal to the possibility that a miraculous event may save their loved-one from death?” and “How might bioethicists respond to miracle-invocations in a morally responsible way?” If I hope to answer the latter, then I must answer the former as well; to understand the parent who says “A miracle from God will heal my daughter’s cancer” one must interrogate the relationships between (minimally) the ideas of God, prayer, faith, miracle, therapy, and death. In short, we have to discern the ways the invocator’s religious imagination functions: we inquire into her moral ontology in hopes of finding the theological values that influence medical decisions.¹

¹ In this dissertation, “moral ontology” refers to proper actions (morality) in relation to those things that exist (ontology). These objects are the things that constitute the moral world. An example, which will be spelled out in additional detail later: Augustine believes that an action’s properness/goodness is contingent upon the individual’s love of God.

The bioethicist must perform such an inquiry if he hopes to understand the values behind such an invocation. Answering these orienting questions entails fulfilling a number of objectives.

The orienting objectives for this project follow:

1. Describe and analyze the ways bioethicists think about the concept “miracle” and the clinical usage of the term “miracle.”²
2. Delineate and categorize the practical strategies scholars of religion and medicine have put forward in response to miracle-language.³
3. Excavate the integral moral, ontological, epistemic, and political commitments these proposed responses rely-upon (either implicitly or explicitly). Identify the inadequacies I find.
4. Rectify these shortcomings by providing a constructive account of four concepts that play a fundamental role in clinical invocations: miracle, faith, hope, and love/care. St. Augustine’s work will provide the foundation of this constructive account.
5. Justify this construction by restoring the connection between the invocator’s miracle-concept, moral ontology, and conception of proper action.
6. Create a taxonomy that shows how this connection functions for those using miracle-language while struggling with end-of-life decisions.
7. Put forward morally responsible responses that benefit patients, their loved-ones, and clinicians by illuminating the values (moral, epistemic, ontological, and political) that cause conflict.

In order to achieve these goals, a number of tasks lie ahead. I have divided this dissertation into five chapters—with this Introduction serving to accomplish the first objective. Objectives two and three will be met with chapters one and two, respectively. Chapter three will

² Here I am making a distinction between ideas that rely on other ideas (concepts) vis-à-vis ideas as we use them in speech (terms). Conceptual analysis herein relies on questioning the relations between concepts; while the analysis of terms involves interrogating and clarifying of the way words are used in contextualized settings.

³ In this dissertation, “scholars of religion and medicine” denotes those scholars and clinicians who consider interactions between religion (systems of beliefs and sets of practices focused on ultimate meaning) and medicine (as another set of culturally influenced ideas and practices focused on the health and well-being of individuals and groups).

address goals four and five; with the final two chapters dedicated to the sixth and seventh tasks. With the remainder of this introduction, I will: 1) adumbrate this manuscript's chapters, 2) clarify the methodological commitments required of the orienting tasks, and 3) describe and interrogate the conceptual and clinical usage of "miracle" as one finds it in literature on religion and medicine.⁴

Overview

Religious terms do not fit well into the prognostic schemes physicians, surgeons, and nurses know and use. This discord leaves most physicians uncomfortable when addressing theological commitments in clinical settings. Medicine's prognostic schemes function efficiently without concepts such as "God," "prayer," or "miracle," but, patients may not understand themselves, their communities, or their worlds without such notions. While scholars have published "practical responses" to the clinical use of "miracle," there have been no published works that: 1) systematically review the ways scholars examine and respond to clinical miracle language, 2) interrogate the implicit moral values, epistemic commitments, and ontological assumptions that structure these practical responses, 3) construct an description of miracle-language that connects the cardinal concepts of miracle-invocations with accounts of proper action, 4) categorize the manifold clinical uses of "the miraculous," or 5) proffer responses sensitive to the vicissitudes of the invocator's beliefs. If successful, this dissertation will make a positive contribution in each of these five areas; overall, this dissertation contributes to debates in bioethics and clinical bioethics by providing a taxonomic analysis of clinical miracle language

⁴ This phrase, "the literature," here represents what I take to be a collection of works by scholars of religion and medicine. The authors of these works come from distinctive backgrounds and employ different methods; nonetheless, what connects them is their concern with issues pertinent to the study of religion and medicine.

that has been firmly grounded in a coherent account of the intricate relationships between theological values, clinical reasoning, and moral ontologies.

In chapter one, I will provide an analytic overview⁵ of contemporary responses to clinical miracle language. The orienting goal for this first chapter is to show how scholars of religion and medicine envision *proper responses* to clinical miracle-invocations. I will analyze six (6) categories of responses found in the literature: 1) epistemic questions, 2) theological negotiation, 3) spiritual assessment, 4) empathetic imagining, 5) appeal to professional values, and 6) intolerance. Groupings one through five (1-5) are not mutually exclusive, in fact, a number of sources suggest employing some combination of these responses. The authors of these strategies include physicians, nurses, bioethicists, chaplains, and psychiatrists, while the primary target-audience are physicians and nurses faced with the practical problem of dealing with those who use such language.

Responses usually begin by suggesting that the clinician evaluate the clinical knowledge of the invocator: perhaps his hope for a miracle is based in a misunderstanding of the patient's diagnosis or prognosis. A number of authors conclude their strategies with the reminder that when options are exhausted then legal services or ethics committees may be required. As we will see, what happens in between questions of clinical understanding and calling for external help varies: the literature on this subject proffers no single, standard way of responding to miracle-invocations. Although the majority of scholars interested in this topic accept that miracle-language has a place in the clinic, those who argue that western medicine should not tolerate miracle-language make up an important subset of dissenting voices. These philosophers argue

⁵ An "analytic overview" describes and captures the cardinal themes and methodological commitments one finds in some body of literature. This mode of analysis, in this context, systematizes and categorizes responses to clinical-miracle-language.

that a society committed to a just distribution of resources is a society that makes decisions with public reason (*ratio*), not personal pseudo-reasons inundated by theology's brackish waters.

These practical strategies help busy clinicians who, quite admirably, respond to religious language with questions rather than consternation. However well-intentioned, these responses raise a number of questions: "Are these responses justified?—and if so, how?" "What are the theological implications of such strategies?" and, most pressing, "What values provide the foundation from which such practical responses are built?" With chapter two, I begin interrogating the *explicit* values and excavating the *implicit* moral, epistemic, and political values buried in these responses. This analysis will illuminate the moral ontologies that motivate the literature's practical responses. The overarching argument of this chapter is this: the moral ontologies these practical strategies depend upon are at odds with the moral ontologies of the invocator, owing to the fact that health-care professionals and patients (or her loved-ones) feel fidelity toward different objects: one toward the standards and norms of the scientific endeavor, the other toward God.

As chapter two explores the values that make up medicine's responses to miracle-language, chapter three investigates the interlacing values behind the patient's invocation. An adequate understanding of the invocator's worldview requires an in depth look at the connection between miracle-invocations as an expression of faith and the moral ontology from which such expressions spring. In chapter three I argue that miracle-invocations can represent complex moral ontologies that place fidelity to God as a cardinal duty. Using a number of works by St. Augustine (354-430), I clarify the ways in which the theological imagination connects self-hood, knowledge, and ontological commitments with a unified conception of proper action.⁶ The topics

⁶ Although I will clarify and detail my use of "theological imagination" later, for now, the processes of theological imagination involve a specific cognitive activity: the manipulation of theological images, concepts, and experiences.

I address include: ontological hierarchy, personhood, proper action, and the virtues of faith, hope, and love. This chapter provides a formal account of how a miracle-concept can interact with other moral and theological concepts. While a formal account tells us much about the sophisticated structures that give rise to miracle-invocations, it will also be necessary to discuss the ways miracle-invocations function in end-of-life settings. Without such a discussion, the connection between the theological imagination and concrete practices would remain opaque.

The fourth chapter proposes a taxonomy of clinical miracle-invocations. With the help of philosopher Jan Patočka (1907-77), we will create a better portrait of the invocator's religious imagination. At the broadest level, I divide miracle-invocations into two kinds: unshaken and existential. I base this distinction on the invocator's willingness to discuss her conceptual scheme—her degree of openness. The unshaken invocator is closed-off from the questions the ethicist poses; with this kind of invocator, the suffering he has seen or experienced in the clinic has had no impact on his conception of what is and what is good. On the other hand, some invocators—existential invocators—have been affected by their clinical experiences. The existential invocator is open to conversing with the ethicist about her conception of the miraculous because her conception of the world and self has become unstable—as clinical events have had a profound effect on the invocator's worldview. The outcome of this authentic existential struggle may be 1) pedagogical: wherein the invocator learns something new about her sense of self, community, and/or world, or 2) tragic: wherein the invocator's conceptual scheme remains fractured and shaken—leaving him with no real sense of self or what is.

Within the unshaken category we find, what I will call, political-invocations. The political use of “miracle” designates a process whereby the invocator uses the term to carve out a

The theological imagination contributes to ways we think about and discuss the miraculous. In the clinical, end-of-life scenarios I attend to, the theological imagination plays a foundational role in reasoning and decision making.

space beyond medicine's ken, a space where theological terms emit greater influence. When patients or families use theological terms such as "miracle" in the political sense they are not struggling with their relationship to the Divine; instead, the term affords an opportunity of influence. Also within the unshaken category, we find the doxological use of "miracle." This kind of invocation occurs when one responds to traumatic illness with uncritical praise of God and God's Plan. One's place in the world, conception of God, and sense of community remain untouched even when suffering seems unfair, God appears unjust, and prayers remain unanswered. We find fixed conceptual schemes in both the political and the doxological use of "miracle."

The concluding chapter, chapter five, moves from the ways theological imaginations function (descriptive analysis) toward the issue of morally responsible responses to miracle-invocations (normative analysis). I argue that conservative notions of clinical ethics consultation may be able to respond to doxological miracle-invocations; however, these strategies fail to properly respond to existential miracle invocators. The world of the existential invocator has been shaken by the clinical suffering she has witnessed or experienced directly. To ignore this kind of suffering would be a significant oversight on the part of the ethicist. The ethicist should use her skills in empathetic imagining and critical analysis to help the invocator find a coherent conception of her self, community, and world.

Methodological Commitments

When I began paying serious attention to the question "What do patients (or their loved-ones) mean when they say 'miracle'?" I assumed a multitude of fields had replied to some aspect of this question. Qualitative sociological analysis (and ethnography) would have been applied to

focus groups, numerous patients, and clinical situations. The medical humanities would have something to add about the dramatic suffering invocators routinely experience. Clinicians from the growing field of religion and health would have used quantitative methods to analyze nationwide trends and tendencies. Pastoral care providers and bioethicists would have provided numerous case studies with characteristic analysis. I thought that maybe even philosophers and theologians had supplemented (and critiqued) the aforementioned fields—using their analytical skills to show implicit assumptions and unsavory implications. But I found very few sources dedicated to this specific question. I assumed this project would involve substantial critiquing, criticizing, and problematizing of entrenched accounts of clinical miracle language; however, I found less substantial analysis than I anticipated. This finding was both disheartening and exciting. Given the clinical importance of miracle terms for so many American patients, it was disheartening that more sustained and rigorous research had not been done; however, I was also excited—and still am excited—because I would have the opportunity to inaugurate a more sustained discussion. Therefore, it is my hope that this project might serve as a catalyst for scholars who find the issues surrounding clinical-miracle-language attention-worthy.

The content and parameters of a project's orienting questions determine the methods with which one answers the question. Historical questions require historical methods; sociological questions require sociological methods; bioethical questions require bioethical methods. Bioethics, however, is a young field, a field that often deals with both concepts and practices. It is a field whose practitioners include physicians, nurses, theologians, philosophers, anthropologists, historians, and others. With such a pedigree, methods flourish. Since my orienting questions and projected goals address the use of theological concepts in clinical

settings, this dissertation requires an approach that can address both theory and practice.⁷ That is, we have to get a sense of 1) how the invocator uses “miracle” in relation to other concepts, and 2) how the term actually functions in a clinical setting. Without a robust understanding of the conceptual aspects of the term, analysis of its practical aspects will fail to provide clinical insight—we would be left reacting rather than responding. As I will show, one of the inadequacies of bioethics today is the casual slide between discussing concepts as they are independent of experience and concepts as they function clinically.

So then, the question becomes: What methodological commitments follow from my want of performing both conceptual and practical analysis of clinical miracle language? One option would be donning the cloak of the philosopher of religion. The philosopher of religion, however, proffers an analysis of “miracle” that goes beyond the scope of this project, as she purportedly describes the miracle-concept *in itself*. Her work asks, for example, “Can miracles *actually* happen?” “How do the laws of nature relate to miraculous events?” “Is God the cause of a miraculous effect?” One need only appeal to Section X of David Hume’s *An Enquiry Concerning Human Understanding* (1748) for a paradigmatic example of a philosophical analysis. Depending on one’s interpretation, Hume argues either: 1) against the real possibility that a miracle could ever occur in nature or, 2) against the theoretical possibility that one could justifiably/rationally accept the occurrence of a miraculous event. In either case Hume’s argument tells us little about the ways Christians might use a miracle-term as they suffer—and that is fine, as this task is not the philosopher of religion’s concern. What this means for this

⁷ Of course, there are many good reasons to question any steadfast division between theory and practice. Continental philosophers have worked very hard to convince us that a dichromatic distinction is historically grounded in untenable assumptions about selfhood and experience; for example, see the first chapter of Hans-Georg Gadamer’s *The Enigma of Health: The Art of Healing in a Scientific Age* (1996). Nonetheless, I will maintain a soft division between theory and practice.

project is that the methods of the philosopher of religion could not answer my orienting questions—at least in any exhaustive manner.

Christian theology (both in its historical and constructive personas) should assist in any rigorous analysis of religious language, but this discipline alone cannot answer our orienting questions. Unlike philosophy of religion, theology provides hermeneutical resources for the interpretation of biblical sources. Historical theology, especially the thought of Augustine provides a much-needed theological foundation for my analysis of essential religious concepts: belief, faith, hope, love, and miracle, for example. But like philosophy of religion, the methods of theological reflection alone cannot fulfill my objectives. Putting forward an account of the varieties of miracle-language those near death employ requires a firm foundation in this-worldly experiences. No analysis of “miracle” from a single, myopic theological lens (no matter how historical or dynamic) could anchor this task. If successful, this dissertation should smell of the *practice* of religion—it should show how practitioners *use* concepts to navigate affliction and dying.

I gathered, initially, that exclusively qualitative methods could center my understanding of how the term “miracle” functions in clinical settings. To figure out what “miracle” means, why not ask the people who use the term? However, relying solely on this approach would result in a project that would leave wanting the interrogation of the values (both manifest and latent) found in miracle-invocations. That is, ethnography is not *bioethics*—if we take ethics to necessarily involve the interrogation of values, meaning, and proper action, as I do. Describing *what* the patient assumes, intends, and says when hoping for a miracle does little to tell us: 1) what values are at play, and 2) how this situation ought to be addressed in a morally responsible manner. Qualitative research done in medical institutions can, undoubtedly, have practical

implications for the clinical bioethicist. For example, Sharon Kauffman's ethnographic study *...And a Time to Die* (2005) provides grist for those clinical ethicists who experience the turbidity of America's ICUs, but she neither interrogates implicit values nor sets-forth explicit, practical responses for the ethicist. Bioethics goes beyond description to the normative, so an exclusively qualitative approach would fall short.

Enough with what this project isn't. As I said, my orienting questions and objectives require an approach centered on the methods found in bioethics. But the scope of bioethics ranges from the theoretical (think of the theologian or philosopher analyzing the relationship between fetushood and personhood) to the practical (the clinical or research ethicist addressing specific questions about clinical values and institutional policies). In between, we find issues of concern to both the clinical ethicist interested in reflecting on his practices, and the theorist concerned with contextualizing her conceptual analysis. Or, to put this designation differently, theoretical bioethicists give little thought to concrete situations, instead concentrating their efforts on conceptual analysis. They try to clarify ideas with minimal attention to specific events or people in the world. Popular methods found within this theoretical realm include Aquinian natural law, Kantian deontology, and Millian consequentialist utilitarianism.

On the other hand, practical bioethics does not pay much attention to questions of conceptual relationships until these relationships directly affect clinical or research practices. On the clinical ethics side, real cases need resolution in a timely manner. This context gives little thought to theoretical discussions of the abstract nature of rights or the good. On the biomedical research side of practical bioethics, scholars discuss policy issues regarding, for example, an institution's implementation of a DNAR/I order or a nation's guidelines concerning stem-cell

research. Practical bioethics emphasizes informed practice, while theoretical bioethics emphasizes conceptual reflection.

In between the clinic and the clouds we find reflection upon practices. The most fertile and historically noteworthy methods in this area of bioethics are: principlism, casuistry, feminism, narrative inquiry, phenomenology, and virtue ethics. Each of these approaches could provide an orientation from which one could discuss the conceptual schemata and concrete practices found in clinical miracle-invocations. And I believe any of these approaches could lead to a better understanding of clinical miracle language. With this dissertation I hope to not only analyze the values behind (or embedded in) discursive practices, but also put forward a practical account of just *how* a clinical ethicist should respond to miracle-invocations; therefore, an appeal to the middle of this spectrum seems most appropriate. If my theoretical analysis does not illuminate the ways bioethics can be practiced, then I cannot answer the questions that orient this dissertation.

My tasks require an approach that has been labeled “applied ethics.” This label seems appropriate insofar as I show how Augustinian conceptions of imagination, proper action, and ontology can help clinical ethics consultants better understand miracle-language in clinical, end-of-life settings. In this manner, then, I *apply* some theoretical structures to clinical situations—theoretical structures that may be alien, to some small degree, to clinical practices. An analogy: let’s say you arrive home after the sun has set. Your plans for the evening involve reading the final chapter of Vladimir Nabokov’s *Invitation to a Beheading*. Good choice, but you need light. You could light a number of candles, get out a flashlight, open up the blinds and read by the light of the moon, or—do what you usually do—flick a switch and read under the light of your reading lamp. Candle, flashlight, moonlight, and lamplight: each of these sources would shed

light on your book in different ways. As your overarching goal is to understand and enjoy what Nabokov has written, finishing *Invitation* under your reading lamp may be your best option. Here, Augustinian concepts and the analogous reading lamp both represent a great method for accomplishing the goals at hand. Could one take a different approach? Of course, but I am committed to the proposition that Augustine's thought illuminates the ways patients and surrogates invoke God's healing power in clinical, end-of-life settings.

I am proposing what John Arras calls a "normative theory of limited scope" (Arras 2010, 60). While I believe Augustine's moral thought may help us get a better grasp of the complex meanings behind miracle-invocations, I am not committed to the possibility that the Saint's philosophical insights could easily apply to other areas of bioethical inquiry. His thought *may* improve our understanding of topics such as abortion rights, prenatal screening, the right-to-die, or clinical scenarios that lack any apparent Christian language. However, my scope is much narrower. I am not arguing that Augustine's voice benefits every, or even most, controversial issues in bioethics; rather, I am arguing that the Saint's work clarifies the values present in clinical, end-of-life discussions where a patient or surrogate invokes the term "miracle."

The Meaning and Use of "Miracle" in Clinical, End-Of-Life Settings

Now that I have expressed my methodological commitments, I feel free to move toward addressing the ways scholars of religion and medicine think about "miracle" both as a concept (i.e., what does "miracle" *mean*) and as a term (i.e., how is "miracle" *used*). The remainder of the Introduction answers this question. I will describe ten (10) ways scholars of religion and medicine discuss the miraculous: both in its conceptual and locutionary guises. These descriptions show: 1) what kind of sources scholars appeal to in their descriptions, 2) how

scholars negotiate the tensions between miracle-concept and miracle-invocation, and 3) the ways scholars understand the theological and political status of miracle-invocations. In other words, the Introduction analytically reviews the significant historical, cultural, and medical resources from which miracle-responses spring.

Appealing to Philosophy of Religion

First, we find a popular approach in an essay by William Stempsey. Stempsey argues that the concept “miracle” has no place in medicine in his “Miracles and the Limits of Scientific Knowledge.” He begins with contemporary philosopher of religion Richard Swinburne’s definition of the miracle-concept as “an event of an extraordinary kind, brought about by a god, and of religious significance” (quoted in Stempsey 2002, 1). A vague and broad definition that lends itself to numerous interpretations depending upon how one defines event, extraordinary, brought about, god, and religious significance; nonetheless, no matter how one defines these terms, metaphysical and epistemic questions linger. Stempsey divides the intellectual history of the study of “miracle” into three camps: 1) the pre-Hume medievalists, with their emphasis on metaphysics, 2) Hume, with his turn to epistemic concerns, and 3) those who have written post-Hume.

He begins with Augustine’s conception of miracle. Stempsey’s Augustine shows a strong metaphysical emphasis, describing Augustine’s view thusly, “in bringing about a miracle, God does not act in contradiction to nature’s order, which God has originally created. Rather, God activates an element that has been there from the beginning but has been hidden to human observation” (*ibid.*, 2). I believe Stempsey wants us to notice that cause and effect (a topic for

metaphysics) occupies Augustine's attention as he defines "miracle": hence this concern with God's powers of "activation."

Greatly influenced by R.J. Fogelin and Antony Flew, Stempsey describes David Hume's analysis of "miracle" as an epistemological, not metaphysical, undertaking. Stempsey's Hume does not question *if* miracles have happened—or even could happen—as this is a metaphysical issue; instead, Section X of *Human Inquiry* answers an epistemic question: given what we know about the unreliable nature human testimony, could we *ever know* if a miracle took place? Hume is skeptical (*ibid.*, 3). He argues that humans are not reliable enough interpreters and reporters: our testimonies concerning the miraculous inevitably contain spurious and exaggerated aspects. Hume concludes that if a religious system plants itself in the soil of human testimony, then human judgment could never deem said religious system "true." A troubling conclusion for the Big-Three monotheisms.

Stempsey then moves into a discussion of the laws of nature, hoping that a turn back to metaphysics will be conducive in illuminating the relationship between medicine and miracles. Alastair McKinnon, C.S. Pierce, Alfred North Whitehead, and Charles Hartshorn form the backbone of his analysis (*ibid.*, 4, 6). Stempsey gives Whitehead the bulk of his attention, but finally sides with Hartshorn's Whiteheadean conception of nature: "the view that the laws of nature are absolute statements of the way things must be is wrongheaded. A strong dose of epistemological skepticism in the face of a miracle claim is certainly warranted. However, one can maintain that miracles are metaphysical impossibilities only from a particular metaphysical worldview, and such a worldview may not be the best account of the totality of our human experience" (*ibid.*, 7).

This insight matters for medicine because physicians are scientists, and scientists are determinists (*ibid.*). Stempsey defines “determinism” as “the view that the state of the universe U at present time t is wholly a function of the state of the universe at past time t–1; U at t–1 is a function of U at t–2, etc., back to the beginning moment of the universe, if one exists. Thus, in principle, the present state of the universe is completely explainable in terms of past states of the universe” (*ibid.*). A deterministic metaphysics excises the possibility of a miraculous event, as all events can be explained by appealing to previous, physical processes. Those exceptionally positive clinical events (e.g., a cancer’s spontaneous remission) should not be labeled “miraculous” from medicine’s frame of reference. Such a “miracle” *must* have a non-Divine, physical cause—we just happen to be ignorant of this cause. Stempsey’s conclusion: “Physicians have no epistemological grounds for declaring any cure miraculous. Miracles are theological (or philosophical) entities, and not medical entities. All physicians can do is to determine whether a cure is scientifically inexplicable according to the current epistemological standards of medical science” (*ibid.*,7). Thus, we see that Stempsey’s conceptual analysis of “miracle” employs theologians and philosophers to investigate the term’s epistemic and metaphysical facets.

Appealing to Historical and Constructive Theology

The bioethicist and the theologian rarely share goals, but bioethicists lean on theological methods when constructing a definition of "miracle." In a 2007 article, Daniel Sulmasy provides an extensive, six-part definition of miracle as:

- (1) a real, individual event, the occurrence of which must be (or must have been), at least in principle, susceptible to empirical verification;
- (2) an event which must be extremely unusual or historically unprecedented from the perspective of empirical scientific knowledge;
- (3) must evoke widespread wonder;
- (4) must be something freely given by God and not conjured;
- (5) must be understood as a special sign from God that transcends the bare facts of the case and communicates a spiritual message; and
- (6) must have been

affirmed as a miracle by the community of believers to whom the message of the miracle must be addressed, at least indirectly. (Sulmasy 2007, 1227)

A condensed version of this definition found in the same article: a miracle is a "historically unprecedented expression of God's rationality, love, and creativity with respect to the world" (*ibid.*, 1224). Sulmasy goes on to explain and justify this definition using philosophy of science (to justify his conception of nature's laws) and theology (to justify his definition's God-concept).

Like Stempsey, Sulmasy appeals to Thomas Aquinas and Hume; unlike Stempsey, Sulmasy constructs the above original definition. Sulmasy finds Hume's conceptions of both nature's laws and God unconvincing given Hume's Deistic theology (*ibid.*, 1223).⁸ For Sulmasy, Aquinas proffers a much more palatable conception of nature, God, and miracle. Sulmasy appropriates Aquinas' notion of nature as he argues against Hume's ontological and epistemic commitments. We must make a distinction, Sulmasy's Aquinas argues, between an event that would be contrary to nature and an event that would be contra the *order* of nature (*ibid.*, 1224). The first event would be a "miracle" for Hume; while the second event would be a "miracle" for Aquinas. However, Aquinas' conception of nature depends on his theology; specifically, his conception of God as the occurrent/sustaining cause of all aspects of nature. The result: God is not some alien thing outside of nature whose actions cause gross disturbances. It then follows that if God were to perform a visible miracle, God would not be working against nature itself—that would be impossible for the occurrent cause—but against how we commonly perceive nature's order (*ibid.*).

Commitments about the laws of nature also follow from Aquinas' conception of God as sustaining cause, leaving Sulmasy with the task of a philosopher of religion. He writes, "a phrase

⁸ Unfortunately, Sulmasy does not address Hume's most powerful critique: that no religion could ever be founded upon miracle-testimony.

such as the ‘laws of nature’ can only make sense if it is interpreted as ‘the order of nature:’ a set of descriptions about how things usually operate [...]” (*ibid.*, 1224). Against Hume, Sulmasy holds that nature’s laws are always *ceteris paribus*, “other things being equal” (*ibid.*). That is, the laws of nature are useful rules when contemplating the physical things in the universe because, in order to do science, we must treat fluctuating variables as constant (*ibid.*). For example, when an evolutionary biologist does a study of migration patterns, she must treat reproductive patterns as if they were not susceptible to extreme change. This method gives scientists the power of abstraction; without such a power, science could never make universal generalizations. The methods of science may apply to every natural event, however, since they can only offer *cet. par.* inferences, the scientific method could never provide an exhaustive explanation of any single event.

Miracles have an objective nature for Sulmasy (*ibid.*, 1225). Jesus’ Resurrection either did or did not happen (*ibid.*). However, “objective” here cannot mean that if a miracle has occurred, then the laws of nature have been violated. This was Hume’s mistake (*ibid.*). Instead, we ought to describe a miracle as a violation of the *order* of nature. Given God’s attribute as the occurrent cause of all things, and the *cet. par.* nature of scientific universals, it is nonsensical to ask “Did this event fracture nature’s immutable order?” When we ask such a question, we conflate conceptual schemes (one theological, one scientific) (*ibid.*, 1225-26). Recall, the brute, objective fact of some event cannot exhaust the *meaning* of said event. Believers and scholars can explore the theological, philosophical, psychological, sociological and historical meanings of a miracle-event, while the scientist could question the event’s objectivity.

Sulmasy is one of the few scholars of religion and medicine who mentions and addresses the conceptual economy we find in this give-and-take between God and those praying for a

miracle. This economy of the miraculous, as I will call it, rings problematic as we wonder: 1) what kind of deity needs to be goaded into acting miraculously? and 2) how might one go about prodding God properly? Leaning on Mircea Eliade (1907-1986) and Acts 8:9-24, Sulmasy makes a distinction between provocation and conjuring. Provocation is a genuine religious act in which the petitioner requests something (here: a cure) from a being that holds the power to grant such a request (*ibid.*, 1226). Then the provoked deity reacts, causing the requested event (*ibid.*). Conjuring (contra provocation) places the impetus of power in human abilities, not divine mercy. Here the human makes requests of God. Those humans who conjure assume they control the Spirit; they brashly tell the Divine what to do. To successfully conjure would be magic, but provocation centers on the relationship between the petitioner and God, not the result. Therefore, we should consider provocation a religious act, and conjuring a blasphemous misunderstanding of Divine Action (*ibid.*).

Sulmasy makes this distinction with a specific goal in mind: he hopes to justify petitional prayers. As the name displays, these prayers petition God for something the petitioner feels God (and only God) can provide (*ibid.*, 1227). Think of those loved-ones fervently praying that God will restore the suffering patient to full cognition and physical health. These prayers do not inform God of God's duty to heal (this would be conjuring); instead, these petitions provoke God's loving action. For Sulmasy, such pious actions: 1) make God aware of the believer's needs, 2) show the believer's investment in a loving relationship with the Divine, 3) exhibit a radical dependence on God, 4) open the supplicant's heart to God's overwhelming grace, and 5) are events that qualitatively change situations—that is, petitional prayer concerning some state of affairs affects the situation simply because the situation has been prayed-about (*ibid.*). The

clinical up-shot for Sulmasy: praying for a miracle-cure makes sense given the nature of the miracle-concept and our relationship to the Divine.

After this sortie into ritual studies, Sulmasy delves into the communal and public aspects of miracles. A miracle-event could never be private, since God sends miracles as signs to God's *communities* (*ibid.*). Miracles must be public events that bear witness to God's loving relationship with the whole of humanity. Using both Ludwig Wittgenstein (1889-1951) on the impossibility of a private language and the etymology of *religare*, Sulmasy writes, "There are no private miracles. Miracles are public; they belong to the community of believers and not merely to the person who experiences the miracle. Miracles are signs from God, meant not just for one but for all. Miracles only become miracles when they are accepted as such by a community of faith" (*ibid.*).⁹ This final aspect of Sulmasy's conception of "miracle" pushes his definition away from philosophy of religion toward ecclesiology—the branch of theology that address the nature of the Church. We are no longer appealing to a miracle-concept, but a group's criteria for the designation of an event as "miraculous." Let us move on from philosophy and theology to bible-based discussions.

Appealing to the Bible

Other scholars of religion and medicine approach the possibility of clinical miracles with Scripture orienting their analyses. In *Embracing Our Mortality: Medicine in the Age of Miracles*, Lawrence Schneiderman appeals to the Bible for his definition of "miracle": quoting Luke 18:27, "the things which are impossible with men are possible with God" (Schneiderman 2008, 89). The

⁹ We can already feel clinical reverberations. Sulmasy's definition excludes the possibility of a miracle based solely in an individual's subjective interpretation of an event; therefore, in clinical contexts, hope for a miracle is hope for some event that one's community deems feasible.

author emphasizes the vast distinction he sees between miracles as they occur in the Bible, and miracles as patients expect them. Of all the impressive things humans can do, we cannot, by definition, perform miracles (*ibid.*, 90). When a miracle occurs, God is the only party responsible. By Luke's definition, if a human caused the event, then the event could not be called miraculous. In the context of contemporary medicine (Schneiderman's central concern), this means that no clinician or researcher should describe rare events as "miracles," and no patient should ask a miracle of their health care team (*ibid.*, 89, 91).

Schneiderman believes western medicine employs technology in an unreflective fashion. Using primarily case studies, Schneiderman argues that medicine has made false promises; medicine has generated the "false hope" that ICU technology has the power to stave off death *ad infinitum* (*ibid.*, 105). The sick and their loved ones have come to expect that clinicians ought to keep the dead alive: any available technology has become a beneficial technology. While Luke tells us that only God performs miracles, medicine actively promotes the possibility that humans and their machines can work miracles (*ibid.*, 101-112).

Charles Pinches holds that *any* definition of "miracle" ought to revolve around Jesus' healing miracles (Pinches 2007, 1236). He begins with a "skeletal definition" of "miracle" from Aquinas: "those things which are done by divine agency beyond the order commonly observed in nature" (*ibid.*). However, Pinches asserts that any Christian definition of the miracle-concept must take the biblical narrative as its standard; therefore, in order to add some flesh to the skeleton, Pinches discusses a number of Jesus' healing miracles. The miracle periscopes included in the New Testament testify or bear witness to "a truth beyond them" (*ibid.*). Pinches observes that heals for the sake of identification; that is, Jesus identifies himself as the Messiah and Savior of Humanity through healing miracles (*ibid.*, 1237). Pinches emphasizes the real-world, nitty-

gritty situations where Jesus works his miracles, as Jesus' physical presence connects the afflicted with their healer (1238).

For Pinches, each New Testament miracle illuminates an aspect of: 1) the miracle-worker, 2) the direct recipient of the miracle, and 3) the witnesses to the miracle (*ibid.*, 1238). Once the miracle-worker heals the recipient, the witnesses (including, for Pinches, the readers of the accounts) interpret the event. It is with this hermeneutical problem of interpretation where Pinches adds the most bulk to Aquinas' definition. Returning to his central point, Pinches quotes John 20:30-31, "Jesus did many other signs in the presence of His disciples, which are not written in this book. But these are written *so that you may come to believe that Jesus is the Messiah, the son of God*, and that through believing *you may have life in His name*" (emphasis mine). Pinches worries that contemporary readers "resist" the true meaning of a Bible-centered definition of "miracle" because we forget that Jesus connects those he has healed to the readers, and the readers to each other (*ibid.*, 1237-1238). Just as those healed return to life, if we recognize the Messiah-hood of Jesus then we too "may have life" (*ibid.*, 1239). Pinches wants us to accept that a Christian understanding of the miraculous must include this connection of the Savior (1), the physically healed (2), and the potentially saved (3). Therefore, Pinches steadfastly believes we cannot hope to understand a miracle-event without taking biblical hermeneutical imperatives into account.

Appealing to Etymology

Other commentators elucidate the use of "miracle" etymologically. For example, both Elizabeth Heitman and Jakub Pawlikowski trace the English term back to its Latin roots. Pawlikowski refers to the noun *miraculum* (a "wonder") and the Latin verb *mirari* ("to wonder")

in his introduction to “The History of Thinking about Miracles in the West” (Pawlikowski 2007, 1229). For him, this etymology shows that a miracle-event ought to cause wonder in those who experience it. Going farther, he writes that a miracle “must also be in some way unusual, extraordinary, or contrary to our expectations [...], related to nature (being in some sense beyond, above, contrary to nature, etc.), and triggered by factors differing from natural causes that are already known” (*ibid.*). This etymological description does not tell us much. If the individual’s intellect is the criterion for the presence or absence of a miracle, then the term is subjective, completely. Philosophy and theology have no place in an analysis of the concept. One would simply search one’s own stock of knowledge, and pose an insular question, “Does this event go against what I know of nature’s common course?” Pawlikowski takes up the lens of the historian in hopes of supplementing his etymological analysis. Awkwardly jumping from the Ancient Greek cults of Asklepios to the 20th century’s philosophers of religion Swinburne and Hartshorne, Pawlikowski tries to adumbrate “the history of thinking about miracles in the west” (*ibid.*) An insuperable task for a book, let alone a journal article. Pawlikowski concludes the article with an observation that holds for any conception of the miraculous, “Different approaches to miracles are a consequence of differences in understanding nature and God” (*ibid.*, 1234). We could argue with Pawlikowski about his assertion that one’s conception of miracle is a *consequence* of one’s understanding of nature and God (depending on how strong his idea of “consequence” may be), nonetheless, he is right: any coherent thoughts of God, nature, and miracle intertwine.

This etymological approach functions in a similar fashion for Heitman. She also appeals to the Latin verb “*mira*” (“to wonder at”) in the introduction to her presentation, “The Expectation of Miracles and Ethical Issues that it can Create.” She writes, “a miracle is an event

that amazes us, both because it is unexpected and because it leads to inexplicable good” (Heitman 2000, 1). Heitman here traces the amazement and wonder we feel when confronted with a miracle to two requirements: 1) the miracle must be unexpected, and 2) the miracle-event must cause some positive outcome (*ibid.*, 3-4). We do not wonder at humdrum occurrences, and we do not deem “miraculous” those rare events that lead to inexplicable bad. Heitman, like Pawlikowski, promptly moves on from an etymological analysis, leaving us with a subjective emphasis on our own expectations and evaluations. As Heitman’s presentation focuses on the clinical aspects of praying for a miracle—in the context of oncology—we ought not to expect an analysis of the miracle-concept *in itself*. For now, we see that etymological analysis leads to an emphasis on personal astonishment without illuminating the nature of the miracle-concept itself.

Appealing to Scientific Methods

While still appealing to the Latin roots of “miracle,” other scholars orient their discussion of the nature of miracles from an explicitly secular *Weltanschauung*. Richard Peschel and Enid Rhodes Peschel describe their perspective on the miraculous as that of the “physician-scientist.” The Peschels commence their analysis by combing through the annals of history; however, their real interest remains present-day discussions of miracle terms. Hoping to capture our contemporary usage, they describe three distinct aspects of “miracle”: 1) the religious meaning, 2) the lay meaning, and 3) the scientific meaning (Peschel and Peschel 1988, 395-96). First, a religious miracle “is an event that apparently contradicts known scientific laws and is attributed to a supernatural cause, especially to God” (*ibid.*). So here we find two material aspects of scholarly definitions of the miraculous: 1) the contradiction of scientific laws, and 2) a supernatural cause. The Peschels refrain from further analysis of the religious meaning.

The “lay meaning” of miracle leaves out God’s causal role and science’s laws; instead, the laity think of the miraculous as “something marvelous, amazing, or wonderful that seems quite unexpected or unpredictable” (*ibid.*, 396). Examples the Peschels list: miracle drugs, the miracle of love, and the miracle of life. In these phrases we find no direct attribution to the Divine, nor are the laws of science confounded. God plays no (direct) role in the creation and administration of pharmaceutical “miracle drugs,” and research scientists break none of nature’s laws when testing a therapy’s potency. The “miracle of love” sounds like a hackney greeting card category that has little to do with nature’s laws. While some may view the birth of a child as a “miracle of life,” arguing that human life is, in general, “unexpected or unpredictable” would be a challenge, as one is faced with nearly seven billion examples.

The Peschels define a scientific miracle as “as an extremely unlikely event or an event that has an extremely low probability of occurring: a spontaneous remission, for example, or a recovery from a disease from which most people die” (*ibid.*). So, thus far, we have a conception of miracle grounded in statistics. What counts as a “low probability?” Like Pawlikowski and Heitman, the Peschels mention the verb *mirari* and the noun *miraculum* as they clarify the connection between the three distinct species of the miraculous. Religious, lay, and scientific miracles contain wonderful, marvelous, astonishing, and awesome aspects (*ibid.*). The Peschels point out that physicians rarely label marvelous and rare events “miracles” (although they could according to the Peschels’ definition); instead, physicians appeal to more statistical, sterile language—calling such events “spontaneous remissions,” “cures for unknown reasons,” or “unexplainable events” (*ibid.*).

According to the Peschels Scientists and physicians have no incentive to investigate the causes of a spontaneous remission because scientific miracles *must* occur, by definition (*ibid.*,

397). Statistical analysis attests to this sentiment: if about half of one percent of all cancer patients experience an unexplainable, spontaneous remission, then the oncologist ought to expect that a small numbers of her patients will inexplicably survive against-all-odds (*ibid.*).¹⁰ The physician-scientist's vocation does not include finding causal explanations for these rare events; indeed, for the Peschels, this task does not belong to "the scientist" at all, since the scientist acknowledges that rare events must occur (*ibid.*).

Appealing to an Anthropological Analysis

Following this thread of clinically oriented descriptions of "the miraculous," anthropologist Joan Cassell's *Expected Miracles: Surgeons at Work* (1991) comes to mind. Prompted by a semi-ironic comment from an anonymous surgeon's assessment of his own performance, Cassell uses the term "miracle" as a metaphor to illuminate the ways surgeons practice their craft (Cassell 1991, 6, 213). Six characteristics of "religious miracles" overlap with the "expected miracles" surgeons produce. Both classes of miracles are: 1) rapid, 2) spectacular, 3) definitive, 4) attributable to some responsible entity, 5) performed by some authority with great power, and 6) unpredictable (*ibid.*, 3). Much of Cassell's study can be read as an analysis of the relationships between miracles in their surgical and religious guises. Surgical procedures are complex, but singular, events; therefore, the concrete and time-sensitive nature of such procedures makes rapidity of great import (*ibid.*, 3, 35-37). Also, the nature of such events requires that the surgeon himself have the prowess and skill to make rapid decisions (*ibid.*, 36-37). Like Jesus' turning of water into wine at a wedding in Cana, the surgeon "propels the beneficiary from a disvalued to a valued state: sickness to health, death to life, water to wine"

¹⁰ See Michael Shermer's "Miracle on Probability Street" (2004) for a similar analysis.

(*ibid.*, 3). We must deem such a transformation “spectacular” (*ibid.*, 38). Miracles and surgical operations share the quality of being both definitive and irreversible—both may permanently augment human bodies (*ibid.*, 3, 38). An incision becomes scar tissue and remains part of the body; a removed appendix stays removed.

Responsibility also factors into both operations and miracle events, as both actions can be attributed to a single entity: surgical miracles to the surgeon, religious miracles to God (*ibid.*, 39). One may direct her blame or praise at a single individual who must take responsibility for success or failure. Of course, others may participate in such performances, but we rightfully give *ultimate* responsibility to “an all-powerful commander” (*ibid.*). This veil of omnipotence comes from, according to Cassell, not mere technical prowess and practical wisdom, but a hyper-masculine personality with “leadership ability” (*ibid.*, 40). Indeed, surgeons have “special powers”: in the operating room, the surgeon must believe that only her deft abilities may save the patient from certain death (*ibid.*, 3, 44, 50). Still, uncertainty and mystery are characteristics of miracles and surgical operations (*ibid.*, 3). Statistics may provide murky projections of what might happen, but each procedure, each patient, each disease harbors particularities; therefore, each procedure is a unique operation where aggregate statistics could never represent the future with certainty (*ibid.*, 48). In both the operative theatre and the Church, obscurity clouds the outcome of any petition, leaving mystery surrounding even routine procedures.

Appealing to Methods in Pastoral Care

As one would expect, scholars in the field of pastoral care and chaplaincy show an interest in the clinical usage of “miracle.” Using the case of a dying infant, James T. Wagner and Tami L. Higdon put forward three “generic features” that those hoping for a miracle exhibit

(Wagner and Higdon 1996, 26). Born with leukemia, a nameless boy suffers through his first year of life as his mother prays to God for a complete, miraculous recovery (*ibid.*, 24). Upon his final admission to a pediatric intensive care unit (PICU) the clinical team intubates the boy, at the behest of his mother (*ibid.*). Weeks go by; the boy's mother remained insistent: their son will remain full-code while waiting for God's miraculous action (*ibid.*, 25). The PICU staff knew that soon his endotracheal tube would dislodge and the mother would insist upon reintubation. The staff invited boy's mother into the room when the tube finally fell out, so as to show the trauma involved in reconnecting the tube. After a few minutes, the mother told the team to stop. The boy was placed in his mother's arms to die (*ibid.*).

Wagner and Higdon identify three qualities found in such cases. First, someone believes that God will, eventually, intercede in order to save the sick in some physical sense (*ibid.*). Second, intensity of prayer is the means by which the invocator hopes to influence Divine action. Third, the believer shows a "narcissistic focus" on the needs of their own family (*ibid.*). This myopic view causes the invocator to lose sight of both the "facts of the case" and the needs of other patients (*ibid.*). In such scenarios, praying for a miracle creates distance between the believer and the clinical reality (*ibid.*). The authors, unfortunately, fail to explain why the boy's full-code status conflicts with other patients' essential care. Instead, Wagner and Higdon continue their essay by discussing how religious belief may function as a negative coping mechanism, defined as a psychological defense that staves-off feelings of guilt and abandonment (*ibid.*, 26). The leukemic boy's mother, the authors hold, uses an idiosyncratic conception of the miraculous in order to cope with her son's physical deterioration. When a clinician witnesses a miracle he should give thanks to God, but he must remember that such events: "[...] are inexplicable, cannot be duplicated, and never result in proof that there is a God [...]" (*ibid.*).

Additionally, Wagner and Higdon claim that “historical theologic [*sic*] reflection” does not support the actions of supplicants such as the boy’s mother. Both prolonging life while waiting for a Divine gift and praying for a miracle display negative coping strategies (*ibid.*). Let us move on from a pastoral care perspective to the reflections of medical historians.

Appealing to the History of Medicine

Although medical historians have little at stake in debates surrounding contemporary clinical miracle language, their work shows a keen sensitivity to the ways medicine and theology negotiate distinct ideas of suffering and death over time. Jacalyn Duffin is a Canadian hematologist who became interested in healing miracles after blindly reviewing four bone-marrow samples for the Vatican—as she later learned (Duffin 2007, 699). The four slides told of a patient suffering from severe acute leukemia with a remission, relapse, and a final remission. The leukemic patient claims that he or she survived this confrontation with leukemia thanks to numerous prayers directed at Marie-Marguerite d’Youville (1701-77). Duffin later found out her diagnostic findings became part of the canonization testimony of St. d’Youville. A decade after attending the canonization ceremony for the Saint in 1990, Duffin began researching the role of the scientist in miracle testimonies at the Secrete Vatican Archives. The Archives house a file, a “*positio*,” on every official candidate for beatification (which requires two certified miracles) or canonization (which requires, minimally, two additional miracles). In her sprawling survey of three hundred and thirty three (333) *positioes*, (dated c.1600-2000) Duffin found six hundred and seventy-seven (677) miracles. To her surprise, over ninety-five percent (95%) of said miracles involved bodily healing, and nearly every *positio* contained testimony from medical authorities (*ibid.*, 706, 708).

Duffin's research shows that the Vatican's designation of a "miracle cure" depends on medicine's standard of care. Before the 19th century, saints performed miraculous healings for those physical illnesses that the cleric, the doctor, and the laity could recognize: skin diseases, blindness, paralysis, tremors, and non-functioning limbs (*ibid.*, 710). By the early 19th century, illnesses had moved to the body's interior. These additional sites now required advanced diagnostic methods—and the importance of medical specialists increased (*ibid.*, 713). Take the example of tuberculosis/consumption. If someone claims to have miraculously survived this ailment (thanks to the direct intercession of some saint), then the patient's doctor would become an integral part of the case—who else could tell the difference between consumption and an unsightly bloody cough?

Duffin also notes the interesting relationship between miracles and technological innovation. The stethoscope, thermometer, X-Rays, tools for blood-pressure measurement, and the EEG—these diagnostic technologies show up in the *positioes* soon after their invention (*ibid.*, 717-18). Indeed, the Vatican requires that the *miraculé* experienced top-notch medical care (*ibid.*, 718). If she has not, the holy-person's case for beatification or canonization stalled: additional miracles would be required. Duffin points out that the Vatican must depend on medical expertise because it, the Vatican, insists that the sick receive the best treatment medicine can provide. To return to TB, records show that soon after Koch's discovery of the bacillus that causes TB (1882), the Vatican began requiring that any possible *miraculé* with TB had tested positive for the bacillus. As medicine advances, so must the Vatican's criteria for saintly intervention.

The Vatican has relied on medical professionals to illuminate three essential criteria for the occurrence of a miracle: 1) completeness, 2) durability, and 3) instantaneity (*ibid.*, 727). The

cure must be complete insofar as the affliction has vanished entirely from the body of the *miraculé*. While scar tissue and other vestiges of medicine's activities may remain, no trace of the illness can remain. Concerning durability, the saintly cure must last for the life-time of the patient. When the *miraculé* dies, his death must have been caused by some illness or trauma in no way related to his miraculous healing. Finally, speed becomes a necessary condition for such a miracle. Duffin states that doctors felt most comfortable discussing the rapidity of a cure (*ibid.*, 727). In the *positioes*, the swiftness of the patient's recovery routinely surprises the testifying professionals. An example: "When asked if such a cure might have taken place naturally, the doctor would reply confidently—"perhaps, but not so quickly" (*ibid.*). The Vatican requires that each miracle-cure exhibit these three necessary (but not sufficient) conditions; therefore, medical practitioners and experts have become the sole group with the ability to assess these requirements of the miraculous, according to the Vatican.

Appealing to Quantitative Data

Scholars in the growing field of religion and health do not define the term "miracle;" instead, in these quantitative studies the respondent supplies the content. This form of scholarship asks questions such as, "Do you believe in religious miracles?" and "To what extent do you believe in divine intervention, or the possibility of miracle [*sic*] that might change the course of your illness?" (Mansfield et al. 2002, 402; True et al. 2005, 175). *Nota bene*, when the respondent answers either "Yes" or "No" (or some variation thereof) we learn *that* some person does or does not believe in divine intervention. Such information is useful when describing broad, aggregate trends of religious belief across time or comparable segments of society. For example, the former question listed above comes from a quantitative study Christopher J.

Mansfield (et al.). The authors culled data from a telephone survey of 1,033 residents in Eastern North Carolina. A few of the more pertinent findings include: nearly eighty-eight percent (87.5%) of respondents responded in the affirmative when asked if they believe in religious miracles, with nearly sixty-three percent (62.6%) saying that they *definitely* believe in religious miracles (Mansfield et al. 2002, 403). Also, over half of the surveyed (58%) “believe that God probably acts through religious healers to cure people,” with a third (33.8%) holding a firm belief that God acts through religious healers (*ibid.*). When asked if they believe God acts through medical professionals to cure the sick, eighty percent (80%) affirmed this belief, and nearly half of the overall population claiming that they *definitely* believe God acts through physicians (*ibid.*).

Like most studies in religion and health, Mansfield’s work includes comparative statistics on race, gender, education, health status, religious affiliation, and annual income. Take this comparison for example: Mansfield found that ninety percent (90%) of African Americans believe that God works through medical professionals, while the general population believes at a slightly lower rate of eighty percent (80%) (*ibid.*). Concerning comparisons of health status, respondents who rate their health as “poor-to-fair” are twice as likely to discuss spiritual concerns with their doctors than those in “very good-to-excellent” health (*ibid.*, 406). Gender also plays a role, as women are twice as likely as men to discuss “spiritual issues” with their physicians (*ibid.*).

Quantitative studies in religion and health help us recognize broad trends. If I were a health care provider in Eastern North Carolina Mansfield’s findings could be quite valuable. To know that nearly nine out of ten residents believe God can work miracles may influence my clinical actions. However, despite their analytical rigor, such studies tell us little about *the*

content of respondents' beliefs. How do North Carolinians conceive of the miraculous? What makes a miracle different from a fortuitous event? When answering such questions, the respondents would surely appeal to disparate stories, familial relations, accepted church teachings, and/or unorthodox beliefs: making their answers specific, textured, and of marginal use when analyzing region-wide trends. Most studies in "religion and health" leave such questions for the clinic; therefore, we would be fool-hardy if we trekked across these studies in hopes of finding astute and nuanced descriptions of the miraculous.

Appealing to Clinical Experience and Common Sense

Cindy Hylton Rushton and Kathleen Russell published the literature's most detailed exploration of clinical miracle language in 1996. In "The Language of Miracles: Ethical Challenges," philosophy and theology implicitly inform their definition of the miracle-concept; however, the authors do not cite any specific philosophers or theologians. Rushton and Russell describe the miraculous in three ways, first, from a "spiritual perspective."¹¹ This perspective describes the miraculous as "God's intervention in the world that defines [*sic*] human capacity" (Rushton and Russell 1996, 64). We can safely assume Rushton and Russell intended to write "defies" rather than "defines." They go on: "Miracles may also be viewed as a vehicle of meaning, a sign, that invites a personal response of commitment or faith. In this sense, miracles involve a personal and existential dimension that is not refutable by reason or scientific fact" (*ibid.*). Rushton and Russell's description contains concepts our previous scholars entertain (examples: God, intervention, sign, and scientific fact). Additionally, miracles are "unexplainable events or actions that challenge the limits of humans, technology, or apparently

¹¹ This designation appears equivalent to my use of "miracle-concept."

contradict known scientific laws” (*ibid.*). Unfortunately, Rushton and Russell do not interrogate their notion of “scientific laws,” and they leave us to interpret what “the limits of humans” might be; nonetheless, they observe that both clinicians and patients use the term when technological prowess overcomes the near-certainty of death (*ibid.*). With this description, miracle-language will always have a place in the clinic because surprising, rare events will never—by definition—cease (*ibid.*). One need only recall the introduction of renal dialysis, heart transplantation, influenza vaccines, or chemotherapy: yesterday’s “miracle-technology” becomes banal and expected.

A Concluding Thought

I will conclude this introduction with a concise review and a look forward. I have: 1) explained the impetus behind this project, 2) set a number of goals, 3) illuminated the scope and methodological commitments required of this project, and 4) analyzed the cardinal ways scholars of religion and medicine describe and interrogate both the concept of “miracle” and the clinical use of the term “miracle.” Also, this Introduction serves to set up this project’s second task: the delineation and categorization of practical strategies scholars have put forward in response to miracle-language. Let us then move on from what the term might *mean* or how the term might *function*, to how we might *respond to* the term.

CHAPTER I

RESPONDING TO MIRACLE LANGUAGE: A CRITICAL REVIEW

In introducing this project, I have shown ten (10) germane perspectives on “the miraculous.” To reiterate, if one asks the question, “What do scholars of religion and medicine have to say about miracles?” see above. It is my hope that the Introduction gives the reader a good sense of the philosophical, theological, and clinical resources scholars of religion and medicine employ when thinking about what a miracle *is* and how the term might function *in clinical settings*. In this chapter, I take up the related—and more explicitly ethical—query, “According to scholars of religion and medicine, how should clinical professionals respond to theological language (especially ‘miracle’ or ‘God’s will’) found in clinical, end-of-life scenarios?”

It seems appropriate to begin with the practical strategies bioethicists and clinicians have developed in hopes of properly caring for those who justify their clinical decisions with Christian tenets. I have categorized the literature’s responses into six (6) categories: epistemic questions, empathetic engagement, theological negotiation, spiritual assessment, appeals to professional values, and intolerance. This sexpartite division reflects six common, conceptually robust, and well-explained modes of response. These categories do not exhaust the practical strategies found in the literature. For example, other popular responses include requesting the presence of other

hospital services (e.g., chaplains, psychologists, or lawyers),¹ or the patient's religious authorities.² Still, they represent what I consider the cardinal responses one may find.

Most scholars advocate a combination of these responses—the exception being those who argue that health care providers should not tolerate miracle language insofar as it influences clinical decision making. I have yet to encounter a scholar who argues that a *single* strategy could adequately address every miracle-invocator's situation; nonetheless, some scholars emphasize one response over others—arguing that one method may be *particularly* expedient.

I would like to begin with a story. This story will act as a touchstone for the practical strategies our authors offer; additionally, a narrative will give the reader a sense of the clinical realities that surround miracle invocations. Mrs. Judith O'Shay (a pseudonym) suffered a hemorrhagic stroke in the spring of 2013. She recovered to some degree, and returned home to live with her son Steve in Nashville TN, with her daughter April nearby. Mrs. O'Shay also had a second daughter (I'll call her Maria) who lived in Tennessee, but not near Nashville. A few months after her first stroke, Steve found his mother unconscious in their kitchen. At VUMC, Mrs. O'Shay was diagnosed with status epilepticus, a neurological condition that left her experiencing constant brain seizures. When I first saw her, she was unconscious, on ventilator support, and not responsive to her surroundings.

The Neuro-ICU attending saw two paths ahead for Mrs. O'Shay: aggressive care or palliative care. The aggressive path included a tracheotomy, surgical debridement, a feeding tube, and burst-suppression therapy (BST). A controversial therapy, BST employs numerous

¹ For example, Elizabeth Johnston Taylor suggests contacting the institution's chaplaincy service (1999, 393), and Carlos Eduardo Pavia finds that psychologists may be of use in order to ensure the invocator is coping with stress properly (2012, 444).

² For example, James F. Buryaska (2001).

anesthetics (in this case, propofol) to place Mrs. O’Shay in a drug-induced coma, with the hope of stopping her constant seizures. It’s a dramatic and impressive therapy when successful, but the Neuro-ICU team believed Mrs. O’Shay would not survive the propofol coma. As the BST would be the lynchpin of the aggressive course, all teams agreed that the best way forward would be a transfer to VUMC’s Palliative Care Unit, where she would be extubated. While she may survive extubation, the clinicians imagined that she would die soon after.

While all the children agreed that their mother would not want the aggressive path, on the morning of the transfer, Maria refused to have her mother taken from the Neuro-ICU. Maria was insistent: her mother should remain on the aggressive path because God needed time to work a miracle. With enough prayer, Maria believed God would reward the family with Mrs. O’Shay’s complete recovery. For Marie, palliative care was not only giving up on her mother, but equivalent to giving up on God. Now what? With this case in mind, let us visit six responses scholars of religion and medicine have posed to address such situations.

Epistemic Inquiry

Raising epistemic questions—questions about what the patient believes or knows—is a common response when patients employ clinical miracle language. Indeed, for a number of scholars, this is the first step the clinician ought to take when attempting to understand an invocator’s assertion.³ What does the invocator know (or *think* he knows) about the patient’s condition? The medical team may pin their hopes on a misunderstanding: perhaps the invocator just simply doesn’t understand that his loved-one is so close to death. Perhaps he fails to see that the medicine’s technological and pharmacological prowess has reached an end point in terms of

³ Examples include: DeLisser (2009), Brett and Jersild (2003), and Rushton and Russell (1996).

curing their loved-one's illness. This strategy makes sense, as numerous studies show that miscommunication often occurs during end-of-life conversations (Brett and Jersild 2003, 1648). Perhaps the invocator has not realized that medicine's abstract clichés, "we are at the end of the line," "we have no more tricks up our sleeves," and "we should hope for the best, but prepare for the worst" apply to her loved-one's situation. Or, as Brett and Jersild put it, "Clinicians should ensure that patients and families firmly grasp all relevant diagnostic and prognostic information. Similar to conflicts expressed in secular terms, conflicts framed in religious terms may resolve when clinicians attend closely to the informational needs of patients and families" (ibid.,1648). Lather, rise, repeat if necessary.

This process makes sense. Informed consent would be a meaningless formality if a patient or surrogate fails to grasp: what's wrong, what proposed therapy may help, and what complications may arise. In a number of studies, patients and their surrogates reiterate the paramount importance of accurate diagnostic and prognostic information. In a 2003 study from Gerard Silvestri (et al.), the authors asked people with advanced lung cancer, their caregivers, and oncologists to rank the importance of the following factors when considering treatment options: the cancer doctor's recommendation, faith in God, ability of treatment to cure disease, side effects, family doctor's recommendation, spouse's recommendation, and children's recommendation (Silvestri et al. 2003, 1380). This list reflects the rankings of both the patients and their caregivers—in descending order of importance. The oncologists also rank "the cancer doctor's recommendation" as the most important factor when making clinical decisions, while ranking "faith in God" last. Relatedly, a study by Latifat Apatira (et al.) found that ninety-three percent (93%) of surrogates feel medical professionals must not avoid prognostic discussions

with surrogates even if such information may mute the hope felt by a surrogate (Apatira et al. 2008, 863).

Rushton and Russell also feel assessing the family's understanding of the patient's moribund condition comes first, as the invocator may: 1) lack pertinent information, 2) have experienced poor communication with those providing information (Brett and Jersild's main worry), and/or 3) disagree with the proposed care plan (Rushton and Russell 1996, 64). Different problems require different solutions.

Rushton and Russell acknowledge that reiterating clinical facts may help clarify all three problems. However, agreement upon the truth of some clinical fact does not entail agreement upon the *interpretation* (Rushton and Russell say "conclusion") of some fact (*ibid.*). So, diagnostic disagreement may come from a different interpretation of clinical facts, rather than a misunderstanding. A distinct interpretation of medical facts, Rushton and Russell want to make clear, "does not necessarily signify that the parent is irrational or lacks understanding" (*ibid.*). Indeed, the professional's goal need not involve convincing the invocator that her (the professional's) interpretation of clinical facts is the correct interpretation. Such actions sew rancor rather than clarify the patient's condition (*ibid.*). In these situations, intra-/inter-familial relationships may have worn thin due to ambiguity and hardship; while health care workers feel frustrated when their words and deeds do not have the salubrious effect intended. Discovering what the invocator believes or knows is often difficult in these strained clinical encounters. Rushton and Russell caution clinicians against obdurately repeating the same information to the same people (*ibid.*). Showing the invocator that he just has not grasped all the facts of the case is ham-fisted and inexpedient when disagreement actually hinges on the *interpretation* of facts.

This epistemic response requires a deft and nuanced understanding of the invocator's beliefs about the clinical situation.

Concerning this subjective interpretation of significant facts, a study by Elizabeth A. Boyd (et al.) found that only *three* of one hundred and seventy-nine (3/179, or 2%) surrogates for ICU patients at "high-risk of death" depended solely upon their physicians' prognostic declarations when making substituted judgments (Boyd et al. 2010, 1271). Interviews revealed that other factors often eclipse clinical prognostication; examples: the patient's will to live, the surrogate's interpretation of the patient's physical appearance, the patient's proven ability to overcome past illnesses, the surrogate's healing presence at the bedside, and "optimism, intuition, and faith-based beliefs" (*ibid.*, 1272-73). A rosy flush of the cheeks on an otherwise ashen face, a previous victory over pneumonia, the power of positive thinking, or a belief in God's power to heal even those with terminal illnesses: any of these beliefs may very well signal, for the surrogate, that the ICU physician's terminal prognosis could be incorrect or premature.

Responding to miracle-invocations with epistemic questions of diagnostics and prognostics is made all the more difficult by clinical uncertainties. The air of prognostication is redolent with ambiguity; even at the end-of-life when the patient seems patently moribund to all involved, uncertainty lingers. A 2000 study by Nicholas A. Christakis and Elizabeth B. Lamont asked three hundred and forty-three (343) Chicago-area doctors to estimate how many days remain for their hospice-referred patients.⁴ The authors found that the participating doctors regularly overestimated the number of days their patients would live; concluding that only twenty percent (20%) of the doctors' predictions were accurate: with sixty-three percent (63%) predicting that their patients would live significantly longer than they did, and seventeen percent

⁴ The criteria for hospice referral in Illinois include the physician's belief that the patient will die within six months of referral.

(17%) underestimating their patients' longevity (Christakis and Lamont 2000, 470).⁵ The authors find that this “systematically optimistic” tendency contributes to two end-of-life problems: late referrals to hospice care, and an undue prognostic optimism for the patient or his decision maker (471). Uncertainty follows any prognostic endeavor; still, when answering the question, “How long does the patient have left?” prognostication becomes even more problematic. Such studies show that even after designating a patient “terminally-ill,” her time-of-death remains illegible. This makes answering the question, “But are you *certain* my grandma is so close to death?” with an unwavering “Yes” inadvisable.

Instead, let us imagine how an ethicist informed by the scholars who promote this strategy might respond to Mrs. O'Shay's daughter Maria. He would begin with diagnostic and prognostic questions. Is the aggressive path really as untenable as it seems? If so, the ethicist would do his best to make sure all of Mrs. O'Shay's family understand her present condition and future medical possibilities. The patient suffers from a complex neurophysiological problem with the aggressive path contingent upon an anti-intuitive therapy; therefore, the clinical ethicist motivated by this strategy would be willing to invest his time in facilitating conversations between health care workers and the family. Here, the ethicist facilitates effective communication. He understands the ways Maria and her siblings react to clinical facts—remembering that even physiological states of affairs call for understanding and interpretation. If it so happens that clinical misunderstandings provided the basis Maria's hope for a miraculous recovery, then this approach serves to reorient this hope into a more feasible goal, for example, the hope of a good death. If, however, Maria continues to insist on the aggressive path after she

⁵ Here an “accurate prediction” is defined as between 0.67 and 1.33 times the actual survival date.

exhibits a clear understanding of the clinical aspects of her mother's care, then a number of scholars suggest moving onto addressing the surrogate's religious beliefs directly.

Theological Negotiation

Theological negotiation involves interrogating religious commitments. This strategy has two steps: first, understand the invocator's theological concepts, second, put forth alternative explanations of contested theological concepts, if necessary. In this literature, we find an assortment of proffered alternatives—varying from broad suggestions to specific strategies for understanding and/or replying to specific religious concepts.

Let us begin on the broad side. Rushton and Russell hold that the clinician should first make a good-faith attempt at understanding what the invocator might mean by “miracle” (Rushton and Russell 1996, 64). The hospital worker should not assume that a miracle-invocation necessarily entails the clinical assertion that God will completely, permanently cure the invocator's loved-one. Rushton and Russell put forward three contrasting descriptions of such invocations: 1) hope for a longer life, 2) the experience of fewer, less painful symptoms, or 3) survival with disabilities (*ibid.*). Hoping for this kind of miracle can be healthy; therefore, health care workers should tolerate such expectations (*ibid.*). Such hopes help families set goals. If the patient's progress does not match the family's expectation, the family realizes they may need to set more realistic goals (*ibid.*). The clinician should differentiate between hopefulness, optimism, and denial (*ibid.*). So then, what happens if the goals become unreasonable—if hope begins to harm, rather than benefit, the patient? In this case, Rushton and Russell hold that challenging the faith of the invocator is justified. Unfortunately, they leave the reader without a description of how this challenge proceeds; fortunately, they provide a hypothetical example of

harm: if the surrogate treats the patient solely as a means for achieving fidelity to a religious tenet, then the surrogate “is disrespectful to the life of the [patient]” (*ibid.*). Rushton and Russell admit that taking the further step of *responding to* this disrespectful temperament with a new plan of care may be an onerous task. So for the authors, the proper response to clinical miracle language involves both understanding, and if necessary, challenging religious beliefs.

In an article in *Chest*, intensivist Horace M. DeLisser puts forward a more specific, “practical approach” for clinicians in conflict with miracle-invoking families. DeLisser’s first step: “explore the meaning and significance of a miracle” (DeLisser 2009, 1643). This exploration, for DeLisser, provides the clinician with the opportunity to discern “what the physician is ‘dealing with’” (*ibid.*, 1644). This inquiry works as a non-argumentative opening volley (*ibid.*). When a physician carves out a space for discussion of so important a topic (for the family at least), she shows respect for, and tolerance of, the family’s beliefs (*ibid.*). Perhaps the physician will hear the invocator tell of a universe where the Divine has the power to overcome the laws of nature, or perhaps the invocator believes their loved-one’s current illness is a test of faith (*ibid.*). DeLisser writes that such tenets may express hope in the patient’s recovery—a hope which may express a healthy optimism or an unhealthy denial. Additionally, miracle language may reflect “anger, frustration, and/or hurt over some aspect of care” (*ibid.*). Independent of the invocator’s conception of the miraculous, the physician should provide a “balanced, non-argumentative response” (*ibid.*). At this point DeLisser begins proffering alternative explanations for the invocator’s cardinal tenets. If the surrogate sincerely hopes a miracle will cause a miraculous recovery, then the physician may respond by pointing out that there is always some achievable good the invocator can hope for (*ibid.*). Unfortunately, DeLisser does not illuminate what these goods may be; nonetheless, he makes it clear that if the family’s hope has been

spurred on by some slight or insult, the physician should reestablish trust by appreciating their emotions, accepting responsibility for the slight, apologizing, and “putting in place a plan for ensuring good communication and resolving any lingering issue” (*ibid.*).

When responding to the invocator who truly believes that God will intervene for their ill loved-one, DeLisser believes “little will be gained by trying to directly challenge the family about its belief” (*ibid.*). Rather than arguing about conceptions of God, the physician should: emphasize nonabandonment, cite professional obligations, reframe the meaning and manifestation of miracle, and suggest that if a miracle would occur, physicians can do nothing to prevent it (*ibid.*, 1645).⁶ Regarding this reframing of miracle, a helpful tact may include discussing the possibility that the miracle has *already* occurred, or *will* occur in some other form (*ibid.*). DeLisser’s examples of miracles that may have already occurred: perhaps disaffected family members reconcile, or an aberrant child reorders his life in light of his parent’s death, or the patient’s dignified temperament as she faces *quietus* might be the sought-after miracle. Additionally, for the family who has faith in an all-powerful, all-knowing, and all-good God, the doctor may point out that if God decides to heal the patient, not a soul on earth—let alone a few health care professionals—can adulterate or thwart the will of Providence; if this is true, then the family should be willing to focus on the patient’s comfort rather than some ever-receding panacea (*ibid.*). DeLisser hopes these practical strategies will “provide the family with information and additional perspectives that the family can use to reshape their thinking, understanding, and experience of the current situation” (*ibid.*).

Other scholars go farther than DeLisser, claiming that physicians should actively promote alternative Christian interpretations of fundamental concepts. Let us revisit the work of Brett and

⁶ I will address DeLisser’s claim that such actions do not “directly challenge” the invocator’s beliefs in the next chapter.

Jersild for one such response. In “‘Inappropriate’ Treatment Near the End of Life” our authors put forward, and then critique, a number of religious rationales for continuing “aggressive medical care” (Brett and Jersild 2003, 1643). First, when patients or families insist upon aggressive care while waiting for Divine action, the clinician could put forward a different understanding of God’s healing relationship with the world (*ibid.*, 1646). Many Christians believe that divine healing does not occur via God’s direct participation in some action. We see divine healing mediated by human relationships, not some alien, external God who deigns to restore a few but leaves others decaying (*ibid.*). Of course an unexpected, miraculous recovery might happen, but such a recovery should not be considered an “appropriate expectation” for the family of someone demonstrably moribund (*ibid.*).

Second, Brett and Jersild address the insistence that giving up on aggressive care is tantamount to giving up on God, on God’s Covenant with God’s beloved community (*ibid.*). The patient’s sickly condition affords the invocator an opportunity to test his faith (*ibid.*). When this occurs, the faithful oppose any action that could hasten the physiological death of their loved-one. The patient’s room becomes The Coliseum—a place where the faithful must prove their fidelity to God’s Covenant. Brett and Jersild reframe this quest by putting forward the view that withholding certain life-sustaining-technologies shows respect for God’s Creation (*ibid.*, 1647). A natural aspect of God’s Order is the death of the body, and we must acknowledge that medicine cannot stave-off physiological deterioration; therefore, one shows fidelity with God Covenant even when aggressive treatments cease (*ibid.*).

The third scenario Brett and Jersild discuss involves the related conviction that God has created all human life sacred and worthy of preservation, no matter what the quality of that life may be (*ibid.*). This tenet has come to be known as the “sanctity of life principle.” If the

invocator holds this view, the authors suggest the clinician draw a distinction between life as a freely given gift from God and life as maintained by machines (*ibid.*). When humans lose cognitive function, when machines do their breathing, circulating, and secreting, medical technologies sustain life, machines have replaced nature's divine order (*ibid.*).

The redemptive value of suffering constitutes the final scenario Brett and Jersild address. When responding to the family who finds redemption in corporeal suffering, the authors suggest the following appeal: the value of suffering is contingent upon the ability of the sufferer to accept her affliction for the sake of some higher purpose (*ibid.*). Those afflicted with dementia or some other devastating cognitive impairment could never suffer for their own spiritual integrity. Such suffering is contingent upon the ability to say to oneself, "Yes, I am willing to undergo these physical afflictions for the greater good of my soul." Suffering for the sake of suffering misrepresents the Gospels (*ibid.*).

Two Catholic theologians, Russell B. Connors, Jr. and Martin L. Smith, take a similar methodological tack as Brett and Jersild, but place their "re-imagining" of Christian symbols within medicine's fluctuating secular obligations. Western culture has influenced medicine by emphasizing autonomous decision making, pushing technological advances, and promising "complete and achievable wellness" (Connors, Jr. and Smith 1996, 23). The public now believes that routine medical treatment includes miraculous technological cures for any sickness, at any time. Connors, Jr. and Smith argue that Christian theology may aid in correcting this overemphasis on autonomy. Christian thought contains "a storehouse of alternative narratives, images, and symbols that can help to reshape attitudes and convictions about what constitutes appropriate medical treatment" (*ibid.*, 25). If the patient or his family members justify inappropriate or unjust actions with a stilted Christian belief, then re-imagining concepts and

narratives may be appropriate (*ibid.*). To this end, the authors propose four theological correctives for four oft abused theological propositions.

The first clinically problematic assertion our authors identify involves the notion of individual autonomy. They find an unhealthy “fixation” on individual rights dressed up in theological regalia (*ibid.*). Too many Christians prefer the good of the individual to the good of both the Christian community or the good of society (*ibid.*, 26). They forget the community; and consequently, these Christians think little of their debt to others. Catholic theology reminds us, according to Connors, Jr. and Smith, of our “communal connectedness” (*ibid.*). God commands love of God and love of one’s neighbors. Obeying these commands requires reckoning the care of the dying with the burden this care places on one’s neighbor. Implicitly appealing to the notion of distributive justice, the authors employ the distinction between ordinary and extraordinary medical therapies to argue that placing a financial burden for a loved-one’s care on the larger community is unjust (*ibid.*). Ergo, insisting upon burdensome medical care does not heed God’s command to love thy neighbor.

The second alternative Christian position Connors, Jr. and Smith put forward addresses an unorthodox conception of God, a belief in a “God of rescue” (*ibid.*). It is true that God is a miracle worker, and a Christian should, of course, believe this tenet; however, this belief must be placed within broader truths about God, miracles, and suffering (*ibid.*). God calls God’s people to “face suffering and death with courage and hope” (*ibid.*). For the faithful Christian, God does not *merely* work miracles—God does not *merely* rescue the faithful from agonies; therefore, keeping this hermetic image of God in mind is not only myopic but idolatrous (*ibid.* 26-27). A more inclusive portrait of the Divine paints God as Emmanuel, God-with-us (*ibid.* 27). Connors,

Jr. and Smith defend this “counter-image” by appealing to Exodus 3:7-8, with God telling Moses:

I have witnessed the affliction of my people in Egypt and have heard their cry of complaint against their slave drivers, so I know well what they are suffering. Therefore I have come down to rescue them from the hands of the Egyptians. (Quoted in *ibid.*)

They observe that pericope shows a God who knows when God’s People unjustly suffer (*ibid.*). And God does something about it, God comes “down to rescue” (*ibid.*). The authors claim, however, that since “God does not suspend the processes of human living,” the God of Exodus is God-with-us (*ibid.*). Faith in Emmanuel means faith in a God who lovingly transforms the World, without impeding prosaic human experience. The upshot: the Christian should replace the God of Rescue with the God-with-us.

Next, the authors turn their blunt-force analysis to the belief in miracles. They realize that miracle stories permeate the Gospels. Still, the Rescue God who breaks the laws of nature to heal those who sincerely petition impedes healthy end-of-life decision making (*ibid.*, 28). Therefore, Connors, Jr. and Smith believe the clinician might correct this notion of the miraculous. The corrective: focus on acceptance and transformation rather than bodily health (*ibid.*). The *faithful* Christian prays for the ability to accept the ending of a loved-one’s terrestrial existence—for the ability to move on from tragedy (*ibid.*). She does not pray (or, at least, not *solely* pray) that God’s salubrious hand grab ahold of the dying; she trusts Emmanuel. The healthy Christian finds peace in natural processes, in human experience (*ibid.*). The authors hold that the invocator’s transformation from grief to acceptance is a miraculous event (*ibid.*). God-with-us works these miracles of acceptance and transformation.

The final alternative Christian position Connors, Jr. and Smith put forward revolves around the concepts of life and death. In end-of-life scenarios where the family insists that the

clinicians employ every possible technology. Acting on this request may provide a few more minutes of physiological existence, but the physician ought not to entertain such a wish (*ibid.*). Medicine cannot forestall death indefinitely. Fervent prayer is not some weapon in an unwinnable battle against corporeal dissolution. Such Christians forget the Resurrection (*ibid.*, 30). Borrowing the term from Charles Curran, the authors focus on “resurrection-destiny” (*ibid.*). This phrase denotes a Christian disposition and corollary set of beliefs about life and death. The Christian oriented via resurrection-destiny need not fear death; instead, this Christian accepts that death transitions the soul into full love of God (*ibid.*). Of course, one should struggle against illness and place a high value on bodily integrity, but still, the Christian oriented by resurrection-destiny refuses to hang onto mere physical existence.

Let us return to Mrs. O’Shay, and begin imagining what the bioethicist confident in theological negotiations might say and do. She would begin with questions that clarify Maria’s religious commitments. Inspired by Rushton and Russell, the ethicist would discern what Maria is hoping: more quality time with her mother, less pain, survival, or something else. Maria’s “miracle” may be analogous to the hope that the patient experiences as little suffering as possible as she slides for moribund to *mori*. Put differently, initially questionable miracle language may cloak a clinically palatable motivation for care. Maria can be hopeful without being in denial; however, if Maria continues to advocate for an aggressive path that harms her mother (with physical pain, disrespect), then the ethicist can challenge the validity of this theological mode of reasoning. With DeLisser in mind, this challenge would be respectful, tolerant, and “nonargumentative.” If Maria holds that God will rescue her mother from illness by complete recovery, the ethicist might suggest that perhaps a miracle has already happened, in some fashion. Or, the ethicist might bring a latent implication to the surface: given that God is all

powerful, there is no action any doctor or nurse could perform that would obviate God's will; therefore, palliative care and the hope for a miracle need not be mutually exclusive.

Going further, the ethicist could follow Brett and Jersild's suggestions. She could suggest that the hope for a miracle cure is an inappropriate expectation for Maria because God has created a natural order wherein humans decay. We can see this aspect of God's order gaining ground on Maria's mother. Maria may continue insisting upon aggressive treatments (even if they harm Mrs. O'Shay) because she believes that suffering is an inescapable part of Providence. On this point, the clinical ethicist could argue that one person cannot ask another to suffer for their own spiritual integrity. Neither Scripture nor the health care profession accepts that one person can inflict this kind of pain upon the unwilling. Or perhaps the clinical ethicist could take the tack Connors Jr. and Smith promote by emphasizing the connection between individual and community. It is unlikely that Maria's community holds that the faithful must always choose aggressive care over comfort measures. Besides appealing to the community, the clinical ethicist could also—prompted by Connors Jr. and Smith—introduce Curran's "resurrection-destiny." This introduction may involve asking Maria if she believes in the resurrection of the body and everlasting spiritual life for her mother. As she probably does, the clinical ethicist could promote the belief that God will surround Mrs. O'Shay with God's full love after bodily death, therefore, Maria may realize that the path that alleviates suffering is not inconsistent with a path that moves toward God's embrace.

Spiritual Assessments

The authors mentioned in the previous section advise against hostile or condescending attempts at theological correction. They accept that the invocator's religious beliefs may inform

the conceptual frame from which the invocator views the world; therefore, the clinician should not delve into these waters in a cavalier manner. Other ethicists express their reticence more forcefully. Sulmasy points out that very few physicians have training in the relevant disciplines required for astute theological discussion (Sulmasy 2006, 1390). Even with the above responses ready-at-hand, the clinician may very well fail to grasp the intricacy and historical bulk these concepts possess for the invocator. A physician qualified in undertaking such conversations would have some training in pastoral care, practical theology, or spiritual development (*ibid.*). Without sustained experience in these areas, designating one's conception of the miraculous as "lacking sophistication" is "presumptuous, at best," according to Sulmasy (*ibid.*). Rather than expressing a foundational theological truth, those demanding "futile care"⁷ in hopes of Divine Intervention may be expressing frustration or worry about abandonment; therefore, the physician may harm, rather than help, if she critiques the invocator's conceptual scheme (*ibid.*). Instead of critique, Sulmasy argues that medicine should be based on an expanded model of care, what he calls "bio-psycho-social-spiritual" medicine. Sulmasy grounds this model in what he rightly calls "Spiritual Assessments." Spiritual assessments are tools that clinicians (usually physicians or psychiatrists) may employ when interrogating the relationship between religious belief and psychological well-being. These measures intend to illuminate the spiritual life of those patients who respond to clinical suffering (her own suffering or that of another) in manifestly religious terms.

As these assessments represent an important clinical response to theological language (in general) and miracle language (in particular), I will adumbrate the primary goals, methods, and themes for three of the most popular spiritual assessment tools the FICA, the SPIRIT, and the

⁷ A very problematic phrase. See Robert L. Fine's "*Language matters*: 'sometimes we withdraw treatment but we never withdraw care'" (2007).

Brief RCOPE⁸—created by Christina Puchalski (et al.), Todd A. Maugans, and Kenneth I. Pargament (et al), respectively. The FICA and the SPIRIT have been introduced as exploratory tools for discovering what patients think of spiritual issues, while the Brief RCOPE proposes an assessment of an individual patient’s religious coping abilities. Tables 1 and 2 provide a general description of the FICA and SPIRIT.

Table I.1. Maugans’ SPIRITual history

Mnemonic	Description	Sample Question
S	Spiritual belief system	What’s your formal religious affiliation?
P	Personal spirituality	What does spirituality/religion mean to you?
I	Integration with spiritual community	Do you belong to any spiritual community?
R	Ritualized practices and restrictions	Are there specific practices you carry out?
I	Implications for medical care	Are there any barriers to our relationship based on religious or spiritual issues?
T	Terminal events planning	As we plan for your care near the end of life, how does your faith impact your decisions?

Table I.2. Puchalski’s FICA

Mnemonic	Description	Sample Question
F	Faith and belief	Do you consider yourself spiritual or religious?
I	Importance	What importance does your faith or belief have in your life?
C	Community	Are you a part of a spiritual or religious community?
A	Address in care	How would you like me, your health care provider, to address these issues in your health care?

Concerning participants, Maugans has proposed the SPIRIT for competent patients of any age, at any stage of health or illness; while Puchalski presents the FICA for physicians caring for the dying (Maugans 1996, 14; Puchalski 2006, 398). Notice the common distinction between

⁸ The Brief RCOPE is based on Pargament (et al.) “The many methods of religious coping: Development and initial validation of the RCOPE” (2000).

“spirituality” and “religion.” Maugans describes spirituality as “a belief system focusing on intangible elements that impart vitality and meaning to life's events. Often, we express our spirituality through formalized religions (Maugans 1996, 11). Puchalski similarly writes, “spirituality can be understood as a person's search for ultimate meaning in the context of religious values, beliefs and practices or other expressions such as relationships with families, communities or work as well as the arts, nature and the humanities” (*ibid.*, 15). This division between spirituality and its expression in various forms is important for those addressing religious-language in clinical contexts. The question “Do you go to a church, synagogue, temple, or mosque?” merely asks whether the respondent’s spirituality has taken an institutionally sanctioned form, thus turning a spiritual assessment into a question of religious affiliation. While this question may commence a spiritual history, Maugans and Puchalski look for a detailed picture of spiritual lives, as the primary goal of both the FICA and the SPIRIT is caring for the whole person (Maugans 1996, 11; Puchalski 2006, 398). This amorphous commitment to “holistic care” is a reaction against bio-psycho-social medicine as a comprehensive model of patient care. In this way, Maugans and Puchalski join Sulmasy in promoting a bio-psycho-social-spiritual model.

The Brief RCOPE has been used as a clinical tool for spiritual analysis (this is Sulmasy’s usage), but Pargament proposed the tool as a psychometric implement (Pargament 2011, 52-53). Specifically, the Brief RCOPE seeks to measure a patient’s ability to cope with the stress that often accompanies “crisis, trauma, and transition” (*ibid.*, 51). The authors define religious coping as “efforts to understand and deal with life stressors in ways related to the sacred” (*ibid.*, 52). Pargament divides the Brief RCOPE into two categories based on positive or negative coping behaviors—with each category containing seven subscale items. See Table 3.

Table I.3. Pargament's Brief RCOPE

Positive Religious Coping	
1.	Looked for a stronger connection with God
2.	Sought God's love and care
3.	Sought help from God in letting go of my anger
4.	Tried to put my plans into action together with God
5.	Tried to see how God might be trying to strengthen me in this situation
6.	Asked forgiveness for my sins
7.	Focused on religion to stop worrying about my problems
Negative Religious Coping	
8.	Wondered whether God had abandoned me
9.	Felt punished by God for my lack of devotion
10.	Wondered what I did for God to punish me
11.	Questioned God's love for me
12.	Wondered whether my church had abandoned me
13.	Decided the devil made this happen
14.	Questioned the power of God

During the interview, the clinician ranks the patient's answers with a Likert-scale ranging from "not at all" (0) to "a great deal" (3) (*ibid.*, 55). Depending upon the patient's score in the two categories, the clinician will get a better sense of how the patient is coping (positively or negatively) with a major life-stressor, such as intensive care admission or the illness of a loved-one. Such a psychometric may help the clinician understand if her patient is coping with stress in a positive or negative manner (Sulmasy 2006, 1389).

The Brief RCOPE is meant to illuminate connections between positive/negative religious coping and psychological, physiological, and social variables (Pargament 2011, 59-66). A number of studies in religion and health have found correlative significance between positive religious coping and: quality of life, caregiver satisfaction, energy, and pain tolerance (*ibid.*, 64, 65). However, most studies concentrate on the relationship between negative religious coping and quantifiable health outcomes. For example, studies have found negative coping associated with anxiety, lower quality-of-life, depression, paranoid ideation, and (on the explicitly

physiological side) higher IL-6 levels⁹ in cardiac patients (*ibid.*, 67). For Pargament, these “outcome variables” associated with Brief RCOPE scores show that this psychometric can be used in clinical and counseling situations (*ibid.*, 72).

Let us take a look at the relationships these authors find between spiritual assessments and meaning-making. Spirituality (“religion” for Pargament) gives meaning to a person’s life; or, minimally, the spirituality processes show *that* some person is searching for meaning in her life (Pargament 2011, 52; Maugans 1996,13; Puchalski 2006, 402; Sulmasy 2006, 1387). Our authors hope their tools illuminate the ways the afflicted find meaning and value in suffering. Each of the authors feel that alleviating suffering requires more of the professional than the bio-psycho-social model takes into account. If medicine takes the imperative to heal seriously, then medicine must address the spiritual problems that arise in clinical suffering: not just physical pain, not just psychological suffering, not just social injustice, but spiritual strife as well.

A medical model that fails to take the patient’s religious commitments seriously will consistently fall short of respecting the dignity of the whole person (Sulmasy 2006, 1387-88; Puchalski 2006, 400). Puchalski makes her case for the inclusion of spiritual assessments by appealing to the American Medical Association’s “Principles of Medical Ethics.” This document says that every American “physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights” (quoted in Puchalski 2006, 400). A worthwhile goal; but, both Sulmasy and Puchalski claim that American medicine cannot respect the inherent dignity of a patient if it continues to ignore those religious concepts that buttress conceptual schemes (Sulmasy 2006, 1387). Dignity, for Puchalski and Sulmasy, is the ultimate

⁹ IL-6 levels represent an immune system’s response to trauma—notably after surgery and during major depression. For an interesting study of IL-6 and psychological trauma see Michele Fornaro (et al.) “Increase in IL-6 levels among major depressive disorder patients after a 6-week treatment with duloxetine 60 mg/day: a preliminary observation” (2011).

human value: if you are a human, then you have dignity (*ibid.*). Dignity supports all other values for these thinkers; therefore, when medicine violates the dignity of a patient's spiritual integrity, the profession infringes upon fundamental quality that makes us human. Respect for a patient's humanity and respect for their spiritual beliefs go hand-in-glove.

What might these structured responses look like regarding Mrs. O'Shay's clinical experiences? This question may be a bit out of place because, as mentioned above, these tools have been created for patients, not surrogates. First and foremost, the ethicist would ask questions concerning any formal religious affiliations Maria might have. Maria's religious affiliation could provide insight into her motivations for hope in a miracle-event. Her views may be in line with the teachings of her faith; or her beliefs may be idiosyncratic. If her assertions about the miraculous are at odds with (or, at least, not aligned with) her tradition, then community leaders may be able to help clarify theological tenets and practices. In either case, knowledge of her community could provide insight into the presence or absence of a social support system. Additionally, the ethicist might ask if Maria's religious beliefs overlap with Mrs. O'Shay's; as knowledge of the patient's thoughts about bodily suffering, the nature of death, or the role of salvation might create empathy for Maria's situation. Perhaps Maria sincerely believes aggressive treatment is in her mother's best interests. Such an insight would not change Mrs. O'Shay's therapeutic course, but it may illuminate Maria's steadfast rejection of comfort measures.

The ethicist motivated to discover Mrs. O'Shay's beliefs would also ask April and Steve about their beliefs vis-à-vis their mother's beliefs. The goal of such conversations is to get a sense of Mrs. O'Shay's religious values. Again, while these conversations may not affect clinical outcomes, they may contribute to the overall well-being of the suffering patient. As Sulmasy and

others point out, religious beliefs and rituals can give meaning and value to a person's life; even to the point of providing a fundamental orientation from which one views all the world's events. Therefore, care for the patient as a whole person requires attention to those tenets and practices that ground the patient's conception of what is.

Empathetic Imagining

All of the responses I have discussed require time, patience, and understanding on the part of the clinician, as well as openness on the side of the invocator. Responding to an invocation of God's miraculous power with epistemic questions, theological negotiations, and/or spiritual assessments display willingness to invest in conversation for the sake of a better understanding of the patient's beliefs and motivations. Numerous bioethicists place great value on a process I am calling "empathetic imagining." Synonyms for "empathetic imagining" include: sincere empathetic concern, being fully present, respectful attention, building or expressing empathy, deep respect, and presencing. In this section, I analyze clinical responses to religious-language that include discussions of empathetic imagining.

Sulmasy refers to this disposition as "empathetic concern" (Sulmasy 2006, 1389). He even goes so far as to say that if the clinician shows "sincere" concern while discussing spiritual issues, then perhaps "nothing more may be needed" (*ibid.*). His point: perhaps just being there and listening to the patient will alleviate spiritual anxiety (*ibid.*). Questions of the mechanics of this process do not concern Sulmasy; indeed, his own constructive proposal for spiritual assessment begins with the simple declaration that the clinician should make an empathic connection with the patient and/or her loved-ones (*ibid.*). Daniel O. Dugan, in an article on futility and end-of-life care, offers nine "guidelines for effective communication" when

clinicians responding to a family who prays that a miracle will heal their loved-one. Dugan's third guideline: "identify communication goals." Dugan suggests that the ICU-team share its specific ambitions with the invocator, and the invocator must do the same with the team (Dugan 1995, 236). When clear communication does not happen, misunderstanding—or worse, coercion—may occur (*ibid.*). Dugan worries that telling the invocator that he is forcing the team to consider futile treatment may be coercive (*ibid.*). Instead, Dugan wants the ICU team to make it clear that the patient is at the center of any possible treatment options. The clinician shows care for the patient by sitting with the invocator, listening to him, and "express[ing] empathy and concern" (*ibid.*, 237). For Dugan, this expression takes shape in asking the invocator about the patient's values (*ibid.*). Once the ICU-staff understands the patient's values, treatment goals can be openly discussed with the family. So, for Dugan, expressing empathy becomes a central aspect of ICU care; without empathy one will fail to learn what the patient finds important. Therefore, for incapacitated patients, empathy becomes a required response if clinicians wish to allow the patient's values an effect on ICU decision making.

In the Introduction, I mentioned the work of Lawrence Schneiderman. His most recent book, *Embracing our Mortality*, argues that imagination and empathy ought to form the foundation of patient care. According to Schneiderman, for too long medicine has endeavored to understand the sick with statistical analysis: hoping care will follow quantitative analysis. Instead, Schneiderman argues that the power of the "literary imagination" should mediate medicine's infatuation with technology-driven patient care (Schneiderman 2008, 69). Imagination and empathy are the most important intellectual exercises for clinical medicine. For Schneiderman, authentic care (he calls this an "ethic of care") requires understanding, understanding requires empathy, and empathy requires imagination (*ibid.*, 15, 137). Like skilled

fiction writers, clinicians should exercise the imagination if they hope to properly care for the patient—if they hope to circumvent a treatment regimen that blindly reflects medicine’s technological exigency. Actively imagining the circumstances of another person requires a “fictional attitude,” a disposition that medical school does not cultivate (*ibid.*, 15). The clinician must be willing to set aside questions of validation and quantification and instead ask, “What would it be like *to be* this person—to think the way he thinks?” (*ibid.*, 70-71). Answering these questions for oneself entails flights of fancy: asserting conclusions that may have a tenuous relation to reality (*ibid.*).

Schneiderman insists that these fantasies create an empathetic connection between the clinician and her patient. The clinician might be wrong about various aspects of this self-transposal; even so, the process instills a sense of connection between the clinician and the suffering patient. Schneiderman gives a number of chapter-long examples of this connection. In chapter five, he imagines the everyday experiences of one of his elderly patients, “Susan Lowery.” Mrs. Lowery lives in a nursing home—surrounded by artificial flowers and a convenient thermostat—she experiences stasis rather than nature’s constant, dynamic fluctuation. Schneiderman admits that imagining the life-circumstances of another person (who one only knows in a clinical setting) involves fictions and missteps; however, Schneiderman discovered a connection between Mrs. Lowery and himself; imagination lead to empathy, empathy to understanding, and understanding to better care.

In the following chapter, titled “Hoping for a Miracle,” Schneiderman addresses a family hoping that God will cure their baby “Agnes” (*ibid.*, 87-91). Given the book’s trajectory, one would assume the author will use his imagination to get a sense of the parents’ *Weltanschauung*, but Schneiderman’s focus is elsewhere. Instead, he critiques: 1) a conception of the miraculous

based in human power, and 2) medicine's uncritical vow to perform miracles for patients, especially children (*ibid.*, 96-97). Medicine makes promises that it cannot keep when it uses the miracle language. Proper medicine, since the time of Hippocrates, has guided bodies on their natural path toward improved health—it gently nudges nature along her course. Only charlatans promise unnatural, too-good-to-be-true miracle cures (*ibid.*, 92). When a brochure for a children's hospital deems its halls a “place where miracles happen,” medicine not only betrays its history, but also gives the public the impression that medicine can endlessly stave off death (*ibid.*, 98). Schniederman does not attempt any flights-of-fancy with any miracle-invocators, unfortunately. I will return to this process of imagining the worldview of those hoping for a miracle in chapters three and four; for now, I will take up another conception of empathetic imagining: Schenck and Churchill's “practicing presence.”

In *Healers: Extraordinary Clinicians at Work*, David Schenck and Larry R. Churchill discuss the nature of healing; specifically, the authors seek to illuminate the ways in which healers *practice*. From a series of interviews with fifty (50) medical practitioners—identified by their peers as healers—Schenck and Churchill find eight (8) essential skills these clinicians practice: 1) do the little things, 2) take time, 3) be open and listen, 4) find something to like, to love, 5) remove barriers, 6) let the patient explain, 7) share authority, and 8) be committed and trustworthy (Schenck and Churchill 2011, 3-25). Although the authors do not posit any specific responses to miracle language, their work provides insight into these processes of empathetic imagining. In chapter three, “How Healing Happens,” Schenck and Churchill illuminate the Eight Healing Skills through the work of a single practitioner. JM tells his or her interviewer that “presence is being willing to be led, and not feeling like you have to orchestrate” (*ibid.*, 73). With this process of “being truly present,” Schenck and Churchill distill a number of

characteristics left unmentioned by our previous authors. Being present (synonyms found in chapter three include “mindful listening,” “full embrace,” and “stillness”) is not a technical skill a proficient student can simply pick up; instead, the ability to be present requires a certain temperament or disposition (*ibid.*, 73, 81). Clarifying the relationships between being present and healing, JM makes a distinction between “presence” and “provision” (75). Provisions are those tangible, quantifiable goods health care workers provide via technical know-how, e.g., JM mentions surgeries and prescriptions. Although one may instantly recognize a healing presence, being present is a process that we cannot categorize in terms of concrete benefits and technical expertise (*ibid.*, 73-75). Intuition—not understanding—becomes the primary mode of interpreting and recognizing the needs of the patient (*ibid.*).

Listening openly requires much of the healer. One of the especially difficult challenges involves allowing the patient’s concerns, priorities, and stories to dominate the conversation (*ibid.*, 74). As JM makes clear, the patient takes the lead as she conveys her concerns and values (*ibid.*, 74, 77). Like the Pyrrhonian skeptic, the healer who practices presence suspends her judgment while remaining open to uncommon, or disagreeable, assertions (*ibid.*, 75). Even if the patient misunderstands some aspect of his care, it is important that the practitioner gives the patient the chance to think aloud and speak uninterrupted. JM calls this “mindful listening.” Indeed, listening without judgment may be both the most important (and most difficult) part of being present (*ibid.*, 80, 76).

JM’s conception of being present may involve a fictive imagination; however, the upshot of being present is not empathy leading to understanding leading to authentic care, as we saw for Schneiderman. For JM, this process has more to do with *pathos* than epistemic commitment. Rather than actively imagining what it might be like to be the patient, the clinician becomes

passive. To explain this disposition, the healer appeals to metaphors of becoming “empty” and “hollow” (*ibid.*, 79). JM finds this passive presencing a gift, a privilege (*ibid.*, 76). One’s own concerns and commitments dissolve and placidity reverberates throughout one’s daily activities (*ibid.*, 80). Those little annoyances no longer annoy; those daily snares no longer entrap (*ibid.*, 81). Healing occurs *in the healer* when the stillness required to mindfully listen permeates other practices. The clinician becomes attuned to a “rhythm” present in stillness (*ibid.*, 80-81). Schenck and Churchill’s interviews show that presencing heals not only the patient, but also helps the clinician cultivate her own healing persona.

It seems fitting to conclude this section by discussing Elizabeth Johnston Taylor’s work “Spiritual Conflicts Associated with Praying about Cancer.” In this article, based in thirty (30) patient interviews, Johnston Taylor looks at the ways patients with cancer cope by using prayer (Johnston Taylor et al. 1999). Johnston Taylor found that many interviewees prayed for strength, constancy, and understanding after their diagnoses, with a number of the patients praying that God would miraculously restore their health (*ibid.* 391). When the fruits of such petitions failed to mature, the interviewees questioned the nature of prayer, control over life-events, responsibility and bargaining, God, meaning in life and death, and self-worth (*ibid.*, 390). For those patients who did not directly petition God for a cure, but looked to the Divine nonetheless, prayer took some other form: conversational, recitational, or meditative (*ibid.*, 386). Johnston Taylor has found that patients do their best to protect whatever conception of the Divine they already possess—even at the expense of finding their own actions inadequate (*ibid.*, 391). For example, when prayers to God went unanswered, the patient (protecting his God-concept) would assume he had prayed in a deficient manner (*ibid.*). Better to take the blame oneself than have a

foundational theological concept demolished—or, minimally, upset— when God shows indifference to personal suffering.

Johnston Taylor suggests four practical strategies for clinicians attending to the health of cancer patients with “spiritual pain” (*ibid.*, 392). The first two responses are of interest here: “presencing” and “naming the silences.”¹⁰ Caring for someone undergoing spiritual conflict can be an Augean task, as other duties—involving patients with *physical* pain—tempt the clinician to move on. However, Johnston Taylor suggests that clinicians stick around and be “truly present” for the patient (*ibid.*). The clinician goes about cultivating this positive health outcome by “naming the silences.” Those undergoing spiritual pain have questions. They propose these questions to themselves and to the Divine. Johnston Taylor wants clinicians to carve-out a space for the discussion of uncomfortable topics. As the author puts it, “[by] ‘naming the silences’—identifying these discomforts—their power is broken” (*ibid.*). Monologue becomes dialogue and the dull shadow of spiritual pain is exposed to the disinfecting light of conversation.

Returning to Mrs. O’Shay, what might empathetic imagining look like here? It would begin with listening—listening to Maria, April, and Steve. The ethicist’s task would involve understanding Mrs. O’Shay’s values and, secondarily, the values of her loved-ones; her goal would not be data gathering or convincing the family that aggressive care is futile. Her goal would be to communicate honestly, and question what it might be like to be one of Mrs. O’Shay’s children, or even Mrs. O’Shay herself. The clinical ethicist would, following Schneiderman, flex her literary imagination in order to get a better sense of each person’s investments and concerns. Once the ethicist internalizes these concerns, an empathetic connection between the clinician and her interlocutors can lead to understanding, and

¹⁰ The other two responses: “appropriate self-disclosure” and “referral.”

understanding to better care. Or, as Schenck and Churchill put it, being present with those suffering, rather than merely discussing health care provisions, might lead to a healing relationship between the ethicist and the afflicted (patient or not). This kind of relationship promotes the good of the patient and the good of the team (including the ethicist herself) without pushing an agenda. For Schenck and Churchill, the ethicist would become a more passive actor, an actor whose own commitments fall aside, leaving her open to the possibility of addressing the suffering of others.

However, let us imagine that this empathetic approach does not create a connection between the ethicist and Maria. Perhaps Maria considers this disposition intrusive or disingenuous. This would not surprise us: everyone, and every service, has an agenda; therefore, she (or her siblings) may view this attempt at truly understanding her grief with skepticism. How could any hospital worker truly empathize with her sentiments, her concerns, her history? While it may be possible, skepticism regarding the ethicist's intention seems justified at this point. So, then how might an ethicist continue her attempt at facilitating understanding between conflicting parties?

Appeals to Professional Values

Physicians, nurses, and clinical bioethicists are health care professionals. Thus far, I have concentrated my analysis on responses that do not explicitly appeal to professional duties. As I mentioned above, one could read the sequence of responses here outlined as escalating suggestions: first, make sure the invocator knows what's going on clinically; next, see how the invocator uses the term, and critique if necessary; after that, try putting yourself in the position of the sufferer. (This is an oversimplification, of course: the responses proffered do not promote a

stilted, linear approach.) If the clinician and the invocator cannot find an amicable path forward, a number of sources suggest explicitly informing the invocator of the professional obligations (or duties) clinicians have toward patients. These professional duties include appeals to principles such as: respect for the patient, futility, autonomy, beneficence, non-maleficence, and distributive justice. In this penultimate section, I will analyze how scholars employ notions of professional integrity when responding to clinical miracle language.

With this practical response, the status of the invocator (be he the patient or the surrogate) becomes important. Previous strategies could be applied to either the patient or the patient's surrogate with equal potency. However, when disagreements concerning a patient's therapies arise, the professional's obligation to the *patient* vis-à-vis her obligation to the patient's *family* form two distinct sets of obligations. Put simply, an appeal to the integrity of the profession explicitly aligns the physician with 1) the good of the patient's overall well-being or 2) the professional's responsibility to herself—not the direct interests of the family.

The 1983 President's Commission report on "Deciding to Forego Life-Sustaining Treatment" gives us a sense of how professionals think about patient well-being. In this document, the Commission argues that connecting the overarching goals of health care with the bodily integrity of the patient should orient end-of-life conversations. If it is agreed that the goal of the American health care system is to maximize the well-being of each patient, then how should the system maximize this well-being? One possibility would be to maximize benefit with the standard of "best interest" in mind (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1983, 26). This standard poses the question, how would a "reasonable person" act if she was undergoing the same situation as the patient? But, according to the Commission, the health care system should not apply this

question *carte blanche* to any and all patients entering the system. To do so would undermine an essential aspect of any person's well-being: his ability to make choices ("self-determine") (*ibid.*). The system ought to respect the individual patient's ability to self-determine, here defined as "the capacity to form, revise and pursue his or her own plans for life" (*ibid.*). This preservation allows the patient to define *for herself* what an improvement in her well-being might look like; accordingly, the system shows respect for an individual's general well-being by allowing psychological interests to inform her care (*ibid.*). According to the Commission, patients have the right to their own conception of well-being, even if these conceptions may go against what the best interest standard tells us a reasonable person would believe about wellness. Therefore, while a "reasonable person" might undergo some suggested therapy, if the system actually respects the patient's interest in integrity, the system will respect his ability to say, "No, while others may want this therapy, I do not" (*ibid.*).

Notice, the Commission here emphasizes self-determination as the negative right to turn-down some suggested therapy, not the positive right to receive a therapy the patient's health care team deems inappropriate. The Supreme Court of the USA ruled in 1997 that citizens have the right to turn down medical treatment (even if it hastens death) *because* humans have the right to bodily integrity (*Vacco v. Quill*, 117 S.Ct. 2293, 1997). If the patient says, "No, I do not want artificial hydration, another round of chemotherapy, or renal dialysis," then to perform any of these actions would violate her bodily integrity—assuming he can give acceptable reasons for this decision.¹¹ If he says, "I don't want to suffer anymore," or "My life was great, but now it's time to my life ended," then performing unwanted treatment is tantamount to assaulting his bodily integrity and disrespecting his right to go against the "reasonable person" standard.

¹¹ Controversies over "acceptable reasons" form the political undercurrent of this dissertation.

However, some scholars argue that respecting a patient's well-being involves more than refraining from assaulting those who reject the best interest standard. They argue, if medicine accepts that promoting well-being is an integral part of respecting the patient, then these patients also have the right to spiritual well-being. In a case report from 1997, Frank Feigenbaum (et al.) argues that patients have the right to choose what he calls "spiritual integrity" *over* "physical integrity," if they can adequately justify their preferences (Feigenbaum 1997, 462). He tells of a pregnant 15-year-old Jehovah's Witness who persistently refused the possibility of a blood transfusion. However, the neurosurgical team was quite worried that if she hemorrhaged during the procedure, she would bleed-out, leaving the patient and the fetus dead (since she refused additional blood). All parties agreed that the patient had the capacity to make her own decisions and understood both the risks and the benefits (for both herself and the fetus) of declining the suggested surgical procedures (*ibid.*, 461). The patient was able to explicitly state her hierarchy of goods: 1) fidelity to Jehovah, 2) preserving the life of the fetus, 3) preserving her own life. Since the patient could illuminate and justify this hierarchy, ethics and neurosurgery agreed that the surgery could proceed. The health care team preserved the spiritual preferences of the patient over the biomedical good of physical integrity (*ibid.*, 462). Therefore, under such circumstances, respect for the patient includes both bodily and spiritual well-being.

We have been viewing professional integrity from the angle of non-maleficence, the duty of health care workers to, first, do no harm. Do not assault the patient's body, and do not assault the patient's religious beliefs—assuming they can give reasons for their beliefs. But we also find the value of autonomy woven throughout this discussion. One need only read "self-determination" to notice this value's presence. While the patient's overall well-being has taken

precedent thus far in this section, let us look closely at the second good listed above, the autonomy of the professional.

Let us imagine that Mrs. O'Shay *had* said that independent of any quality of life assessment, she wanted to be kept alive because she, like Maria, holds that God simply needs time to work God's miracles. The voice of the patient and the voice of the surrogate Maria would harmonize. Against their medical judgment, should the health care system continue on the aggressive path because a patient wants certain therapies? Does medicine have the obligation to accept spiritual preferences as informing decision making? No, not necessarily. Such an action could very well violate the clinician's sense of professional integrity. Keep in mind: self-determination (a negative right for the patient) does not entail the positive right to any and every therapy the patient deems essential for the preservation or improvement of her bodily or spiritual well-being. In such a scenario, if her physicians believed that the aggressive path would be an inappropriate way to care for her, then the pledge to do no harm may take precedence. As professionals, if the physician or nurse believes that a therapy would harm rather than benefit the patient's physical well-being, the clinician does not have an obligation to perform the therapy, even if the patient wishes it so.

That said, allow me to unpack this notion of professional integrity by relating it to requests for "inappropriate treatment" founded in a religious rationale. In an article titled "Requests for 'Inappropriate' Treatment Based on Religious Beliefs" Robert D. Orr and Leigh B. Genesen argue that it would be a mistake for clinicians to dismiss religiously grounded requests without first interrogating the contents of such beliefs. Their noncommittal conclusion is that professional integrity may lead to the refusal of treatment if the justification for treatment comes solely from an individual's religious beliefs. But this is not always the case, on occasion

religious commitments might be strong enough to support the conclusion that an “inappropriate” treatment is sometimes appropriate (Orr and Genesen 1997, 146). Explicitly building on Orr and Genesen, James F. Buryska posits a more concrete method by which the clinician might weigh the benefits and afflictions in such situations.

Buryska poses five (5) questions that, he believes, will help judge if the physician’s professional integrity should win out over the patient’s spiritual well-being. First question, “Does the claim conflict with clinical, legal or other indications?” (Buryska 2001, 119). As is often the case in the clinic, if the patient wants an illegal procedure, then the patient will not receive the therapy. Legal requirements come before moral commitments. But what if there is some question about clinical indications? Then, Buryska posits the second question, “Does the claim pose a conflict of conscience for those providing care?” If the answer is “Yes,” then, according to the author, we find “competing autonomies”—a clinical situation where (at least) two sets of preferences conflict (*ibid.*, 120). 1) The physician feels some action (or omission) would violate her conception of proper action. 2) The patient believes his own conscience will be violated if the action does not occur. Next, the clinician poses a third question, “Is it a positive or a negative right that is being claimed?” As we have seen, and Buryska notes, competent Americans have a negative right to say “No” to a therapy they deem inappropriate, but this does not translate into a positive right to receive any therapy for spiritual reasons (*ibid.*). To take away this negative right would violate, according to Buryska, the patient’s autonomy thereby harming her overall well-being. So, how should the clinician decide between these competing autonomies? How does the clinician know when her designation of a medically inappropriate treatment takes precedence over a patient’s right to self-determination, or even when a therapy should not be offered given the scarcity of resources? Buryska makes the perhaps unintentionally entertaining observation,

“it is this [i.e., debate over these clashing autonomies] that has fuelled in recent years the debate about ‘medical futility’, unresolved at the time of writing” (*ibid.*).

The author’s fourth question: “Is the culture or religiosity that supports the claim rooted in a community? Or is it idiosyncratic?” (*ibid.*). Patients often justify their claims for inappropriate treatments by appealing to institutional structures. They tell the clinician that their authorities simply do not allow the continuation or cessation of some procedure. Buryska reminds his reader that the faithful may have misinterpreted the teachings of their institution, or perhaps, substituted their own beliefs in place of the teachings of their religious authority (*ibid.*). Of course, one can believe whatever one wants about the Divine, and one should feel free to question one’s institution; still, Buryska reminds us that *if* the patient uses his religious community as a justificatory mechanism for his belief, then the clinician should investigate the relationship between the patient’s belief and the community’s belief. We should consider a belief that has a communal foundation an authentic expression of a cultural or religious value. While an idiosyncratic view may turn out to be true (Buryska asks us to think of Galileo), without communal support, religious propositions lose much of their strength (*ibid.*, 121).

The fifth and final question: “Is the person making the claim willing to suffer for it? Or expecting that others suffer for it?” We respect people who accept the consequences of their actions. We have disdain for those who insist upon some course of action while expecting others to shoulder the burden. This “intuitive distinction” helps the clinician discern the level of commitment an invocator shows when insisting upon a therapy for theological reasons (*ibid.*). Many therapies involve physical pain—especially those therapies present in end-of-life scenarios. Buryska writes that there is a basic “existential reality” at play here: you can suffer in hopes of staying true to your conception of the world, but it would be unfair to ask others to

suffer for your beliefs (*ibid.*). The clinical upshot is twofold: first, the person suffering for his beliefs must *be* the person suffering for his beliefs, and second, those who have idiosyncratic views must confront the fact that the USA health care system does not cater to those with peculiar conceptions of autonomous action and spiritual well-being (*ibid.*).

Let us continue this conversation with a response that (explicitly) interlinks miracle-invocation with public policy. In a press release titled “Should Religious Beliefs be Allowed to Stonewall a Secular Approach to Withdrawing and Withholding Treatment in Children?” pediatrician Joe Brierley (et al.) analyzes seventeen (17) cases in a pediatric ICU (PICU) over a three year period. Out of two hundred and ninety (290) deaths in an unnamed PICU, in seventeen cases, the child’s family refused the PICU team’s attempts at withdrawing or withholding treatments that they, the team, deemed inappropriate (Brierley 2012, 1). In eleven (11) of these cases, family members insisted upon such therapies out of “religious conviction” (*ibid.*). Five (5) of these situations were resolved after the institution included local religious authorities in discussions with the patient’s parents (*ibid.*, 2). However, the remaining six (6) cases continued, as the families staunchly refused to discuss their theological beliefs, and the PICU could not locate any nearby religious leaders (*ibid.*). In each of these six cases, the families practiced a version of Christian-Africa evangelicalism. These families believed God would miraculously cure their child if given additional time. This fundamental belief meant medical information played only a limited role in the family’s decision making (*ibid.*). The families asserted (or maybe argued, Brierley does not say) that aggressive care must continue *ad infinitum* (*ibid.*). Eventually, five (5) of these children died—despite aggressive care—with one (1) child returning home with severe neurological disabilities (*ibid.*, 3).

The author places these cases in a political framework. Medicine in western, secular societies gives more credence to the beliefs and practices grounded in established religions while placing less trust in the practices promoted by theological newcomers (such as these Christian-Africa evangelicals practicing in London) (*ibid.*). Brierley wonders: if we accept male circumcision—a painful procedure based on religious conviction rather than clinical indicators—why not accept the practices connected to Christian-African evangelicalism? This “arbitrary hierarchy” calls for a more transparent mode of adjudicating these unfortunate situations where children undergo physical pain for the sake of their parent’s spiritual convictions (*ibid.*, 4). The western PICU should not be a site where health care professionals determine which religious practices deserve tolerance (male circumcision) and which should be shunned (continued aggressive therapy while waiting for God to heal an individual) (*ibid.*).

Arbitrary social convention should not force pediatric intensivists to perform burdensome treatments on neurologically devastated infants (*ibid.*). Instead, pediatric professionals should create and promote legislation that explicitly promotes the good of non-maleficence over the good of a parent’s spiritual well-being). In the meantime, professionals should lobby for a process that shortens the time between a “futility designation” and a court order (*ibid.*). Second opinions, ethics committees, and months of in-house discussion: these mechanisms rarely provide solutions. The clinician gets no closer to allaying the physical pain of the infant. Despite bad PR and unfamiliarity, requests for court adjudication should be common rather than exceptional. Months of debate signifies months of physical pain; therefore, if PICU teams hope to seriously promote the best interests of treatment would be her mother’s best path forward.

Respectful Rejection

I will conclude my discussion of practical responses to clinical miracle language with a quick word from those who argue *against* the inclusion of spiritual well-being into medical care. As the title of this section implies, this final response differs from the previous five (5) responses in that these scholars suggest clinicians should respect, but not tolerate faith-based precepts when discussing end-of-life decisions. These scholars buttress their arguments with a distinction between rational inquiry and the irrational religious imagination. In “Two Worlds Apart: Religion and Ethics” Julian Savulescu argues that Orr and Genesen promote the well-being of those who believe in the miraculous over and against the well-being of those who do not believe in such events (Savulescu 1998, 382). Savulescu founds his critique in a political observation: western democracies allow individuals to pursue their own interests (and their own orienting conceptions of what is good) up until the point these interests begin infringing upon the rights of others to do the same (*ibid.*). Savulescu applies this observation (along with Aristotle’s Principle of Equality) to two sets of clinical cases (*ibid.*). With the one set, we find a patient justifying her need for therapy based on religious tenets, while with the second set, a patient seeking a bone marrow transplant for personal, selfish reasons. An example of the former set:

3a. A woman has a third relapse of leukemia after two bone marrow transplants. Her doctors say her chance of surviving are less than one in a million. The health authority responsible for funding this treatment claim that they cannot afford another transplant in these circumstances. She requests another bone marrow transplant because she says that a miracle will occur. (*ibid.*)

From the latter set:

The same [clinical situation] as 3a except this woman is an atheist who believes that the risks are worth taking, and she doesn’t care about the people who will be denied treatment if she uses up scarce resources in this way. She has no sense of social justice. (*ibid.*)

Savulescu tells us that Orr and Genesen must argue that the religious rationale behind 3a entitles the invocator to a therapy out of reach for the patient in 3b (*ibid.*). However, as 3a’s belief in the

miraculous is irrational, a social institution such as a hospital has no obligation to respect such incoherent assertions (*ibid.*). When health care systems tolerate such claims, they forget the distinction between religion and ethics (*ibid.*). Religion has as much to do with ethics as it does mathematics—all three are very distinct modes of human inquiry. “Religion is about faith; ethics is about reason” (*ibid.*). Orr and Genesen baldly assert that the interests of Christian fundamentalists be placed above any concerns about distributive justice (*ibid.*, 384).

Savulescu and Steve Clarke depict the clinical upshot of this distinction between religious nonsense and ethical rationality in “Waiting for a Miracle . . . Miracles, Miracism, and Discrimination.” If the invocator cannot present evidence for her decision with reason, then the clinician is under no obligation to entertain the request (Savulescu and Clarke 2007, 1258). Even if we were to accept that a miracle may have occurred in the past, the invocator must show that reason indicates the clinical team should wait for a miracle cure *in this case* (*ibid.*, 1262). To that end, Clarke proffers five criteria to determine whether reason should assent to the possible occurrence of a miracle.¹² Savulescu and Clarke conclude: 1) they have yet to find sufficient evidence for reason to assent to the occurrence of a miracle-event, and 2) without sufficient evidence of a rational foundation, medicine is under no obligation to entertain the hope that a miracle-event will occur.

¹² The five criteria:

1. We are confronted with repeated, reliable reports of a type of event which is an anomaly to a well-established law of nature.
2. The relation between the law and the anomaly is such that we are unable to rationally justify allowing the exception as a *ceteris paribus* clause to the law, and we have no realistic expectation of being able to do so in the foreseeable future.
3. Accepting that the anomaly is a supernaturally caused violation of the well-established law of nature, a miracle does allow us to explain its occurrence by placing it within a theological framework.
4. Explaining the anomaly as miraculous allows us to retain the well-established law as an exceptionless regularity, when appropriately restricted to the description of naturally caused events.
5. The theology we commit ourselves to when postulating the occurrence of miracles does not itself raise too many further problems for the coherence of our stock of accepted beliefs to warrant its rejection. (Savulescu and Clarke 2007, 1261-62)

The authors tell us that when a medical establishment performs therapies because of an irrational appeal to the possibility of a miracle, they act in an irrational, unjust manner. Thinkers such as Orr and Genesen promote “miraclism”: the discriminatory practice that unjustifiably favors those who believe in the miraculous at the expense of those who refuse to believe (*ibid.*, 1259). The titular neologism “miraclism” intends to sow immediate disapproval as it resonates with the cadence of other problematic classes of discrimination: ableism, ageism, classism, heterosexism, racism, and sexism. Western medicine, and certainly bioethicists, should not promote such discriminatory practices even at the expense of an individual’s spiritual well-being (*ibid.*, 1262).

Regarding Mrs. O’Shay’s situation, since Maria supports the aggressive path of BST with a faith-based appeal to the possibility of a miracle, rather than a reason-based appeal, Savulescu and Clarke would argue that the Neuro-ICU team need not accept Maria’s rationale for the continuation of aggressive therapy. Indeed, if the health care team were to accept an irrational motivation for the continuation of therapy, they would participate in the unjust practice of miraclism.

Concluding and Transitioning

This inaugural chapter has described and applied six relevant responses to miracle-invocations proffered by scholars of bioethics and religion. We have seen five responses that concentrate on tolerating miracle language: strategies that emphasize clinical knowledge, theological re-imagining, spiritual assessment, empathy and understanding, and professional commitments. The other notable response—intolerance—promotes respectfully ignoring any attempt at clinical extortion with religious language. It is my hope that I have fulfilled the second

objective named in the Introduction: delineate and categorize the practical strategies scholars have put forward in response to miracle language.

There is a problem with these responses, however—for the clinical bioethicist at least. This problem revolves around questions of justification. Why should the ethicist accept that these strategies are appropriate responses to clinical miracle language? What makes these responses proper clinical actions? Do such strategies do justice to the complexity of miracle-terms? Are these strategies morally responsible? In order to answer these questions, we must interrogate the moral, epistemic, ontological, and political commitments that comprise these practical responses. In chapter two, I hope to fulfill the third task set out in the introduction: excavate the integral value commitments these proposed responses rely upon.

CHAPTER II

INTERROGATING AND EXCAVATING

THE PRACTICAL RESPONSES

In previous sections of this dissertation, I identified the ways clinicians talk about “the miraculous” both as a theological-philosophical concept (in the introduction) and as a religious expression relating to medical care (in the first chapter). We are now in a position to excavate the moral values buried beneath these discussions. To speak broadly, in the previous chapter we saw bioethicists and religious studies scholars recommend six practical responses to miracle-invocations. In this chapter, we will see how these scholars *justify* these practices. I hope chapter one has left the reader wondering: why should the ethicist respond in *this* manner? Why, for example, should health care workers negotiate theological tenets, perform spiritual assessments, or appeal to professional practices when reacting to miracle-invocations? Are these practices morally justifiable? In order to answer these questions, we must figure out what these responses assume about medicine and moral action.

In this chapter, I fulfill this dissertation’s third objective: an excavation of the integral value-commitments these proposed responses rely upon (either implicitly or explicitly).¹³ To

¹³ Why, you might ask, is this excavation the next step of my analysis? Why not begin analyzing the ways miracle-language functions for the patient straightaway? These are fair questions. I believe the clinical ethicist must also be an *ethicist*: a scholar who interrogates the moral values that make up the theoretical issues and real practices she finds in clinical spaces. The clinical ethicist is not a clinician that merely clarifies muddled communication, listens empathetically, or has “the tough conversation” with a disgruntled family. Although these actions could indeed form part of her professional identity, she must also work to clarify the moral values present in individual clinical situations. Her ability to interrogate, clarify, and question implicit values (be they moral, political, epistemic...) sets the ethicist apart from her peers. Social workers, chaplains, good nurses, and sensitive physicians might clarify miscommunication, listen with open-minds, or discuss end-of-life issues with honesty and clarity, but the clinical ethicist has to do more: she has to critically reflect upon the values that constitute medicine’s beliefs and practices—both hidden and manifest. Therefore, in this chapter I begin earnestly acting as a clinical bioethicist by analyzing and questioning the moral values and norms that contribute to medicine’s responses to clinical-miracle-language.

facilitate this excavation, I will provide thematic and argumentative analyses of the moral, epistemic, professional, and ontological values I find undergirding the six practical responses. In each section of this chapter, I will visit one (or more) of these previously-seen strategies, in hopes of unearthing the assumptions made by our practical responses as they move from *describing* clinical states of affairs, to *prescribing* proper medical care.

For example, all of the responses we have seen in chapter one (with the exception of “respectful dismissal”) assume that spiritual preferences should have an effect on medical care. We are dealing with a question of degree: just *how much* power should spiritual preferences have in determining what has traditionally been a strictly medical judgment? The clinical imagination (see below) interprets miracle-invocations as reflections of psycho-spiritual preferences; therefore, one way of theorizing the practical responses would be to think of them as part of a larger conversation between psycho-spiritual preferences and medicine’s goals. To see this, in the second section of this chapter, I will reconstruct a number of the most compelling arguments in favor of including psycho-spiritual factors. These arguments will give us an opportunity to investigate fundamental moral terms, as well as the appropriateness of miracle-language in medical decision making.

This chapter explores what I am calling the “clinical imagination.” The term “clinical imagination”—mentioned in the introduction, but left undefined—denotes processes of empathy, interpretation, imagination, understanding, and projection that clinicians carry out when practicing medicine. As a theoretical construct (à la Thomas Hobbes’ “state of nature” or John Rawl’s “original position”), the clinical imagination negotiates professional and personal commitments. I hope to show how moral, epistemic, metaphysical, and ontological values contribute to the clinical imagination’s conception of *what* exists in the world, and *how* one

should act in relation to those extant things (what I will call “moral ontology”). While the clinical imagination also operates outside the context of miracle-invocation in end-of-life care, I will concentrate on this context in order to keep this dissertation firmly moored in bioethics’ terrain. Put another way, this chapter answers the question, what do clinicians think about, when they think about miracles?

When the proposed practice fails to attend to the complexity of religious and ethical terms, it leaves behind a sensitive or defensible account of the clinical and conceptual realities. In order to make the case for this conclusion, I must explain the values that provide the foundation for these scholars’ conceptions of miracle and medical practice—both implicit and explicit.¹⁴ Of course, clinicians do employ value-laden language, but stagnant platitudes such as “the good of the patient,” “the progress of medicine,” or “for holistic care” are insufficient for the clinical ethicist. I’ll begin with the first practical response we examined in chapter one, the response I labeled “epistemic questioning.” This practical response stresses the power of medical information in decision making. But, what holds up these practices? And why should the clinician undertake this response to miracle-language? To answer, we will excavate the ontological, metaphysical, moral, and—especially—epistemological values the clinical imagination assumes as it goes about discerning and interpreting medical states of affairs.

¹⁴ I do not argue that the clinician *must* reject the values found underneath its current practical responses to miracle-language; nor do I argue that a patient’s spiritual preferences *should* win-out over the clinician’s attempt to improve bodily well-being. Rather, these practical responses must be justified, argued-for. The clinical ethicist, I believe, has an obligation to question and analyze moral values. Bland assertions about “the good of the patient,” “the progress of medicine,” or “holistic care” are stagnant platitudes that might make sense for another member of the clinical staff, but such assertions are insufficient for the ethicist. I’ll begin with the first practical response we examined in chapter one, the response I labeled “epistemic questioning.” This practical response places importance on the power of medical information in decision making. But, what holds up these practices? And why should the clinician undertake this response to miracle-language? To answer, we will excavate the ontological, metaphysical, moral, and—especially—epistemological values the clinical imagination assumes as it goes about discerning and interpreting medical states of affairs.

Epistemic Questioning: Foundational Ontological and Epistemic Values

In the clinical imagination, epistemic questioning inaugurates any astute response to miracle-language. Nearly every scholar we visited in chapter one advocates assessing the invocator's understanding of the patient's medical condition. For example, Brett and Jersild inaugurate their six-fold response with this advice: "clinicians should ensure that patients and families firmly grasp all relevant diagnostic and prognostic information. Similar to conflicts expressed in secular terms, conflicts framed in religious terms may resolve when clinicians attend closely to the informational needs of patients and families" (Brett and Jersild 2003, 1648). This mode of analysis provides the foundation upon which the other five responses (yes, even "respectful rejection") build their homes; or, working with another metaphor, epistemic questioning anchors the everyday workings of the clinical imagination.

In order to make sense of the ways in which individual bodies function, the clinical imagination makes assumptions about what exists, that is, the clinical imagination has ontological commitments. For the clinical imagination, the body and its causal relations are the primary things that exist and interact. Knowledge of physiological processes becomes prized above other forms of knowing (e.g., social, legal, psychological, or spiritual). I will call this mode of clinical understanding a "materialistic epistemology." The objects of understanding for this mode of inquiry are material states of affairs and their mechanical/chemical interactions.

The value of knowledge for this materialistic epistemology lies in its utility. Without knowledge of the patient's physiological processes, the clinical imagination would halt, unable to perform diagnosis, therapeutic analysis, or prognostication. Psychological states, social concerns, and spiritual affairs have reality only insofar as the clinical imagination can find some physiological evidence of *both* the cause and effect of the non-material phenomenon. For

example, “stress” (an effect) is a psychological series of events based in biochemical interactions between body and environment (the cause). Of course, these scholars may not reduce stress to material causes and effects, but we should not deny that interactions between biochemical substances provide an orienting epistemic object for the clinical imagination.

A number of our authors explicitly promote this response because assessing the patient’s understanding of his condition has become a legal-professional (perhaps even moral) requirement (see: Rushton and Russell 1996, Brett and Jersild 2003, Silvestri et al. 2003, Boyd et al. 2010). Gone are the days of “doctor knows best”: the days when the physician’s authority as expert formed the foundation of the patient-provider relationship. In American medicine today, informed consent provides the backbone of good treatment, according to the practice of epistemic questioning. Clinical medical information comes in the form of diagnostic, prognostic, and therapeutic understanding. Without knowledge of the patient’s diagnosis, therapeutic options, and prognosis, the decision maker is unable to make an *informed* decision—making his dissent or consent to the procedure untethered from *his own understanding* of the medical situation. Since face-to-face conversation provides the medium through which this transfer of information most often takes place, proper communication becomes a necessary (though not sufficient) condition for an informed decision, and an informed decision has become a required prelude to therapy.

Ideally, the process moves smoothly from diagnosis, to prognosis, to informed decision, to therapy—with clear communication pushing the process gently forward. However, a truism: communication and medicine are complicated endeavors, and the ideal rarely overlaps with the clinic. Numerous factors might inhibit the discussion and understanding of clinical information; indeed, it makes sense that our authors promote this mode of epistemic questioning as the

inaugural step in their practical responses precisely because miscommunication and misunderstanding troubles even routine end-of-life care (Curtis 2004, 364-65). Good medical care requires informed consent, and informed consent requires good communication. Medicine's roots run deep in the soil of a materialist epistemology insofar as its primary objects of inquiry are material.

Lucas Zier notes that miracle language might recede, or even dissipate, when the clinician makes a special effort to ensure that the invocator *authentically* understands her medical condition and her medical future (Zier et al. 2009, 115-16). But, what's to be done when the invocator appears to understand relevant prognostic and diagnostic information while insisting that the possibility of a miracle ought to govern medical decision making? Let us return to the family we imagined in chapter one, and imagine that Maria appears to understand all relevant clinical information. She understands her mother's diagnosis and prognosis, and she understands the risks involved in burst suppression therapy (BST); nonetheless, Maria insists upon the aggressive path in hopes for a miracle. Clinical information is processed, analyzed, and—in this case—cast aside as an authoritative mode of interpretation. The decision maker accepts the clinical imagination's account of what is (Mrs. O'Shay's physiological condition) and what has been (a massive stroke with neurological trauma) without accepting the conclusion that BST fails to promote her mother's overall well-being. We see clear communication, and we find no misunderstanding regarding the patient's condition. So then, why does disagreement remain?

Conflict between the miracle-invocator and his health care professionals continues because the invocator's world-view and the clinical imagination hold distinct metaphysical, epistemological, and moral commitments. The clinical imagination and the invocator's religious

imagination disagree over the burden material/physical states of affairs can shoulder. The invocator's imagination finds the materialist vision of the clinician relevant, but not the final or primary word on what counts as evidence for a therapeutic conclusion. The invocator takes additional information into account when making a health care decision: he adduces information that, he believes, should count toward his conclusion without necessarily excluding the prognostic and diagnostic information prized by the clinical imagination's materialistic epistemology.

A materialistic epistemology has a certain scope. The patient's material, visible body becomes a text to be read, understood, and argued-over; as such, the clinical imagination and the invocator's imagination may support differing readings of the patient. Put differently, different readings of the patient entail different interpretations of the same object. The patient's loved-one might find that the patient looks healthier: today her cheeks look flushed, her breathing more steady, and she reacts to the sound of her name (see: Boyd et al. 2010, 1271-73). However, her attending physician disagrees: a mild reaction her drug cocktail has caused the youthful flush; her breathing has steadied because the ventilator setting has been changed; and it is unlikely that she can respond to her name because of severe neurological damage. The clinician believes the patient's body supports her findings—the text of the patient's body contradicts the loved-one's reading. According to the strategy of epistemic questioning, given physiological information, if the patient is read through the lens of a materialist epistemology, the decision maker should reinterpret the patient's body.

Our miracle-invocator finds *additional* states of affairs relevant—even if he accepts the primacy of the clinician's epistemic scheme for diagnostic and prognostic purposes. The object of inquiry (i.e., the patient) remains the same, even as interpretations of the object multiply.

Allow me to draw an analogy between these interpretations. Imagine with me an argument between three scholars of religious studies. One scholar has been schooled in early Christian socio-economic history and Second Temple Judaism; another is a feminist theologian with a passion for social justice; the third is a philosopher of religion with an interest in Christianity's debt to Greco-Roman philosophy. We imagine them brought together to teach a seminar on the Gospel of John. With these distinct backgrounds, our discussants might disagree over whose interpretation of the Gospel of John should win-out as *the* interpretation of the text. The historian says: In order to claim that you understand this text, you must orient your interpretation around the cultural importance of Judaism for the writer of the Gospel. The feminist theologian emphasizes the necessity of understanding gender relations and the women's roles in the early church. And the philosopher of religion says it is impossible to understand even the first verse of John's Gospel without a firm understanding of Neo-Platonism. However, must there really be a *single* interpretation of the text? Can the text have a number of legitimate interpretations—interpretations that result from the questions being posed to the text (Gadamer 1998, especially 161-69)? Distinct questions require different methods of analysis.

Relating this analogy to our topic, the afflicted patient is a text to be read by the clinical imagination, the invocator, and the patient himself. The clinical imagination's reading of the patient fails to provide (for the loved-one) a complete prognostic picture. The invocator might say that an adequate understanding of the patient requires more than the materialistic has recovered every time;" "he has good luck;" "it's not his time;" "I'm here, caring for him;" and "God will work a miracle." In each of these statements, we find forces that exist outside the scope of the materialist epistemology. We see that the invocator's conception of the world contains extra-material objects, such as God. These indicators correspond to a different

conceptual scheme than the one navigated by the clinical epistemology. For the invocator, statistical analysis of material information does not lead the clinical imagination to an adequate understanding of prognostic probabilities. I will call these factors “extra-material indicators.” The invocator, like a number of Boyd’s subjects, believes the patient’s character, her habits, moral ontology, and psychological history should count as prognostic factors (Boyd et al. 2010, 1271-72). We find these extra material indicators in statements such as: “he is a fighter;” “he has recovered every time;” “he has good luck;” “it’s not his time;” “I’m here, caring for him,” and “God will work a miracle.” In each of these statements, we find forces that exist outside the scope of the materialistic epistemology. Neither luck, nor can mental fortitude, nor God’s power cause the materialistic epistemology to reassess its diagnostic and prognostic projections. We see that the invocator’s conception of the world contains extra-material objects, such as God. A materialistic epistemology would remain silent regarding God’s willingness to work a miracle.¹⁵

We should note, however, that extra-material indicators *need not* conflict with the clinical imagination’s prognostic schemes. Our invocator may accept the primacy of the health care provider’s materialist ontology when answering questions of clinical importance—for example, what’s wrong with my loved-one? The invocator however does not accept that the primacy of the materialistic mode of knowing translates into a *complete* picture of the patient’s future. Returning to our analogy, the philosopher of religion would agree that the feminist theologian’s mode of analysis should take priority when dealing with gender politics in the Gospel of John. Nonetheless, our philosopher of religion would disagree that the feminist theologian’s mode of analysis gives us an *exhaustive* portrait of the Gospel’s themes, concerns, and contemporary importance. The point: for the invocator, the inaugural, primary mode of epistemic questioning

¹⁵ William Stempsey comes to the same conclusion, but through different means (2007, 7).

in clinical imagination cannot encompass all that exists and all that can be known; therefore, a materialist epistemology cannot tell the patient's whole story.

Epistemic questioning can quickly transform into dull repetition because of these non-overlapping conceptual schemes. Cindy Hylton Rushton and Kathleen Russell caution the clinician on this point: "For some parents the constant efforts of caregivers to reinforce information *already understood* about diagnosis and prognosis, an apparent focusing on the negative dimensions of the child's condition, and demands for parents to change their viewpoints are viewed a lack of commitment on the part of caregivers to prolong and promote their child's life and well-being" (1996, 64). Even if the decision maker fully understands the physiological evidence, invoking extra-material indicators may give the clinician the impression that the decision maker misunderstands her loved one's condition. When the clinician and the invocator use the same term, for example, "health" or "body" without understanding the content of the other's use, the two parties are speaking past each other and miscommunication proliferates.

Allow me to summarize what we have learned about the values behind epistemic questioning. We've seen how the clinical imagination's ontological, metaphysical, and epistemological values intertwine. The ontological commitment that the patient is an amalgam of physical and psychological processes sets out epistemic parameters and methodological necessities. What can be known are the things present to the understanding; here, biophysical (primarily) and psychological (secondarily) events and processes. Concerning metaphysics, clinically relevant events relate to each other through the cause and effect of material processes. Stempsey, for example, believes that the clinical imagination's conception of cause and effect is strictly deterministic. Even if we disagree with Stempsey's radical view, we typically agree that diagnostic and prognostic schemes do not include extra-material indicators as causal factors. A

fighting disposition, a positive attitude, a robust spiritual life, the hope for a miracle—none of these states affect diagnosis or prognosis, viz., none of these extra-material indicators actually indicate any relevant information from the perspective of materialist epistemology.

The foundation of the clinical imagination's conception of what can be known/understood (i.e., its epistemology) are physiological states of affairs. The clinical imagination values the knowledge gained from physiology and biochemistry over other epistemic schemes. Hippocratic humors and demonic possessions no longer serve as explanatory mechanisms for disease patterns. Evidence-based medicine consults statistical analysis of material bodies—as amalgamations of biochemical processes—when forming an understanding of the patient's condition. We find that the patient's body is the primary site of understanding. Physiologically relevant states of affairs provide the grist for the clinical imagination's decision making strategies.¹⁶ The clinical imagination rejects the notion of spirit, while the invocator's imagination accepts the notion of spirit.

Before moving on to the practice of appealing to professional values, I should address the central problem for the clinical imagination's epistemological stance vis-à-vis moral values: the "is-ought problem." If the clinical imagination's metaphysical and epistemic commitments are purely material, then how could it move from description to prescription? According to David Hume (1711-1776) and his defenders (for example, the philosopher of neuroscience Patricia Churchland), this problem plagues any moral system that cannot account for the gap between declarations about what is (e.g., "oxygen isn't getting to the patient's brain") and statements about what is good or bad (e.g., "we *should* not continue ventilator support"). In Hume's words:

In every system of morality, which I have hitherto met with, I have always remark'd, that the author proceeds for some time in the ordinary way of reasoning, and establishes the

¹⁶ See Jeff Bishop's *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* for a similar sentiment (2011, 112–13).

being of a God, or makes observations concerning human affairs; when of a sudden I am surpriz'd to find, that instead of the usual copulations of propositions, *is*, and *is not*, I meet with no proposition that is not connected with an *ought*, or an *ought not*. This change is imperceptible; but is, however, of the last consequence. For as this *ought*, or *ought not*, expresses some new relation or affirmation, 'tis necessary that it shou'd be observ'd and explain'd; and at the same time that a reason should be given, for what seems altogether inconceivable, how this new relation can be a deduction from others, which are entirely different from it [...] [I] am persuaded, that a small attention [to this distinction] wou'd subvert all the vulgar systems of morality, and let us see, that the distinction of vice and virtue is not founded merely on the relations of objects, nor is perceiv'd by reason. (*A Treatise of Human Nature* [1738]; italics on "necessary" mine 3.1.1.)

Since material states of affairs make up the clinical imagination's ontology, diagnostic and prognostic pronouncements become descriptions without any necessary (or "deductive" for Hume) connection to moral statements. Where then does the imagination find the audacity to make prescriptions if its ontological and epistemic commitments are grounded in the descriptive? In order to make sense of such proclamations, we will expand our inquiry beyond the characteristic processes of epistemic questioning. An analysis of the political, moral, and theological values that holdup the practical response I have called an "appeal to professional values" will help us see how the clinical imagination negotiates the is-ought problem.

Well-being and self-determination: On the values and duties that found the clinical imagination's response to miracle-invocations

The clinical imagination's response to miracle-invocations contains more than epistemic questions. Diagnostic and prognostic expertise provides the backbone of shared clinical decision making, but a backbone does not make a body. Let us add some flesh to the bones, and move onto the response I labeled "appealing to professional values." I will examine the cardinal arguments we find in the clinical imagination's vision of the professional's values and duties. By doing so, we will see how the clinical imagination encounters those non-material, abstract values and duties.

A few questions center this section: What are these professional values? How do these values relate to each other (and the world)? How are these values *justified*? I'll begin with the professional duty to respect the dignity of the patient as a person. One could spend volumes hashing out the intricate relationships between "duty," "respect," "dignity," "profession," and "personhood." So then, to demarcate our discussion, I will begin with the relationships between professional values on the one hand, and the miracle-invocator's spiritual preferences, on the other. This demarcation will pay quick dividends in the form of concise, clear arguments that reveal fundamental moral commitments. In this section, I will examine two profession-based arguments looking to promote the inclusion of spiritual preferences into clinical medical care.

Respecting the dignity of the patient has been deemed a professional and legal duty. This gives rise to medicine's pragmatic interest in understanding what "respect" requires and entails. What then is "dignity" and what counts as "respecting" the dignity of the patient? Sulmasy and others argue that spiritual care should be integrated into American medicine because this kind of care behooves medicine's professed task of caring for the well-being of individual patients. If formalized, the argument I'll call the "argument from well-being" (hereafter: **A: Well-Being**), looks like this:

- P1) A central task of medicine is the improvement of the well-being of the ill.
- P2) The improvement of well-being for the ill involves respecting the patient as a whole person.
- C1) A central task of medicine involves respecting the ill as a whole persons. (From P1 and P2)
- P3) Spiritual beliefs can make up an essential aspect of the patient's sense of personhood.
- P4) The patient's sense of personhood makes up an essential aspect of what it means to be a whole person.
- C2) Spiritual beliefs make up an essential aspect of what it means to be a whole person. (From P3 and P4)
- C3) A central task of medicine involves respecting the spiritual beliefs of the ill. (From C1 and C2)

Informally then: the overall well-being of a patient can include her spiritual beliefs; therefore, if medicine hopes to promote the well-being of the patient, then medicine must respect the spiritual beliefs of the patient. This argument, perhaps seen most clearly in Sulmasy (2002, 42), stems from a conception of medicine that places the patient's overall well-being in the foreground of the clinical endeavor. This is an argument about what medicine *does*—an argument based in medicine's practices. **A: Well-Being** shows the professional seeking consistency between medicine's goals, values, and tasks. Here, good medicine is faithful to the central task of promoting the patient's well-being.

Specifically, this argument relies not only on an account of what good *is*, but also, what kind of good the physician *does*. **A: Well-Being** emphasizes virtuous action as the starting point, as well as the focus, of the medical endeavor. Prior to professional duties or the preservation of rights comes the more fundamental task of improving the patient's physical and psychological welfare. Beneficence is here anchored to the desire to respect the patient as more than a series of biochemical reactions; going beyond a materialistic epistemology, the patient is a more than the sum of its chemical-electrical parts. We here find the professional onus to act from beneficence anchored in the hope that the well-being of the patient be improved, if medicine is to remain faithful to its expressed, professional values. The inclusion of spiritual preferences into routine patient care is justified by medicine's fundamental commitment to general patient well-being.

If we expand **A: Well-Being** to clinical miracle-language, we find:

P5) Miracle-invocations reflect spiritual beliefs.

C4) A central task of medicine involves respecting miracle-language (From C3 and P5).

The conclusion seems uncontroversial, to a degree. Even critics like Savulescu accept that medicine should, minimally, respect the patient's miracle-invocation; however, those who argue against tolerance ascribe to different notions of respect and the medical endeavor, as I will show.

But first, let's return to the central notion of **A: Well-Being**: well-being. As we saw in the first chapter, "well-being" is a quality a thing—in our case, a human—might have. Insofar as "well-being" has a teleological color, a word or two on this argument's debt to a teleological conception of well-being is in order. Clinical medicine, according to **A: Well-Being**, intends to promote a kind of well-being, a kind of proper functioning. When medicine fulfills its purpose, it promotes the overall well-being of individual patients; or, to borrow the language of David Schenck and Larry R. Churchill, medicine functions properly when practitioners of medicine act as *healers*. Let us take a closer look at the twin-notions of well-being and proper action in teleological ethics. This analysis will, I hope, bring to light a number of latent value judgments hidden beneath **A: Well-Being**'s uncontroversial exterior.

We will begin with a metaphysical analysis, and with the father of teleological ethics, Aristotle. The Philosopher analyzes all primary substances (a human, God, a sunflower, a boat) in terms of their four causes: 1) material, 2) efficient, 3) formal, and, most importantly for us, 4) final (*telos*) (*Physics* 195a). For a preliminary example, let's take a cast iron skillet. We find the material cause in the name: iron; the efficient cause would be the factory that made it; the formal cause is its flat, shallow, handled shape, and its final cause would be the cooking or baking of food. For the human: the material cause is flesh, bone, blood, etc., the efficient cause is one's parents, the formal cause is *arete*, and the final cause is *eudaimonia*. *Arete* is the formal cause of the human because *arete* (translated often as "virtue" or "excellence") is the quality of action that allows the human to function properly (Aristotle 1999, 1097b). When functioning properly, humans (by nature, culture, and habit) aim at *eudaimonia*—translated from the Greek as "well-being," "good living," "flourishing," or "happiness" (Aristotle 1999, 1097a-b). As is the case for *any* primary substance for the Philosopher, the formal cause (here: virtue) is a necessary, but not

sufficient condition for the final cause (here: well-being). Just as a skillet must have a proper, skillet-like shape in order to fulfill the end as a cooking implement, a human must have a virtuous character that performs virtuous actions and cultivates virtuous habits if she were to live a good life. In **A: Well-Being**, we find medicine to be a profession that actively promotes the overarching aim of human life: the cultivation of well-being.

But more than virtuous action is needed in order to live a flourishing life, just as more is needed than a skillet-shape in order to be a cast iron skillet. Our material cause must also be in order, serving the *telos*. Good health and adequate wealth are necessary conditions for *eudaimonia* (Aristotle 1999, 1099a). From this teleological perspective, medicine promotes one of the necessary conditions of flourishing—the maintenance of bodily and psychic health. A cast iron pan would not fulfill its final cause if hewed from oak or molded from plastic, just as a human could not flourish if she experienced continuous acute pain or constant seizures.

This analysis shows us that medicine is a goal-oriented practice or action (*praxis*), with the promotion of well-being the orienting goal. The means to this goal include the familiar, concrete tasks that medicine has come to be known for: surgery, prevention, diagnosis, prognosis, and therapy. For the Aristotelian, these tasks—performed properly—require practical wisdom (*phronesis*) (1999, 1142b, 1143a, 1178a).¹⁷ The authors of **A: Well-Being** hope to convince us that medicine's practices should include respecting the spiritual well-being of the afflicted, as well as the more traditional bio-psycho-social well-being. Spiritual beliefs and practices, according to this argument, form a fundamental world-view from which medicine-related preferences spring; that is, for the individual with this kind of belief, spiritual-religious beliefs and practices influence virtuous actions, the formal cause of the individual human. In **A:**

¹⁷ Although *arete* can lead to *eudaimonia*, the *highest* form of *arete* is found in *theoria*. The rational contemplation of the first principles (*theoria*) is better than *phronesis* insofar as *theoria* directly engages the highest portion of the human soul (the intellect) *for its own sake* (Aristotle 1996, 1177a).

Well-Being then, medicine negotiates territory *outside* the material cause of a person, focusing on the formal cause of the good-life: virtue (*arete*). How then should medicine respond to this relatively newfound task of not only improving the material plight of the individual, but her formal and final cause as well?

Adhering to our theme, I will appeal to Aristotle's conception of moral virtue, vis-à-vis intellectual virtue (1999, 1140a-b). For the Philosopher, proper action/virtue is perhaps best seen in the doctrine of the mean. In most situations, the virtuous action falls between two vicious extremes—one deficient, one excessive (1999, 1106b). For example, when donating to a worthy cause, the virtuous action of, let's say, "proper giving or generosity" falls between the deficient vice of stinginess and the excessive vice of extravagance (1999, 1107b). Generosity looks different depending on context and character. The generous action for an elderly woman dependent on Social Security does not resemble a generous action for a middle-aged real-estate millionaire. The morally virtuous action is the median between two vicious actions. In **A: Well-Being**, the professional responds to religious language falls between the excessive vice of evangelization and the deficient vice of harsh criticism. The clinician refrains from evangelization: the unwanted, overzealous promotion of his spiritual beliefs; he also avoids disparaging or belittling the invocator's religious practices, what I called "harsh criticism." In this in between space, we find authors promoting their practical responses. We are beginning to see how Aristotle's metaphysical and moral system underlies the clinical imagination's impulse to promote the patient's overall well-being. Of course, other practical responses are founded not on a teleological, but a deontological sentiment—where language of duty, autonomy, and rights supplant language of well-being, flourishing, and *arete*.

Let us take a look at a second argument for the toleration of spiritual preferences. Two Presidential Commissions orient this argument in the moral *duty* of the professional to respect the patient as a self-determining agent (1982, 68). In these reports, we find rights-language (“right to self-determine”) privileged over value-language. In the Presidential Commission’s *Making Health Care Decisions* we find an argument that appeals to the positive right of the ill (by the mere fact that they are humans) to self-determine (hereafter: **A: Self-determination**).

P1) Humans have the right to self-determine

P2) The critically ill are humans.

C1) The critically ill have the right to self-determine. (Follows from P1 and P2)

DF=1) The “best interest standard” promotes medical care that the professional consensus deems in the overall best interest of the average patient.

P3) The critically ill are patients.

C2) The best interest standard promotes medical care that the professional consensus deems in the overall best interest of the critically ill patient. (DF=1 and P3) (1982, 2-6)

Again, we find little controversy in this argument, but let’s extend this insight into clinical spaces where patients use spiritual preferences when making decisions, a space beyond the Presidential Commission’s report:

P4) Autonomous decisions require self-determination.

P5) Self-determination can conflict with the best interest standard.

C3) Autonomous decisions can conflict with the best interest standard. (from P4 and P5)

P6) Health care professionals should respect the patient’s ability to make autonomous decisions.

P7) Autonomous decisions can reflect spiritual preferences.

C4) Health care professionals should respect the patient’s spiritual preferences. (From P6 and P7)

The argument becomes controversial when the individual’s right to self-determine encounters a conception of care that fails to align with the best interest standard. Here, two spheres of moral responsibility conflict. The duty to practice good medicine (in the form of adhering to the best interest standard) confronts an individual who believes she has the right to go against this standard.

Humans have the right to self-determine (**A: Self-determination P1**). In this argument, a “right” is a fundamental claim that an individual has to live in a certain fashion, specifically, live through self-determination. Autonomy, self-determination, and best interests are intertwined: a decision becomes “autonomous” when the individual determines, without external coercion, that a certain action is in his interest. The right to self-determine comes simply from the fact that we are human beings. Being a human appears to be the necessary and sufficient condition for having the right to self-determine—making this right an intrinsic part of humanity. Medicine goes about respecting this ability by promoting autonomous decisions. Spiritual preferences are here to be respected when they represent the functioning of a self’s ability to determine, to make choices.

A number of deontological terms and concepts lurk beneath **A: Self-determination’s** surface. Self-determinism/autonomy, dignity, and reason are all ideas of signal importance for the deontologist, the thinker who believes duty and rights should center moral analysis. Allow me a few words on Kantian self-determination/autonomy. First, an anthropological point: the human’s unique ability to make autonomous decisions makes our neuro-biological situation unique among other animals. A unique, rational spark in humanity (the species, if not each and every individual) enkindles Kant’s moral ontology. Kant goes so far as to call autonomy the “supreme principle of morality” (2011, IV: 440). But what makes a person autonomous? If I am imprisoned, am I still autonomous? Kant would say that I would indeed remain autonomous (in a moral sense, if not a political sense) because humans have wills that are capable of continued self-legislation. The will is a capacity of the mind that allows each person to act according to her conception of moral laws (2011, IV: 412). Those who use their wills correctly are those who act rationally, i.e., according to universal, rather than subjective, moral principles.

Kant calls such commands of reason “imperatives,” of which there are two kinds. First, we find hypothetical imperatives: commands that one considers good because these commands get the actor something (2011, IV: 414). With hypothetical imperatives, an action is “good only as a means to something else” (2011, IV: 414). For example, “If I want to go to heaven, then I ought to go keep Mom on the ventilator.” The other type of imperative is the categorical imperative. Comparing the two: categorical imperatives are required of all humans, while hypothetical imperatives are not. Categorical imperatives are independent of subjective preferences and belief, making all moral beings subject to its standards. In the *Foundations*, Kant gives us three explicit formulations of the categorical imperative. He claims that all three formulations express the same moral law, but each formulation emphasizes a different *aspect* of the law (2011, IV: 436). The first formulation has come to be known as the Universal Law formulation: “act only according to that maxim¹⁸ by which you can at the same time will that it should become a universal law” (2011, IV: 421). The Universal Law formulation requires the actor to undergo a process of moral reasoning before willing a virtuous action. Accordingly, the person must first analyze the reason for his action. Next, he must expand that maxim to include all people who find themselves in the same circumstance. If the actor can conclude that all people in the same situation ought to act for the same reason the actor wills to act, then one’s maxim is aligned with the categorical imperative. The second formulation is known as the Humanity formulation: “act so that you treat humanity, whether in your own person or in that of another, always as an end and never as a means only” (2011, IV: 429). This second formulation emphasizes the duties we rational/moral beings owe each other. Note that this imperative does not prohibit the use of humans as means; rather, Kant is arguing that it is not possible to treat someone *solely* as a means and still be true to the categorical imperative. To treat someone only

¹⁸ Kant defines a “maxim” as a person’s conscious and explicit reason for acting (2011, 400).

as a means violates the intrinsic worth of that person, and such a maxim cannot be willed as universal (2011, IV: 435).

But what is of intrinsic worth for Kant? This question leads to a third formulation of the categorical imperative, which has come to be known as the Kingdom of Ends formulation: “act in accordance with the maxims of a member giving universal laws for a merely possible kingdom of ends” (2011, IV: 439). I read this formulation as a combination of the Universal Law and Humanity formulations; it takes both the universality and humanity aspects of the categorical imperative into account. For Kant, an individual’s membership in this kingdom requires legislating for the *entire* kingdom. In other words, when a rational being follows the categorical imperative, she is acting as a member of the kingdom of ends.

According Kant, all beings that could potentially be included in the kingdom of ends deserve to be treated with dignity (*Würde*) (2011, IV: 435). Those beings that constitute the kingdom of ends are “persons.” Unlike “things,” objects with merely conditional worth, persons are beings that have *absolute* worth (2011, IV: 428). Or, in the language used earlier, persons are entities that ought to be treated as ends-in-themselves; people deserve to be treated with dignity (i.e., they have absolute moral worth) because of their rational nature (*die vernünftige Natur*) (2011, IV: 428-29). According to Kant, “rational beings [vis-à-vis things] are designated “persons” because their nature indicates that they are ends in themselves” (2011, IV: 428). Importantly, Kant also argues that “the ground of this principle [the categorical imperative] is: rational nature exists as an end in itself” (2011, IV: 429). So we see that for Kant, humans are those entities who deserve to be treated as ends-in-themselves because they are rational by nature.

Since humans are persons, and all persons deserve to be treated as ends-in-themselves, humans deserve to be treated as ends-in-themselves. All humans deserve dignity since all humans have absolute, and not merely conditional, worth. We see here that Kant is not claiming that dignity belongs only to those humans who successfully employ their practical reason by freely choosing to obey the categorical imperative, i.e., those humans who successfully become members of the kingdom of ends. Rather, all humans deserve to be treated as ends-in-themselves even when they do not will their subjective maxims as objectively universal. Each human's absolute worth results not merely from her shared biological makeup as a member of *Homo sapiens*; instead, her absolute worth follows from the fact she is part of a species *with a rational nature*. Even when she does not act according to the principles dictated by reason (i.e., according to the categorical imperative), her absolute worth remains.

I am not asserting that the deontological notions we find in **A: Self-determination** overlap entirely with Kantian moral theory; nonetheless, an analysis of this argument through a Kantian lens does indeed help us understand some of **A: Self-determination**'s fundamental concepts. The backbone of the best interest standard is the "reasonable person;" in other words, what the medical community finds in the average patient's best interest is fortified by the standard regarding what a reasonable person would want. Placing reason at the center of the average patient's best interest supplants other notions of proper action: the patient's best interest is served by the standard of the *reasonable* person, not the standard of the virtuous, just, or caring person, for example. Of course, the reasonable person might also be the just, or virtuous, or caring person, but we are beginning to see that reason (*ratio*) becomes the hallmark mental activity even for those who lack the capacity to make their wishes known.

The bioethics literature makes a distinction between the best interest standard and the standard of “substituted judgment” (see: John D. Arras 1984). Revisiting a few variations on Mrs. O’Shay’s situation might help us see the relationships between these standards. Let us imagine Mrs. O’Shay provided a valid health-care proxy form upon admission. In this form, she named her oldest son “Bruce” her surrogate decision maker. If willing to accept this role, Bruce has the task of making decisions that accord with his incapacitated mother’s known wishes—making his decision a *substitution* for his mother’s decision. Bruce would fail to be a surrogate decision maker if he put his interests above his mother’s; indeed, he would no longer be acting in the guise of a proxy decision maker, by definition. In deontological language, Bruce must make a decision that preserves his mother’s ability to self-determine. Even if he disagrees with the decision, Bruce must place his mother’s autonomy above his own.

Now notice that autonomy/self-determination plays a different role in Kant’s moral philosophy than it does in **A: Self-determination**. For Kant—as we saw—humans act autonomously when we act in accord with the categorical imperative; however, in the clinical imagination, the rational decision and the patient’s self-determination do not necessarily overlap. The clinical imagination is here attempting to balance the patient’s ability to make autonomous decisions with the preservation of the patient’s dignity. We can imagine a conflict between the “best interest” standard and a surrogate decision maker’s substitute judgment. It is in Mrs. O’Shay’s best interest, according to the Neuro-ICU team, that she receives palliative care rather than aggressive care. But Bruce might argue that the patient would want to remain on the aggressive path—saying “I sincerely believe my mother would want to take the slim chance that BST might work...even if she dies, I think she would rather be dead than debilitated.” In such a situation the best interest of the *average* patient conflicts with self-determination of the

individual patient. The ethereal reasonable person standard encounters an immanently present unreasonable request, but an autonomous request nonetheless.

Before moving on to another professional set of obligations, I will say one more quick word on the clinical imagination's conception of dignity. For some authors, for example Sulmasy, dignity has a deontological tinge because it founds the person's value: he writes, "[d]ignity is the word we use to describe the ultimate value of a human being [...] In its intrinsic sense, dignity refers to the value human beings have by virtue of being just what they are—human beings" (2006, 1387) Notice that **A: Self-determination** retains its deontological color with this emphasis on the irreducible nature of human dignity. Recall the Humanity formulation of the categorical imperative, wherein humans preserve the dignity of other humans by treating them as ends—not merely means. In an article on Baby K, George Annas connects the violation of Baby K's inherent worth with her treatment as a "mere means in the grip of her mother's symbolic purposes" (1998, 84). If Annas is right, then Baby K's mother is violating her child's inherent dignity by treating her child as if she were an irrational, unhuman thing. Closer to home, if Mrs. O'Shay's surrogate decision maker (Bruce or Maria) fail to attend to the values of their mother, but instead focus on their own desires, then they may very well be failing to treat their mother as an end. We can imagine Maria hoping for miracle and pushing for aggressive care because her religious convictions entail continued aggressive treatment. In such a case, the surrogate decision maker would be using another person as a means for her own religious fulfillment—rending her intention morally vicious for the deontologist.

The Duty to "Do No Harm" and the "Conscience Clause": Two Arguments that Perpetuate the Futility Debate

Let us continue excavating the response I have labeled “appealing to professional values” by concentrating on the notion of “futility.” Futility is a term that has become unfashionable in biomedical ethics literature, but still overheard in the clinic. The fact that the term is still being used in the clinic is not surprising: first, only the rare physician keeps abreast of bioethics literature, and second, clinical practices require some way of describing therapies that fail to help the patient as a whole. As E. D. Pellegrino has observed, while bioethicists shy-away from using “futility” as a way to describe certain therapies, the *concept* of futility will forever have a place in medicine because professionals must have some way to talk about therapies that do not have a salubrious effect on the patient (2005, 309). But what does one mean by a therapy that does not really help the patient? When does the clinician know that the possible benefits of a treatment outweigh the possible afflictions? These questions make the controversies about the balance between the benefits and afflictions of certain therapies case-specific. Therefore, attempts at quantifying and/or delineating objective futility principles have not been (nor will they be) successful, leaving professional organizations and a number of bioethicists emphasizing site-specific procedures over general principles.

As we have seen, some practical responses invoke the notion of futility when the suggested treatment violates 1) the duty to do no harm, or 2) the clinician’s individual conscience. But the designation of “futility” is a complex process that might spring from a number of rights- or value-based arguments. So then, when does a therapy become futile, and why should a clinician refuse to perform such therapies? In the clinical imagination, we find a number of answers to this question. The first answer is planted in the soil of the Hippocratic Oath: “first, do no harm” (**A: Do No Harm**):

P1) Health care professionals should not harm their patients.

P2) A therapy that provides no benefit to the patient *as a whole person*, causes harm.

DF=1) A futile treatment is a treatment that, if performed, would provide no benefit to the patient as a whole person.

P3) Futile treatment harms the patient.

C1) Health care professionals should not provide futile treatment.

This is a straightforward argument: the clinician has a professional obligation not to harm his patients, and futile care harms the patient. But controversy follows close behind because “harm” and “futility” are loaded terms steeped in political connotations and contextual nuance. I will describe harm as undue physical, psychological, social, or spiritual *suffering* the patient experiences. There are then four areas where harm may be inflicted upon the patient: the body, mind, social/political-body, and soul. Notice that I choose to describe the affliction experienced by the harmed as “suffering.” The term “pain” would fail to capture the harmful nature of the experience. Pain is a sensation that patients experience, but this experience differs from harm in that the patient willfully experiences pain for the sake of some greater interest. A dual heart-lung transplant causes pain, but the patient knowingly undergoes this pain for the sake of the greater good of overall, long-term bodily health.

However, the kinds of therapies that cause harm remain controversial in the clinical imagination due to the complexity of the terms and their practical application. The futility debate will remain intractable and interminable until we examine the latent conceptions of death, personhood, and justice that found this debate. Turning to Mrs. O’Shay, we might ask, would BST cause undue physical or psychological harm to Mrs. O’Shay—making the procedure futile? The Neuro-ICU team certainly thinks so; while her daughter disagrees. Concerning physical harm, the team believes that the therapy could cause undue bodily harm (especially if we consider death a bodily harm). Psychological harm may befall the patient if her wish to forego “aggressive treatment” was ignored or rejected by the team at the insistence of Maria. We

assume the clinician causes harm when performing a treatment that the patient would verbally reject, had she the ability to do so.

The unconscious patient still has interests. Despite her inability to express a preference *in media res*, the patient remains invested in her physical and psychological well-being.¹⁹ BST may cause harm to the social interests of the patient in a number of ways. We may consider the family as a social unit, and we acknowledge Mrs. O’Shay’s investment in the well-being of her family. The family would experience harm psychologically if the team ignored the patient’s wishes. They would witness the violation of their mother’s psychological well-being as the team violates Mrs. O’Shay’s wish to undergo only non-aggressive treatment. Mrs. O’Shay’s connection to other social circles, such as her Church or her professional community, may undergo harm if the team refused to grant her wish to receive only non-aggressive treatment. We can easily imagine these groups undergoing psychological stress if they found out Mrs. O’Shay underwent procedures against her expressed preferences—assuming that undue psychological stress is harmful experience. Also, BST might inflict social harm on the team itself by giving credence to the constant charge that medicine’s paternalistic tendencies have continued despite patients’ rights movements.

But let us also address **A: Do No Harm** from Maria’s perspective. This exercise will show us the malleable and complex nature the fundamental values displayed in this argument. Maria could steadfastly agree with the above conclusion (**A: Do No Harm C2**); we can imagine her saying, “That’s right, the Neuro-ICU team has the duty to provide only care that does not harm my mother.” However, Maria might disagree with the team over the nature of what it means to harm a patient. Maria could argue that the aggressive path as a therapy that causes

¹⁹ What the literature calls a “formerly competent” patient. See: Douglas Diekema’s *Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention* for an example (2004, 245).

psychological stress, but not harm. She may argue that while BST may cause psychological stress, the possible physical good greatly outweighs the probable psychological stress that results from violating her mother's preference. Maria's objection entails rejecting the patient's psychological preferences in favor of promoting her physical (but not her overall) well-being. Or, Maria might argue from analogy. The psychological stress of violating one's end-of-life preferences is akin to the pain of, let's say, a liver transplant or, perhaps something even milder, a tonsillectomy. Whichever side of the spectrum, the point is the same: BST may cause psychological stress, but this psychological stress should be preferred to physical stress of a life suffering with status epilepticus. According to Maria, the team should not consider BST "futile" because the possible benefit to the patient's body outweighs the probable psychological stress.

A few things to notice about this disagreement between Maria and the Neuro-ICU team: first, we hear the drone of utilitarian logic in this disagreement. The heart of this disagreement is not about whether or not the professional *should* perform futile treatment. Both the patient and the practitioner agree that the medical establishment should refrain from harming the patient. No conflict there. The crux of the disagreement occurs over the ways in which one weighs the possibility of future harm and the authority of past expressions of preference. It is, *inter alia*, a question of adjudication and evidence. While the team hopes to obviate physical and psychological harm, Maria prizes the possibility of her mother's recovery from status epilepticus—a bodily interest. These two imaginative projections conflict and bring about a question of utility: which action is the action that brings about the most possible good for the most parties? The team says palliative care. Maria says BST.

In **A: Do No Harm**, we found a *professional* evaluation of harm in conflict with a *personal* conception of undue pain and suffering. But the literature also offers the clinical

imagination an argument against futile treatment based more explicitly in the professional's personal conception of goodness and virtuous living. The lynchpin of this argument is not on the physician *as a professional*, but the physician as a self-determining, autonomous *individual* capable of acting in accord with her own conscience. Formalized, the “argument from conscience to futility” (“**A: Consci. Clause**”) looks like this:

- P1) Health care professionals should be respected as persons.
- P2) Persons have the negative right to not be forced to violate their own conscience.
- C1) Health care professionals have the right to act in accord with their own conscience.
- P3) Providing futile treatment would be an action that goes against the professional's conscience.
- C2) Healthcare professionals should not have to provide futile treatment when such acts go against their conscience.

Daniel O. Dugan informally summarizes a version of this argument: “patients and their surrogates also should respect the moral autonomy of healthcare providers and not coerce them to provide treatments antithetical to providers’ ethical values” (1995, 231).²⁰ Notice that the onus for the designation has transitioned in this second argument. In **A: Do No Harm**, the professional standards of medicine—a communal conception of proper clinical therapy—provided foundational premises. Here, however, the personal standards of the individual practitioner come to the forefront. With **A: Do No Harm**, we found an explicit appeal to a professional conception of what is good: the good action is the action that, minimally, does not harm the patient. Here, with **A: Consci. Clause**, we find the clinician appealing to his own conception of what is good, and his inalienable human right to act on this conception of the good—insofar as this action does not infringe upon the same rights as others. While the professional good might happen to align with the clinician’s conception of the good, the justificatory mechanism by which the professional concludes that a therapy is futile has changed. Rather than claiming that a certain therapy is futile because he has the duty to act in a non-

²⁰ I read Dugan’s “providers’ ethical values” as encompassing “conscience” (1995, 231).

maleficent manner, the professional appeals to the right to have his conception of good respected by the patient or surrogate decision maker.

I find a consequentialist logic snaking its way through both **A: Do No Harm** and **A: Consci. Clause**. We even get a sense of this connection through the terms themselves, “futility” and “utility.” Indeed, the source of conflict in the clinical application of these arguments is precisely the controversial nature of “futility.” Biological, psychological, and social interests and benefits are set against each other using some veiled moral calculus. Which interests deserve preservation? How much psychological stress is too much psychological stress? Let us delve deeper into these questions by attending to the utilitarian underpinnings of **A: Do No Harm** and **A: Consci. clause**.

For the proponent of consequentialism, the consequences of one’s action have prime normative value; that is, the moral worthiness of one’s action depends not on one’s intention (cf. deontology) or one’s characteristic goal (cf. virtue ethics), but the effect of the action. The proponents of classical consequentialism include Jeremy Bentham, John Stuart Mill, and Henry Sedgwick. The central tenet of a consequentialist understanding of morality is the “principle of utility” or “the greatest happiness principle” (Mill 2001, 7). Quoting Mill, this principle purportedly shows that “actions are right in proportion as they tend to promote happiness; wrong as they tend to produce the reverse of happiness” (Mill 2001, 7). Happiness here differs greatly from Aristotle’s *eudaimonia*; Mill writes, “happiness is intended pleasure and the absence of pain; by unhappiness, pain and the privation of pleasure” (Mill 2001, 7). The ways in which this principle of utility is fleshed out distinguishes the sundry consequentialist theories of morality.²¹

²¹ See: Sinnott-Armstrong, Walter, "Consequentialism", *The Stanford Encyclopedia of Philosophy* (Spring 2014 Edition), Edward N. Zalta (ed.), URL = <<http://plato.stanford.edu/archives/spr2014/entries/consequentialism/>>

To perform a consequentialist analysis of the **A: Do No Harm** and **A: Consci. clause**, we should begin with the issue of quantifying and qualifying well-being. Dugan writes, “medical futility is a value-laden and relative term, one whose definition is by no means settled [...] Futile, like appropriate, moreover, is an inherently relative term: futile in relationship to what goal? To whose goal? Two days of unconscious existence in an ICU might be a worthwhile goal to a family wanting additional time to say good-bye or await a miracle, but futile relative to the goals of the healthcare team (e.g., the patient's survival to the point of discharge from hospital)” (1995, 230). The consequentialist finds the morally right action in the greatest amount of happiness for the greatest number of people; so then, the issue revolves around conflicting quantifications of utility, and the duty to act in accord with the greatest utility.

With the principle of utility in mind, let us return to Mrs. O’Shay’s situation. The primary decision to be made is the choice between aggressive care (including BST) and non-aggressive, palliative care. Recall, in our original scenario, Maria pushes the Neuro-ICU team to perform BST because she believes aggressive care would benefit her mother’s physical well-being, and she believes this path would give God ample time to work a miracle. Addressing Mrs. O’Shay’s course of care from the perspective of a consequentialist, it seems apparent that palliative care would be the morally proper action for a number of reasons. First, there is a great amount of psychological, social, and physical harm that the team anticipates if the aggressive path is taken; additionally, the team envisions only a slight chance that any happiness would result from BST and its accompanying therapies. The consequentialist would also factor Mrs. O’Shay’s previously expressed wish to not receive aggressive care when there is little chance of recovery into the situation’s moral calculus. Additionally, if Mrs. O’Shay’s dismissal of aggressive treatment was ignored, harm would come to those with direct interest in seeing Mrs. O’Shay

treated in accord with her desire: her loved-ones especially. We should also remember that the Neuro-ICU team deems BST futile; therefore, if—somehow—Maria forced to perform BST against their conscience, then psychological harm would befall the health care professionals involved in Mrs. O’Shay’s care.

We could rank the anticipated harms of the aggressive path from most severe to less so: 1) the patient’s physical health, 2) the patient’s mental health, 3) the team’s psychological health, and 4) the psychological health of Mrs. O’Shay’s loved-ones. The clinical imagination informed by a consequentialist framework would also rank the anticipated utility of the palliative path: 1) the alleviation of pain, 2) fidelity to the patient’s wishes, 3) benefits to her loved-one’s psychological health, and 4) benefits to the patient’s health care professionals. If this ranking is accurate, then the morally proper action would be placing Mrs. O’Shay on the palliative care path, as it is the action that maximizes utility.

Here, a consequentialist lens helps us better understand **A: Do No Harm** and **A: Consci. clause**. We see the internal calculus of **A: Consci. clause**: the clinician refuses to promote a futile therapy because the anticipated harm trumps anticipated utility. Since the physician has a duty to refrain from harming her patients, futile care would increase harm, not utility. We also see the weakness of **A: Consci. clause** from a consequentialist perspective. When we consider the “conscience clause,” we find the physician, nurse, or pharmacist refusing to administer a standard therapy for the sake of his own psychological (or spiritual) well-being. A few recent examples: a ER doctor reportedly refusing to fully examine a 24 year-old rape victim because dispensing emergency contraception (an aspect of the examination) would conflict with her conscience; a Roman Catholic pharmacist in Illinois who refuses to dispense Plan B (levonorgestrel) because, “I wanted to be able to practice pharmacy in this small town that I live

in where I raised my family and I wanted to be able to do it with a good, clear conscience and sleep well at night” (USA Today 10/24/2009); furthermore, in Wisconsin, the state legislature passed a law allowing health care professionals to refuse participating in even the *discussion* of topics that might lead to therapies that violate the professional’s conscience, such as *in vitro* fertilization for infertile couples (Charo 2005, 2471). The consequentialist would compare the utility of preserving the professional’s psycho-spiritual well-being with the harm caused by their refusal to engage in practices that the profession has deemed in the best interest of the average patient. How one weighs the utility of acting in accord with one’s own conscience against the harm that comes from forcing a patient to seek services elsewhere (or remain ignorant about a standard treatment) is the central conflict for a consequentialist analysis of **A: Consci. Clause**.

Context is of great import when making such a calculation, and we can imagine the consequentialist fluctuating in her assessment. For example, we can imagine a dedicated Roman Catholic obstetrician who invokes **A: Consci. Clause**—refusing to offer *in vitro fertilization* (IVF) as a viable option for an infertile couple. However, since this obstetrician refers his patients to another practice where he believes the couple can get quality IVF treatment. We also imagine that other factors such as distance and financial difference does not cause a noteworthy increase in patients’ burden. Therefore, the consequentialist would deem the exercise of the conscience clause morally acceptable.

We can also imagine a situation wherein **A: Consci. Clause** would be a morally unacceptable action—returning to the small-town pharmacist’s refusal to dispense “Plan B”. First, in rural America, the distances between pharmaceutical dispensaries might pose a major inconvenience for the woman seeking the drug; such an inconvenience that the burden increases greatly. Also, given the time sensitive nature of Plan B, travel may decrease the therapy’s

potency. Both of these demerits could have been avoided had the pharmacist not evoked the conscience clause. We should also factor the pharmacist's justification into our calculations: it seems the pharmacist misrepresents the conscience clause as he does not appeal to *his* conscience, but some amorphous desire to live in a community that prohibits certain actions. The conscience clause is not meant to facilitate social change, but is meant to protect individuals whose personal beliefs conflict with professional expectations.

When we focus on professional obligation we see one of the greatest weaknesses of any medical professional's appeal to the conscience clause. It would be fruitful to compare the medical professional's invocation of the conscience clause with a soldier who claims that his conscience violates a religious imperative of no killing. Unlike the soldier drafted to kill on the front lines, both the pharmacist and the obstetrician freely chose to become part of a professional guild; additionally, these medical professionals could quit their jobs without legal ramifications, unlike the drafted soldier. The central weakness of the conscience clause is that our evocators want to hold opinions that go against the professional consensus (a profession they chose to join) without having to suffer any negative consequences; instead, it is their patients who shoulder the burden. Put simply, medical professionals who evoke the conscience clause privilege their personal conscience over the needs of their patients.

Let us reintegrate Maria's voice into this conversation. Maria might say that she believes her mother's spiritual well-being should be ranked at the top of any moral calculus. I can imagine her saying, "I understand that Mom said she wouldn't want aggressive treatment, but at the time she wasn't thinking about God. She would be willing to suffer to show God her love. Mom would want to continue with BST, a tracheostomy, and feeding support in order to give God time to work a miracle." Maria dissents from the professional consensus because the

consensus fails to attend to the anticipated good that results faith in God: blissful, everlasting life in heaven. Maria's world-view takes spiritual goods into account, and places them at the pinnacle of her own moral calculus. From the point of view of clinical imagination, however, the anticipated happiness from spiritual rewards does not factor into the utility/futility calculations. The clinical imagination possesses no tools for the assessment of potential spiritual states of affairs—medicine does not proclaim the truth of the Gospel over the truth of the Qur'an, or promote the power of Vedic rituals over Zen Buddhist *zazen*. The clinical imagination sets parameters for the use of religious frameworks when assessing the possible goodness of a clinical decision. To that end, let us analyze the ways the clinical imagination addresses the specific *content* of religious belief.

The Images of God Found in “Theological Negotiation” and “Spiritual Assessments”

In this section, I will show a few ways in which the practical response I call “theological negotiation” fails to actually understand and negotiate the theology found in miracle-invocation. Specifically, these practical responses are inadequate for two primary reasons. First, their claims regarding what authentic images of God might be are suspect. Second, these strategies promote an inaccurate portrait of miracle-language. Without a sensitive understanding of how the term “miracle” is being used, the clinical imagination continues to react to a straw-man conception of theological language. To show this, I will begin with an analysis of the kind of God the clinical imagination finds acceptable.

What kind of God do we find in the clinical imagination, and what can God *do* within the clinical imagination? The clinical imagination does not require an Ultimate Entity in order to conduct business as usual (*prima facie*). Think of the values to which the clinical imagination

pledges fidelity: beneficence, autonomy, and dignity, for example. Notice, however, “fidelity to God” lacks merit and power for the professional, clinical imagination. Nonetheless, even if the clinical imagination rejects supernatural explanations, the supernatural continues to linger. To illuminate this point, I will discuss what has come to be known as a “God-of-the-gaps” theology.

God exists in those places where science cannot account for some phenomena. The most recent popular iteration of this attitude comes from proponents of Intelligent Design. Proponents argue that the theory of natural selection by the survival of the best-adapted is accurate at a macro-level; however, they argue that evolutionary biology neglects the micro-level, when intricate adaptations belie such a high degree of craftsmanship that an Intelligent Designer must cause small-scale evolution (<http://www.intelligentdesign.org/whatisid.php>). Therefore, proponents find God in those spaces where evolutionary biology cannot adequately explain some phenomenon or process.

Closer to home, Jaclyn Duffin’s work on the processes of beatification shows the steady encroachment by medical science onto the domain of the miraculous. Year by year, science constricts the sphere wherein Divine Action might take place. The force of God’s love once kept the planets in orbit, but this mode of reasoning no longer holds sway—not because the theological imagination believes God has gotten less powerful (omnipotence does not wane), but because the gap where God can manifest Godself has gotten smaller.

Even without a God, miracle-events have traction in the clinical imagination—think of spontaneous remissions or placebo effects: those rare events of a fortuitous nature that clinicians may contribute to God, luck, or some other as yet unknown cause. It is in this gap the clinical imagination allows the possibility of a miracle-event. We have seen this attitude in the Richard E. Peschel and Enid Rhodes Peschel’s description of the “scientific miracle.” This kind of

miracle is “an extremely unlikely event or an event that has an extremely low probability of occurring: a spontaneous remission, for example, or a recovery from a disease from which most people die” (Peschel and Peschel 1988, 396). This view of the miracle-event accepts that rare, inexplicable events occur on occasion. The clinical imagination would not deem such remissions “spontaneous” if medicine had a physiological account of remission. “Spontaneous” itself serves a substantial purpose: the word acts as an epistemic placeholder in the clinical imagination. The designation sends us a message: “Even though the medical community doesn’t quite understand how this process works, we’ll get there.” The term pushes the imagination to take an account of some yet unknown material mechanism. A spontaneous event may be unexpected, but it need not be opaque. It would surprise us if textbooks and journals called such remissions “inexplicable,” “mysterious,” or “miraculous.” Such labels give the impression that scientific methods may not be the proper tools of analysis for this kind of event. The gap would remain open.

In an entertaining, but unconvincing, article of medieval miracle-healings, Amir Muzur claims that there is no such thing as a “spontaneous healing” because no natural process (including healing) could exist uncaused. His article well represents the clinical imagination’s attitude regarding rare, fortuitous events. The label “spontaneous” merely shows “one more synonym for our ignorance” (Muzur 2002, 68). To deem a remission “spontaneous” is to say, “we know this event was caused by something, but we are not quite sure, *at this time*, what that something is.” Muzur asserts that “intrinsic capacities of the human” cause spontaneous healings; specifically, the author believes the human’s innate capacity for “auto-suggestion”—the unconscious ability to heal one’s physical or psychological well-being—causes inexplicable healings. We can disagree with Muzur on this point, but his article shows: 1) the clinical imagination (my words, not his) takes a metaphysical stance insofar as it rejects the possibility

that some event might be uncaused; that is, outside of a causal chain of material events, and 2) in designating a healing “spontaneous” we appeal to our ignorance of the cause of said event.

The Peschels call a rare event with a positive consequence a “miracle in the scientific sense” (1998, 396). They define “scientific miracles” “as an *extremely* unlikely event or an event that has an *extremely* low probability of occurring” (1998, 397, emphasis the authors’). Our authors view this aspect of the scientific miracle through the lens of statistical probability. The clinical imagination accepts that statistically improbable, fortuitous events do indeed happen. In fact, as the Peschels point out, they *must* happen given adequate time (1998, 397). Simply by the nature of the clinical endeavor, clinicians will experience such fortuitous oddities if they practice long enough. Had the Neuro-ICU team performed BST on Mrs. O’Shay, and this therapy caused the constant seizures to cease, a miracle may have occurred in the scientific sense the Peschels advocate.

But we are left wondering, why include theological language in clinical settings? Is the language just some socio-cultural residue that the clinical imagination uncritically reflects? To answer this question, let’s relate the clinical imagination to the God-of-the-gaps attitude. Miracle-events occur where the tools of medicine cannot reach *presently*. When medicine fails to explain the occurrence of such events, there is a space between the event and medicine’s modes of explanation. As we have seen, the clinical endeavor is a scientific endeavor that takes place within the materialist, deterministic world with a materialistic epistemology. The clinical imagination views a spontaneous remission as an event not yet understood, rather than an event impossible to understand. The Peschels claim that the clinical imagination need not search after the opaque cause of scientific miracles—simply accept that rare events occur, and move on. But

ever optimistic, the clinical imagination attempts to find cures for diseases, explanations for the miraculous, and answers to the “hard problem” of consciousness.

For the clinical imagination, the designation of some event as miraculous signifies that this space is yet uncharted, a territory where reason has yet to plant her flag. The point: the clinical imagination makes room for what the patient might call a miracle-event while the clinician might call a “spontaneous remission,” “placebo effects,” or a “one-in-a-million recovery.” Just as the scientific endeavor continues to close the gap where God may shine through, it does the same for the sphere wherein medical miracles might occur.

The clinical imagination functions without a God-entity (ontological), a sense of Divine Action (metaphysical), or supernatural belief schemes (epistemology). Could miracle-language—and its hallmark theological commitments—ever play a sensible role in patient care? What kind of miracle-event might the clinical imagination *condone*? I have found two images of God that the clinical imagination might condone, and at least one image that our scholars reject. I will interrogate these God-images with the question of justification in mind. That is, how are these images justified?

Connors, Jr. and Smith justify their image of God-with-us/Emmanuel through biblical citation and Charles Curran’s notion of “resurrection destiny” (26-27, 29, 1996). According to them, Emmanuel is an “authentic” image that the clinical imagination might use to “counterbalance” the unfortunate American-Christian predilection to emphasize individual rights over communal goods (1996, 26). Connors, Jr. and Smith advocate that the clinical imagination become a warehouse of narratives and images that the clinician could employ when miracle-invocations prohibit clinical progress (1996, 25). The image of God-with-us might facilitate a “religious re-imagination” on the part of the invocator—remaking her conception of God, death,

and medical progress. This image, our authors say, corresponds to the God of the Bible, making it true and worthy of acceptance by those who accept the Bible; specifically, those who use Christian miracle-language. As we saw in chapter one, the authors contrast Emmanuel with the theological imagination's God of Rescue. The clinical imagination ought to condone the image of Emmanuel, as the image of God-with-us is more faithful to the God of the Bible—this image is “authentic” and based in “communal narratives” rather than individual distortions (1996, 26).

Despite the authors' good intentions, they leave me unconvinced. The evidence Connors, Jr. and Smith put forward with regard to authenticity is confused and weak. As we saw in chapter one, Connors, Jr. and Smith appeal to Exodus 3:7-8, a passage where God tells Moses that God will rescue the Hebrews from their sufferings in Egypt. But instead of showing that the authentic image of God is *not* the God of Rescue, the authors simply assert that we find Emmanuel in the story of Exodus since God “does not suspend the processes of human living” when addressing the needs of the faithful, here, the enslaved Hebrews (1996, 27). But this interpretation is controversial at best, and incorrect at worst. Indeed, the God of Exodus performs numerous actions that inhibit the living of everyday, prosaic life. For example, each of the Ten Plagues shows Divine Action affecting human living for both the Hebrews and the Egyptians. The God we find in Exodus disrupts “processes of human living” by (to name but a few instances) turning the Nile into a river of blood, sending an angel to kill firstborn Egyptian males, parting the Red Sea for a dramatic escape, and then drowning Pharaoh's army (Exodus 7, 12, 14). The Hebrews go from slaves to liberated desert nomads—from laborers to wanderers—because God hardens Pharaoh's heart and disrupts nature's processes. The God of Exodus is more aligned with the image of the God of Rescue than that of the God-with-us. Now, the initial justification for this re-imagining was the inadequacy of the God of Rescue as an *orienting* image of the Divine: an

image that the invocator employs when interpreting the world and herself. The controversy over which image is “authentic” is far outside the scope and methods of our project, but what continues to be of importance is the relationship between the clinical imagination and conceptions of Divine Action.

The larger point for Conners, Jr. and Smith is that the faithful image of God is not merely an image of God as a miracle worker, a rescuer. They hope the clinician might use the image of Emmanuel to broaden the invocator’s commitment; from the possibility of Divine rescue to the possibility that the Divine is already here (1996, 27). God-with-us is present when humans suffer and die, but (Conners, Jr. and Smith claim) God’s presence does not transform suffering into pleasure (1996, 27). Rather, the image of Emmanuel might help the invocator find meaning in his suffering. As the reader may recall, our authors believe that the Emmanuel image takes away the sting of death (1 Corinthians 15:15) by re-orienting the invocator toward his future life in Heaven, his “resurrection-destiny” (1996, 29). Our sufferings in this world may be painful, but Heaven awaits us. Therefore, even though the desire to hold on to our ephemeral bodies is understandable, this attitude misinterprets the Christian message of salvation through Christ (1996, 28-29).

Conners, Jr. and Smith attempt to justify their image of Emmanuel with what they believe to be theological truths founded in particular interpretations of Scripture and the Christian community. Evidence, according to our authors, comes in the form of revelation and sound communal values. This practical strategy advocates a process. The theological truths found in the Christian community can inhabit the clinical memory, dug up, and presented when the clinician hears miracle-invocations.

This notion of justification reveals an important assumption made by our authors: God-with-us is an image that the clinical imagination might *posit* as “faithful to the Christian tradition” or “what follows from biblical narratives,” but Emmanuel need not be a theological truth the clinician must accept. This assumption makes theological negotiation a delicate process—unless, of course, the clinician actually believes his statements about Emmanuel. I say “delicate” because the invocator may take offense at this practical response as it could be perceived as manipulative. Our authors realize that this task requires a deft touch, so much so that they advocate negotiating with the invocator when pastoral care can be present.

That said, why *should* a clinician discuss the nature of God with an invocator? What justifies theological negotiation if the clinician rejects (or minimally, doesn’t accept) a Christian notion of God or Divine Action? We can imagine Mrs. O’Shay’s daughter Maria asserting, “My God works miracles. My God is all-powerful. You don’t go to my church. Who are you to say that my God isn’t the right God?” For Connors, Jr. and Smith, the clinical imagination justifies its response by appealing to the truth of a text and tradition that *the invocator* finds significant—not truth as such. The clinical imagination responds, “You are a faithful Christian, part of a Christian community that takes the Bible as a cornerstone of the Christian life; well...this is what that community believes. That community believes in Emmanuel: God-with-us.” The clinical imagination takes the role of the teacher by informing the invocator that her beliefs do not align with their institutional authority’s interpretation of Scripture. Connors, Jr. and Smith justify this attitude by appealing to the pedagogical nature of theological negotiation. Re-imagining need not require additional images, metaphors, or stories that supplant the invocator’s current understanding. Rather, the clinical imagination elucidates the images the invocator already finds significant. The clinician need not share the Christian faith with the person who believes in the

miracle-working God. Emmanuel need not be true for the clinical imagination; rather, Emmanuel serves as an alternative image that reeducates those who use miracle language.

The designation of a belief as “idiosyncratic” occurs numerous times in our practical responses. For Connors, Jr. and Smith, the individual’s community provides, sustains, and authenticates the beliefs of the individual (1996, 25). The acceptable “broadening” and “re-imagination” of a Rescue God becomes necessary because the God-of-Rescue misconstrues the *community’s* conception of Emmanuel—the invocator’s “narratives can also distort the community’s stories and images in a way that bodes ill for the community, and perhaps even for the individual” (1996, 25). Let me to clarify their point with an example. A primary reason medicine makes exceptions to the standard of care for mature, autonomous Jehovah’s Witnesses has to do with the fact that the prohibition against certain blood products is a *communal*, not idiosyncratic, belief. Medicine respects this prohibition because a mass of individuals (an entity with political power) orients their medical care around the refusal of the therapy. The clinical imagination acknowledges the religious value schemes of such individuals only insofar as they align with the larger group. However, according to Connors, Jr. and Smith, belief in the God-of-Rescue does not accurately reflect Biblical theology. Therefore, the clinical imagination can question the invocator’s image of a Rescue God, as it fails to align with the beliefs of the group the individual claims to be a part of. Without the community, the invocator’s Rescue God lacks political power, thereby reducing the image to a mere idiosyncrasy. As such, the image has power over an *individual’s* value scheme, not a community’s.

Let us move on from discussing God-images in order to take a closer look at the ways the authors of “theological negotiation” justify their conceptions of faith (as a psychological event) and the faithful Christian life. Sulmasy, Brierley, Buryska, and DeLisser all make a distinction

between miracle-invocations that take either an idiosyncratic or (what I'll call) syncretic form. This distinction separates those who hope for a miracle without the credal backing and support of their community from those who do. The former group holds an idiosyncratic conception of miracle—the latter, a syncretic. For example, we can imagine Maria telling the Neuro-ICU attending that her church believes (as she does) that life is sacred and must be protected at all costs.²² Vanderbilt should therefore use aggressive treatment to prolong her mother's bodily functioning at any cost. Maria's voice and her church's creeds align, making her belief syncretic.

However, we can also imagine Maria appealing to the Catholic Church in her bid for BST. She tells the team that she will be going against her church's stance on the sanctity of life if she relents to the team's less aggressive plan of care. In that case, Maria's comments would be mistaken; the Catholic Church would likely hold that BST counts as extraordinary treatment, making it inconsistent with the sanctity of life principle (United States Conference of Catholic Bishops 2009, III:32). She may insist that her community's conception of life aligns with her own (despite countering evidence); or she may reject her community's view. In either case, her community's conceptual scheme no longer anchors her belief—making her belief idiosyncratic. The miracle-invocator's conception of a miracle-event (and its related commitments) must be firmly rooted in the beliefs of a community in order to gain political power in the medical community. The communal connection must be present to make such an invocation worthy of respect as an individually orienting principle.

The idiosyncratic miracle-invocation harbors characteristics that the community rejects. These characteristics might be theological (wrong God-image), metaphysical (God acts differently), epistemic (we don't think you know that), or moral (that's not the right way to act). What justifies this bifurcation between the syncretic and idiosyncratic? Of the authors who

²² We will set aside the fact that this statement is very ambiguous.

promote this tight connection between the belief of the individual and the beliefs of the community, Sulmasy is the only scholar who delves into the distinction between, what he calls, religious (syncretic) beliefs and spiritual beliefs. Using a Wittgensteinian²³ understanding of language, Sulmasy argues:

- P1) Spiritual identity does not require a standard for authenticity.
- P2) Religious identity requires a standard for authenticity.
- P3) Standards for religious authenticity require communal, public conception of religious texts, beliefs, and rituals.
- C1) Religious identity requires a communal, public conception of religious texts, beliefs, and rituals. (2007, 1227)

Informally, religious beliefs are rooted in community, while spiritual beliefs are rooted in one's own theological beliefs. Let us imagine a surrogate decision maker who believes a miracle-event will occur—perhaps he believes God will improve his grandmother's moribund condition. His faith in the possibility of this event springs from his understanding of his religious identity. In order for this faith to have religious (vis-à-vis spiritual) cache, our hopeful grandson must appeal to the texts and beliefs found in his religious community. If the community deems such a hope properly oriented, then the invocator's expression aligns with his community's texts and traditions—making it syncretic. However, if the community and the invocator disagree, then the parishioner's claim is idiosyncratic, a spiritual claim. Just as it would be false for Maria to claim her views on the sanctity of life overlap with the Catholic tradition, here the grandson and his community have conflicting ideas regarding what one should hope for. This leaves the grandson with two options: 1) accept the community's declaration that such hope is a misrepresentation of their texts, beliefs, and rituals, or 2) retreat into the realm of spiritual identity (Sulmasy 1227-28). Sulmasy finds that such a retreat would be unwise—leading the invocator down the infinitely regressive trail of subjective justification. The clinical imagination condones the God-image that

²³ Especially: Wittgenstein 1999, §256-§271.

is present in the community. But, we wonder, why privilege the God of the community over the idiosyncratic God?

We find a pragmatic answer to this question in Brierley's "Should religious beliefs be allowed to stonewall a secular approach to withdrawing and withholding treatment in children?" (2012). Brierley found that religious authorities played a key role when discussing end-of-life issues with the parents of dying infants: "when the religious leader for the particular faith is consulted, the religious basis of the parental resistance is undermined by the cleric and this can enable parents to accept the imminent death of their child in the context of their faith, almost as if they had been given permission" (Brierley et al. 2012, §35). In five cases, after the medical establishment assembled the invocator's religious authorities, the invocator realizes that his interpretation of theological themes may not coincide with his authority's interpretation. The upshot: clerics can act as helpful catalysts by moving the invocator away from the hope of a miracle toward a more statistically probable event.

Before concluding this section and moving on to the practical strategy labeled "empathetic imagining," I would like to say a quick word on the notion of faith as we find in practical strategy I labeled "spiritual assessment." Jeff Levin defines faith as "a congruence of belief, trust, and obedience in relation to God or the divine" (2009, 90). In the clinical imagination, faith is propositional—the faithful assent to some belief that has a supernatural hue. This notion of faith, oriented around adherence to propositional statements, places the clinical imagination firmly in a European, Christian model of religious experience.

Here, statements of faith work a mechanism by which clinicians learn of the miracle-invocator's spiritual preferences. Expressions of faith have an extrinsic value; the clinician does not seek out faith commitments for her own amusement, but for the sake of understanding the

patient's values. With the strategy of spiritual assessment, the invocator is thought to respond to end-of-life "stressors" with his spirituality: beliefs that give ultimate meaning, as Puchalski says (2006, 15). This relationship between beliefs that give meaning and the psychological response to clinical pain and suffering make up the process called "religious coping" (Koenig et al. 2013, 94-96). Religious coping is fundamentally an interpretive, imaginative process that attempts to reconcile what the invocator believes to be true about the Divine with her clinical experiences.

Faith is something an individual has—a possession. The object of faith for the positive-coping psyche is a specific type of God image: a beneficent, loving, nonjudgmental God who performs salubrious actions (Pargament et al. 2011, 52-55). A positively-coping religious psyche envisions a God who supports her in her suffering—purifying and sustaining of her soul (Pargament 2004, 717). The patient with positive coping skills might believe (or come to believe) that God forgives, loves, and cares for those suffering through clinical distress. This is an entity that comforts the sick, and responds to sincere penitence. God reminds us here of a safe harbor as the storm blows and thunders.

The God we find in the imagination of the negatively coping psyche does not share this supportive, caring character. The God image for those who respond negatively to clinical distress is more complex. This God might choose to ignore suffering—refusing to alleviate the faithful's stress; or, the patient might view this God as actively punishing the individual for her sins (Schottenbauer et al. 2006, 514). Not only God, but demons and devils find themselves in the negative psyche. These vindictive entities punish the individual for his sins—they tell him that he deserves to experience pain and tribulation (Pargament et al. 2011, 56).

Which images are true of the world? Is God actually working to heal God's supplicants? Does God relate to the world in such ways? Scholars of religion and health do not have the

methodological resources to answer these questions. Instead, they search for the connection between belief, action (individual or social), and measureable health-outcomes. Again we encounter a version of the “is-ought” problem—giving the ethicist good reason to pause. Even if scholars of religion and health were to discover that certain propositional beliefs (e.g., the belief in a benevolent entity) or activities (synagogue attendance or praying to Allah) correlate with better physical or psychological well-being, spiritual assessments tell us nothing about the truth value of such propositions; neither could these correlational studies illuminate the moral significance of religion and spirituality in human life. What would the proper action be in such a scenario? The clinical imagination does not have authority to force a cancer patient to pray, or tell a heart transplant recipient to envision the Buddha of the Pure Land post-operation. As we saw in the introduction and chapter one, these issues fall outside the ken of the methods at the disposal of a scholar of religion and health. Let us move on to another practical strategy that sets aside the problem of the truth-value of the invocator’s beliefs, at least initially.

Hollowness and the Skills and Knowledge Found in “Empathetic Imagining”

I will now turn to the practical response I have been calling “empathetic imagining.” The authors who promote this response make a number of assumptions regarding the nature of proper action (Dugan 1995; Scheniderman 2008; Schenck and Churchill 2012). With the practice of empathetic imagining, we find no need for a formal assessment of the patient’s spiritual life; instead, the clinician listens, responds, and observes in an organic fashion. Leaving Nietzsche aside,²⁴ let us consider empathy a virtue of an individual’s character. Aristotle (among other Greeks) makes a distinction between a technical skill (*techne*) that one learns as part of the hands-on practice of one’s profession, and the individual appetites, characteristics, and

²⁴ See: *Twilight of the Idols* (1982, 28, 37).

personality (*orexis* and *hexis*) one *brings to* one's vocation (Aristotle 1999, 1098b, 1105b). Empathy has more to do with skill than character. For Dugan, empathic skills facilitate, *inter alia*, good communication and an improvement in the patient's health. For example, Dugan treats empathy as a tool with a great extrinsic value (1995, 326-28). Without empathy the patient and the clinician will never establish a trusting relationship, and without trust, the clinician would fail to discover the patient's needs and values (1995, 325, 327). The clinical imagination invests in this discovery in order to suggest therapies that align with the patient's preferences (see **A: Self-determination**).

For Schenck and Churchill, the healing relationship between patient and practitioner requires a character that can engage in empathetic imagining for reasons other than the expedient establishment of trust. For these authors, empathy is a character trait that the practitioner displays through a number of discrete healing skills, "listening for what and how patients understand; listen for the fear and for the anger; listen for expectations and for hopes" (2012, 238). There are many reasons to employ these skills in the healing relationship, but the fundamental reason is that medicine helps the afflicted "deal with—to cope with, respond to, recover from—the wounds of fate" (2012, 212). The "wounds of fate" are those unfortunate events that befall all people at some point in their lives. Some of us have been born with generic variations that cause pain and suffering; others develop rare cancers that result in debilitating internal injuries; others battle manic depression, or socio-economic oppression. Ideally, the medical professional empathetically responds to these injuries—using her learned skills to begin healing the patient. In addition to empathy, other character traits include: humility, patience, courage, compassion, justice, respect, and integrity. These traits work together to heal the wounds of fate—to heal the bodies, psyches, and souls of the afflicted.

Epistemic concerns also affect the clinical imagination's conception of empathy. An empathetic imagining of the patient requires what JM calls "mindful listening" (Schenck and Churchill 2012, 73-81). This kind of listening can only occur if the clinician withholds judgment about the truth-value of the invocator's beliefs. This kind of listening involves a novel set of epistemic commitments. The healer uses her imagination to set aside her learned skepticism and preference for rational, linear conversation. The clinician leaves behind questions of Truth in order to pursue other goods such as presence, trust, and empathetic connection. Rational inquiry might factor into mindful listening; nonetheless, mindful listening recognizes that correcting clinical information can wait for another, distinct conversation.

Notice a particular metaphysics founds this kind of empathetic imagining. I say "metaphysics" because a particular conception of personhood gives rise to the possibility of cultivating an empathetic character. As the clinician becomes "empty" or "hollow," she passively accepts the beliefs put forward by the invocator. Even if the clinician disagrees that—for example, "The nurses never listen to me!"—he would allow the comment to pass without disagreement. The conversation may be a time of catharsis for the invocator. One's own versions of proper care, best interests, and acceptable treatment are set-aside *in that moment* for the greater good of an empathetic connection. Without this setting-aside of one's own interests, empathetic imagining would be ultimately unsuccessful.

We might also expediently compare empathy with its conceptual cousin sympathy. Following Richard Sobel, I take sympathy to be that process wherein the individual actively attempts to inhabit the invocator's viewpoint, history, and current mental state (2008, 472-73). Empathy and sympathy require vastly different commitments on the clinician's part. Empathetic imagining allows a passive openness to the interests of the invocator, not an active grasping for

narrative details and fleeting emotions. This active/passive distinction separates Schenck and Churchill's version of empathetic imagining from Schneiderman's. For Schneiderman, empathetic imagining hinges upon the clinician's ability to inhabit the invocator's psychic space—to transpose oneself into the *Weltanschauung* of the invocator (see Spiegelberg 1980). The clinician's imagination and the invocator's imagination meld into a new fictive entity in the mind of the clinician. The raw material for this amalgamation comes from the clinician's understanding of the patient's physical, psychic, and social conditions. These conditions provide the material for the "literary imagination" of the clinician (2008, 69). Schneiderman's "empathy" appears to have more in common with sympathy than empathy. This mode of imagining requires a casting off of one's own sense of self, to be replaced (i.e., transposed) by the self's projection of another person (the invocator). The metaphysical acrobatics that accompany Schneiderman's fictive imagination show the challenging, messy nature of slipping from empathetic imagining to sympathetic imagining. Here, the morally appropriate action requires epistemic leaps.

Returning to Mrs. O'Shay and Maria, an empathetic response to clinical suffering could take a number of forms. Following Schneiderman, the clinician could sympathetically imagine himself *as* Mrs. O'Shay and/or Maria. He could imagine what it might be like to find his mother suffering the consequences of a brain injury—with BST as a possible, but inadvisable therapy. The clinician has to answer, for himself, "What is the world like for Maria given her temperament, familial relations, and social interests?" The clinical imagination inspired by Schneiderman might also inhabit the world-view of the patient. This would lead to questions such as: "What would it be like to have my preferences ignored by my family?" "Would I be willing to undergo an experimental therapy for a miniscule chance at a significant recovery?" By answering these questions, Schneiderman believes a closer connection to the lived-experiences

of the relevant players will facilitate better patient care. Alternatively, following Schenck and Churchill, the clinical imagination could listen mindfully to Maria’s voice. The clinician would be present and attentive. Given the combination of Maria’s combative personality and staff time constraints, Maria probably feels railroaded, alienated, or ignored by Vanderbilt staff. Empathetic imagining might allay these feelings and promote better patient care by improving the relationship between the decision maker and the clinical team.

The Two Central Concerns of “Respectful Rejection”

Finally, let us return to the practical response I labeled “respectful rejection.” This strategy promotes respecting the patient’s miracle-invocation, while refusing to tolerate a religious justification for a medical decision. As we have seen in chapter one, Savulescu advocates this practical response. In what follows, I will highlight the social-political underlining of this strategy. One argument for this practical strategy is an argument that appeals to rationality. (Hereafter: **A:Rationality and Rel. Belief**):

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- P1) Irrational beliefs have no bearing on discussions about right and wrong.
 - P2) Religious beliefs are irrational beliefs.
 - C1) Religious beliefs have no bearing on discussions about right and wrong.
 - P3) The belief in a miracle is a religious belief.
 - C2) The belief in a miracle has no bearing on discussions about right and wrong.
 - P4) Medical decisions can include discussions about right and wrong.
 - C3) When medical decisions include discussions about right and wrong, religious beliefs have no bearing.

Informally: since religious beliefs are irrational, medicine—a rational endeavor—need not attend to religious beliefs. If the ethicist accepts this argument, then miracle-language becomes a symptom of a world-view that we should respect, but safely ignore.

However, I find this argument lacking in a number of areas. Minimally, we should not accept this practical response until our authors make additional arguments. This strict dichotomy

between irrational religious beliefs and rational medical decisions appears controversial. For Savulescu, this chasm between religious beliefs and moral thought exists because “religion is about what biblical texts, traditions and figureheads say is right and wrong, and what some theists believe is right and wrong. Ethics is about what *is* right and wrong, about what we have reason to do, what we should do” (1997, 383). Savulescu writes that those who believe in the possibility of a miracle-event “hold irrational and false beliefs” (1997, 383). These are controversial claims that the author should argue for, but he simply assumes it. Perhaps Savulescu means something unconventional by “reason” or “ethics” here, but simply asserting that a religious proposition is irrational and false, seems—to me at least—to be begging the question. Just as Savulescu accuses Orr and Genesen of merely making assertions rather than making arguments (1997, 382), it seems fair to accuse Savulescu of the same problem. This stark division provides the foundation for **A: Rationality and Rel. Belief**. Recall the title of his paper: “Two worlds apart: religion and ethics.” Without simply accepting this chasm between “what religious people *say about* ethics” and “ethics,” Savulescu’s paper leaves the reader where she began, wondering how medicine and clinical ethics should address religious language.

Desiccation surrounds Savulescu’s conceptions of “ethics” and “religion.” We should reject Savulescu’s foundational assertion that ethics employs reason and religious faith “is about” irrational thought (1998, 383). Savulescu must realize that the person with religious faith believes *he* (not the secular ethicist) apprehends truth. Consider this example. If I am a Muslim, I believe the Prophet Muhammad’s prophecy connects my mind with Truth. Just because I find intermediary entities (the Qur’an, rituals, and community) necessary for the illumination of Truth, I would not consider my beliefs irrational or incapable of reflecting Truth. Without an argument, Savulescu’s assertion that only ethics can reveal truth has as much authority as this

example. The religious believer stands on equal footing when she says, “Ethics is about what *people* say is right or wrong; Christianity (or Islam, or Daoism...) is about what *is* right or wrong.” Since the author proffers no criteria that could adjudicate either the ethicist’s or the practitioner’s claim to Truth, I see no reason to accept Savulescu’s foundational assumption.

Together with Clarke, Savulescu presents a better-grounded argument about the relationship between the social requirements of a hospital and respect for individual beliefs

(Hereafter: **A: Against Pref. Treatment**):

- P1) Public institutions should work toward the good of the society overall.
- P2) Medicine is a public institution.
- C1) Medicine should work toward the good of the society overall.
- P3) Preferential treatment in medicine occurs when a patient receives a good that exceeds the standard of care for unacceptable reasons.
- P4) The good of society is not served by preferential treatment.
- C2) The good of society is not served when a patient receives a treatment that exceeds the standard of care for unacceptable reasons.
- P5) Spiritual beliefs are unacceptable reasons for a treatment that exceed the standard of care.
- C3) The good of society is not served when a patient receives a treatment because of spiritual preferences.
- C4) Medicine should not provide preferential treatment based in spiritual beliefs.

The socio-politico underpinnings of **A: Against Pref. Treatment** are noteworthy. Just as I hope the work of Aristotle, Kant, and Mill illuminated the professional arguments above, I believe John Rawl’s contractarian conception of a just society would be instructive for understanding **A: Against Pref. Treatment**. Rawl’s “original position” is particularly important here. The original position is a hypothetical construct that a rational person might inhabit when thinking about social goods and rights. The hallmark imaginative construct of the original position is the “veil of ignorance” (Rawls 1999, 12). When the rational person inhabits the original position, she sets aside her social status and her natural intellectual and physical abilities in order to contemplate what social situation would be most just (Rawls 1999, 154). When we take on the original

position, we find two fundamental principles: “[f]irst each person is to have an equal right to the most extensive liberty compatible with a similar liberty for others. Second, social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be to everyone’s advantage and (b) attached to positions and offices available to all” (Rawls 1999, 83).

In **A: Against Pref. Treatment**, respect for religious beliefs should not extend to the point that the hospital extends preferential treatment to the believer. The authors’ central concern appears to be the possibility that public funds would be diverted to the faithful at the expense of the non-believer. In Rawlsian language, the toleration of a viewpoint does not extend to the point that this toleration causes an impingement of liberty. Only an unjust society would promote or allow certain individuals (here the non-believers) to shoulder social and economic inequalities. When this occurs, the institution commits what Savulescu and Clarke call “miraclism.”

This is a justifiable concern for publically funded hospitals. If we assume medical resources are finite, with all citizens having an equal claim to their fair share of these resources, then an insistence on preferential treatment for the miracle-invocator would provide an unfair advantage to one citizen by virtue of her religious belief. Distributive justice is here founded in the right of each citizen to her fair share of the collective’s medical goods; therefore, injustice/unfairness occurs, according to Savulescu and Clarke, when an individual receives a good to which she does not deserve. Or in Rawlsian language, the liberty of the believer is incompatible with the liberty of the non-believer.

But complexity runs throughout bioethical discussion, and this black and white analysis needs some shading. To that end, let’s compare Savulescu’s example with the story of Mrs. O’Shay. Recall his example:

3a. A woman has a third relapse of leukemia after two bone marrow transplants. Her doctors say her chance of surviving are less than one in a million. The health authority

responsible for funding this treatment claim that they cannot afford another transplant in these circumstances. She requests another bone marrow transplant because she says that a miracle will occur. (*ibid.*)

Savulescu's argument fairs quite well with *this* example. It would be hard to find a scholar who believes the oncologist should exclaim, "Oh, well...that's that! If she thinks a miracle might occur then we should provide every platform for the possibility of this Divine Occurrence." Savulescu believes Orr and Genesen promote such an attitude. In fact, most clinical ethicists would agree that theological language cannot simply convert preferential treatment into proper care by virtue of respecting pluralism.

The argument for **A: Against Pref. Treatment** loses its power when we encounter clinical situations where it is not so clear that either: 1) resources are scarce, or 2) the proposed therapies have a realistic chance of working. In Mrs. O'Shay's story we find a case where the resources required for BST are not necessarily scarce. Housing Mrs. O'Shay in the Neuro-ICU is not a cheap endeavor, but the resources required for the administration of BST—a ventilator and propofol—are plentiful and relatively cheap. Although it is unlikely that BST would improve Mrs. O'Shay's bodily health, the Neuro-ICU team initially considered this therapy in the interest of the patient, despite its experimental nature. Unlike the "one in a million" therapy in Savulescu's example, for a short while, the team believed that BST had a realistic chance of improving the patient's bodily well-being. It was only after the patient began showing no signs of improvement that the team reevaluated the aggressive path initially envisioned. The argument that the Neuro-ICU would be providing preferential treatment based on religious beliefs appears incorrect. Treatment in such cases would not be preferential, but standard, because the clinical indicators—not religious beliefs—factor into the clinical projection of the future. **A: Against Pref. Treatment** loses its force when resources are plentiful or therapies have a significant

chance of improving the patient's bodily well-being, that is, when it is not clear that the therapy would cause social and economic inequalities.

Context is important when determining scarcity as well. Surely we ought to distinguish a refugee camp from a family doctor's office in rural China; a publically funded hospital in the United Kingdom, from a private American Neuro-ICU. In each of these settings, what counts as a scarce resource varies greatly. An infectious disease attending at Vanderbilt Medical Center wouldn't ask, "Should we or should we not begin an antibiotic regimen for this relative aged HIV positive patient?" However, this question might not be answered swiftly in the affirmative in a Syrian refugee clinic where antibiotics are rare commodities.

The probability of a positive outcome varies by context as well. Survival percentages mean little without context. Let us imagine Mrs. O'Shay made her wishes abundantly clear: under no circumstances would she ever want to be placed on a ventilator, even as a bridge measure. Perhaps she watched her aunt slowly expire while on a ventilator after a routine surgery. Even if we assume a fifty percent (50%) chance that BST would return her to her pre-stroke baseline functioning, the ethicist (and the Neuro-ICU team) would be wise to question if such a therapy would be appropriate given her expressed wishes.

We can also imagine a situation where a minute chance of improvement could be in the patient's best interest. Let's say a sixteen year old girl suffering from an inoperable diffuse intrinsic pontine glioma (DIPG) deep within her brain. Her doctors at St. Jude Children's Research Hospital say there is about five percent (5%) chance that the experimental drug vandetanib might eliminate her tumor. Since St. Jude is a financially stable private institution, the vandetanib therapy would be financially inconsequential. The patient has survived other therapies, and so she knows what to expect from this experimental therapy. She tells her family

and her health care providers that she would rather try the experimental therapy than suffer—though certain neurological deterioration—unable to control her mind and body. Even with a small chance of success, the institution, family, and patient may find another round of radiation therapy preferable to a traumatic decomposition. We see how scarcity of resources and probable outcome statistics depend on context; therefore, the ethicist should not consider either expense or low-probability *necessarily* against the standard of treatment.

Savulescu and Clarke reduce the medical enterprise to the practice of biomedicine. **A: Against Pref. Treatment** fails to account for the fact that public hospitals have become institutions wherein medical professionals also distribute non-material resources. We find no place for the psychological and social aspects of medical care when scholars conceive of medicine as the mere stewardship of tangible health-related resources. But medicine does indeed take psycho-social interests into account when deciding upon a clinical regimen. Indeed, we have seen that these non-material interests have become part of routine care in the West. Respecting the autonomy of the individual through the processes of informed consent preserves an individual patient's nontangible psycho-social interests. For example, when the Neuro-ICU team refuses to provide BST to a patient who would not want aggressive treatment, they provide a psycho-social good that does not diminish the manufactured stock of health-related resources. I imagine Savulescu and Clarke would have no problem accepting that psycho-social interests have a part to play in medical care, insofar as these interests do not lead to preferential treatment. Nonetheless, we should not forget that the distribution of health care resources routinely takes into account factors such as psychological and social goods.

Relatedly, I find that Savulescu's arguments ignore the immediacy of the clinical encounter. His work leaves me wondering: Why should the clinical imagination prefer the

abstract duty to preserve (apparently) finite goods over the intimate and palpable clinical encounter? Could a patient's spiritual interests ever justify a breach in the standard of care? For Savulescu, it appears the duty to be stewards of health-related commodities should orient the clinical imagination's diagnostic and therapeutic options, making the patient-doctor relationship a transaction between the provider and the consumer. We find little room to negotiate the possibility that a psychological, social, or spiritual good could ever justify a treatment that goes against the standard of treatment.

Concluding and Transitioning

In this chapter we have dedicated a great deal of effort to understanding the epistemic, ontological, theological, and moral presuppositions that undergird the practical responses we found in chapter one. This portrait of the clinical imagination has a number of shortcomings, most notably, a conception of faith that fails to attend to the complexities of the invocator's imagination. In the first section, we saw how a materialistic epistemology initiates these practical responses. With the second and third sections, we saw the clinical imagination negotiating miracle-invocations with Aristotelian, deontological, and consequentialist arguments—proffering a notion of medical care that strives to respect the patient's religious liberty while promoting a high standard of care. Next, we found a number of important shortcomings with negotiating theological tenets. In the fifth section, we saw how the practical response “empathetic imaging” envisions the moral skills and metaphysics that accompany empathy. Finally, we saw that “respectful rejection” fails to convince us that incorporating religious beliefs into medical care *necessarily* reflects preferential treatment.

While this chapter leaves the reader with a clearer vision of the arguments found underneath the six practical responses, we do not yet have a practical response that the clinical ethicist can wholeheartedly endorse and promote. We have yet to realize such a response because the clinical imagination continues to misunderstand the invocator's theological imagination. The clinical imagination and the invocator's imagination do not share the same moral ontology. Even if the clinical imagination makes room for placebo effects and spontaneous remissions, it does not seat God at the apex of its world-view. The clinical imagination incorporates values and duties into its conception of the world, but God remains shut-out from its schemes of moral commitment. Before calling one response "appropriate" and another "inappropriate," we must delve into the invocator's moral ontology and imagination; there we will find a conception of the world and proper action that is centered on love of God. Unless we provide a sensitive account of the theological imagination, our practical responses will be founded in inadequate notions of Christian faith, proper action, and the miraculous. In order to create such an account, I will integrate St. Augustine's thought into our conversation.

CHAPTER III

ST. AUGUSTINE: A KEY TO UNLOCKING THE RELIGIOUS IMAGINATION

In chapter two, we saw the ways medical professionals imagine and negotiate the various kinds of values at play in their practical responses to miracle-invocations. I also argued that the values the clinical imagination employs have not been sufficiently justified because the clinical imagination often treats miracle language in a stilted and monolithic manner. This leaves the clinical imagination unable to account for the complexity of the miracle invocation. Specifically, the clinical imagination fails to connect the miracle-invocation to the constellation of beliefs that make up the invocator's conceptual scheme. Lacking such a connection, miracle-language is often perceived as a knee-jerk coping mechanism, disconnected from the invocator's conception of self and world. Even when the clinical imagination recognizes the possible connection between selfhood and invocation, the hope for a miracle often becomes an expression of "spiritual preference" (recall, **A:Self-determination**). However, as I hope to show in this chapter and the next, a miracle-invocation may be a more complicated expression of religious belief than our practical responders realize. A complicated system of ontological, metaphysical, epistemological, and moral commitments might lie behind the few words, "I hope a miracle happens."

In this chapter, I will offer a much-needed corrective by adding complexity and nuance to the clinical imagination's conception of religious language. This corrective will serve a constructive foundation from which the clinical ethicist might build morally adequate responses.

I will employ a number of St. Augustine's works as I construct a more accurate account of the significance of the miracle-invocation. My thesis is this: with Augustine's thought, we see an account of the miraculous that illuminates the moral importance of theological language without reducing the invocation to a coping mechanism. Miracle-invocations may reflect deeply held beliefs—beliefs that form the core of the invocator's conception of the world. If this is true, then a morally adequate response to miracle-language must take seriously the possibility that the invocator is expressing a belief that runs to the core of her own sense of self. Therefore, if the clinical imagination wants to uphold any conception of well-being that takes the patient's spiritual preferences seriously, then these invocations must be considered—as they may constitute the invocator's world-view.

If the reader is on board with this project, he may still be wondering: "Why rely on *Augustine's* thought rather than a more recent theologian, maybe a thinker with more contemporary resonance?" Despite the temporal and social-political distance between Augustine and our era, his thought clarifies the latent values (be they theological, moral, epistemic, or ontological) miracle-invokers often assume. Augustine's thought makes strong connections between the fundamental religious concepts we have been negotiating—connections that bring the complexity of faith into focus. Augustine's writings proffer notions of personhood and autonomy that illuminate the invocator's imagination by reorienting virtuous action around love of God and neighbor. Put simply, Augustine will give us an intricate, sensitive, and influential account of the religious imagination. As chapter two is an interrogation of the clinical imagination, this chapter is an analysis of the religious imagination.

Our task does not require an exhaustive understanding of Augustine's conception of the miraculous. To fulfill this task, a number of manuscripts would be necessary. Tracing his

influences, accounting for the relationships he finds between God, goodness, and personhood, and integrating his pastoral theology—these efforts would be necessary for an extensive understanding of the miraculous. Our conversation, however, must be confined to a few essential topics that illuminate the religious and ethical nature of miracle-invocations. Since Augustine's conception of moral action and the good life are impossible to understand without first understanding his conception of what is and what is not, our first task involves an analysis of Augustine's ontological commitments.

Augustine's Moral Ontology: Placing God at the Center of the Good Life

In this section, we will visit a conception of the world that includes God. When analyzing the clinical imagination, we saw that God is conspicuously absent from the moral ontologies medicine uses to discuss proper action. The closest thing we found to a Christian conception of God might be the mysterious force that causes spontaneous remissions and the placebo effects, but whatever medicine decides this force might be, this force does not have any moral significance. But God is an essential entity in the moral and religious imagination of the invocator—leaving the clinical imagination and the religious imagination with disparate moral ontologies. An analysis of Augustine's ontological commitments will help us get a better sense of the miracle-invocator's conception of the world.

If forced to summarize Augustine's moral ontology in one sentence, I could do no better than to say: What exists is good, and that which does not exist is not good. That said, Augustine struggled with metaphysical and moral questions as he weighed the strengths and weaknesses of Roman Christianity in the 380's. In the foreground is this question: "if all is good, and all comes from God, where could evil have its seat?" In *On the Free Choice of the Will* (388-91) (hereafter:

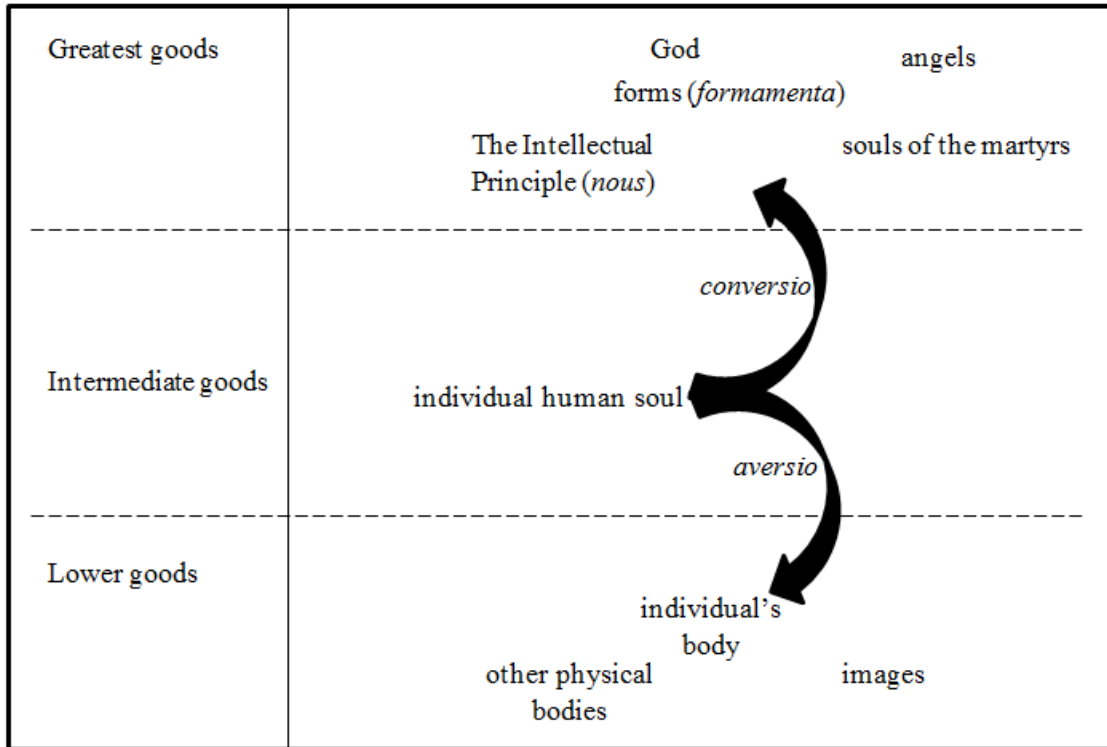
OFCW) Augustine provides a systematic defense of his ontological equation that goodness equals existence. In this dialogue between Augustine and his interlocutor Evodius, Augustine identifies existence with goodness, and vice versa. As such, the quality of goodness inhabits all things—if goodness is absent, then no thing exists. A bit opaque, but his claim makes sense once we clarify its ontological context. Augustine’s thought owes a significant debt to Neo-Platonist thinkers. Before Plotinus and Porphyry introduced the notion of immaterial “spirit” (*nous* in Greek; *spiritus* in Augustine’s native Latin) into Augustine’s intellectual vocabulary, Augustine’s reality consisted of only material things—some completely good (i.e., God), some evil (i.e., Satan), and some amalgamations (e.g., humans). After his encounter with Neo-Platonism, Augustine began conceiving of God as a non-material, spiritual thing who emanated goodness and sustained Creation (Augustine 1998, III.2). A number of insights follow from this sea change in ontological commitments; perhaps the most important: Creation must be good, otherwise it would not be of/from God. Given the biblical evidence for this claim (e.g., John 1:1-2), Augustine would consider such a proposition indubitable. Whence evil, then? Augustine’s novel answer: evil is not a thing; evil lacks any kind of ontological status. He insists—throughout his career—that evil is the privation and absence of goodness/existence.

Let us see how this ontological-ethical commitment translates into the sphere of human moral psychology, action, and character. The self (*persona*) harbors a soul that is the seat of evil in Augustine’s moral ontology. Our souls are placed in a precarious “intermediate” place in Augustine’s scheme of goods/existing things. We can use our souls for either good or ill due to two factors: 1) we have the power to freely choose (*liberatum*), and 2) God has placed our souls between the Greater Goods and the Lesser Goods. These two factors form the foundational

scheme for Augustine's conception of proper action. This uniquely human ability to authentically choose is an Intermediate Good (*media bona*) (Augustine 1998, III.2).

Let us pause on this notion that the human soul (*animus* or *psyche*) is an Intermediate Good. The fallen human soul can do both good and evil. When we turn toward (*aversio*) the Lesser Goods, we do evil; when we turn toward (*conversio*) the Greater Goods, we do well. The Greater Goods—those things the properly ordered soul turns toward—include: the virtues (such as justice, prudence, temperance, and wisdom), the Trinity, spiritual beings/angels, and the Forms (*ibid.*, II.6). The Lesser Goods are things that are not necessary living well and acting virtuously, but since they are created and sustained by God, they are good nonetheless. Think of physical objects as Lesser Goods: e.g., our own bodies and our baser desires. We can take a hedge-fund manager as an easy example. He wants money, power, and political clout in order to satisfy a desire for acclaim and admiration of other people with money, power, and political clout. This desire points him toward Lesser Goods: those things that are impermanent, transitory, and easily lost. Goods like wealth, admiration, and authority are far from permanent. When we turn toward the Lesser Goods, we do evil, but when we turn toward the Greater Goods, we act virtuously.

Diagram III.1 Augustine's Scheme of Goods



Broadly speaking then, the will to choose the action that orients the soul toward better things is the proper action. For Augustine, proper actions—insofar as they are *good*—have an ontological status. Like virtues, the Trinity, the Forms, proper actions *exist*. Augustine discusses “proper action”—the virtuous desires and decisions—in a number of ways. We have seen this turn toward the good in terms of *conversio*. This formulation points to two important aspects of Augustine’s conception of proper action: 1) autonomous choice and 2) the ontological hierarchy wherein the human find herself composed of both material and spiritual substances.

Second, Augustine conceives of proper action as the right use of reason (*ratio*). The human intellect/understanding (*intellegere* or *scire*) assents to the action that accords with what is rational and orderly. Since Augustine’s ontological hierarchy places spiritual goods above material goods, the rational action is the action that preserves this hierarchy. When we (*personae*) choose rationally/act properly, the soul chooses spiritual goods, the Higher Goods—

to choose the material would be irrational and against the order of nature (*esse*). Right reason maintains God's natural order; conversely, irrational action goes *against* the natural order of things.

Third, Augustine describes the distinction between proper and improper action by appealing to the role of one's desire (*cupio*). A desire can be either ordinate or inordinate. In *OFCW*, Augustine makes this distinction by appealing to the desire of a slave to kill his master, and then live free. The desire to live in freedom (*libertas*) appears to be a properly-oriented, virtuous desire. So, might killing, which common sense tells us ought to be bad, actually be *good*?

Augustine: you [Evodius] persuaded yourself such a great crime [the slave killing his master] should be unpunished before you considered whether the slave desire to be free of the fear of his master or only to satisfy his own lusts? For to wish to live without fear is not only the desire of good men, but the desire of all evil men as well. However the difference is this: that the good, seek it by turning their love [*caritas*] away from those things which cannot be possessed without the risk of losing them. Evil men, however, try to remove obstacles so that they may safely rest in their enjoyment of these things, and so live a life full of evil and crime, which would be better named death.

Evodius: I have come to my senses. Now I am glad that I clearly know the nature of that blameworthy desire called lust [*concupiscentia*]. It now appears to be the love of those things which a man can lose against his will. (*ibid.*, I.4)

So it turns out the slave's motivation is *not* the preservation of order; he does not have love, but lust in his heart. The slave may desire to live without fear, but his desire is based in the temporary reprieve that evil actions can offer our tired bodies. The objects of evil desires are the impermanent things of the universe—things that can be taken away from us—things we have little control over. The slave who has an inordinate desire in his heart remains blameworthy, remains vicious, *even if* he decides to act in accordance with the proper functioning of the slave. For Augustine, I am responsible for my *concupiscentia*, my inordinate desire, even if I use reason to overcome such a desire.

Fourth, Augustine discusses the intentional preservation of order as love (*caritas*). Love is the force that motivates proper action. *Caritas* (sometimes translated as “charity”) is the voluntary, proper, virtuous action that preserves Nature’s Order and God’s Law. The desire to love God (the Highest Good thing) makes our actions good, while the desire to love oneself (*cupiditas*)—a lower Good—creates vicious, evil actions. This purview of all morally significant actions makes love/charity the axial concept in Augustine’s conception of morality. This opposition between love of self and love of God provides the foundation for living life either viciously or virtuously. What makes Christianity essential for the good life is the ways in which this faith opens up the individual soul to the grace (*gratia*) of God (Augustine 1887A, 21:29). One might *anticipate* acting virtuously, but without God’s love, truly virtuous actions would not follow.

In *OFCW*, Augustine often equates the state of living in sin with death (1998, II.8, II.14). This was not always the case: God created humankind without sin; however, when Adam freely chose to introduce sin into the world, he also introduced bodily death into humanity (Augustine 1993, 299. 11). The first man turned toward the Lesser Goods, and human nature became perverted, they begin to choose love of self over love of God. In a sermon from circa 413 (just as the Pelagian controversy was beginning), Augustine returns to Enoch and Elijah to argue the related point that death of the human body is unnatural. We must remember that God created the human body immortal (*ibid.*); however, death of the body and soul has become universal for all postlapsarian humans. Worse than bodily death, postlapsarian humanity is born with dead souls—dead not in the sense of inactive, but in the sense of Hell-bound (Augustine 1887A, 39:48). God has enacted this punishment as retribution for Adam’s original sin: Adam disrupted,

disordered what God created, so God justifiably disorders the soul who chose self-love over love of God.

We cannot live a good and blessed life if we do not orient our desires in a manner proper to our soul's intermediate station, that is, if we do not orient our desires toward God (Augustine 1998, III.13). A life of blessedness depends on a constant desire for God. Desire for God is the only proper, orderly desire; choosing to act on this desire is the only proper decision. Indeed, Augustine's ontology requires this conclusion. There is no place for evil desires and vicious actions in Augustine's moral ontology. After all, where would the universe harbor them? Inordinate desire and vicious actions are nothing—they have no place in the Created Order. In other words, the *turn* toward the less good things (*aversio*) cannot come from God, for God sustains only goodness, and *aversio* surely lacks goodness. Indeed, only the soul's turn toward the highest goods (*conversio*) exists.

From Ontology to Belief in Things Not Seen

In the following sections, we will see how Augustinian notions of faith, hope, and love might illuminate the various ways the miracle-invocator's imagination negotiates proper action in clinical, end-of-life settings. This task requires connecting the moral ontology we have been discussing with Augustine's notions of faith, hope, and love (*caritas*). By analyzing “these three” (*illa tria*) modes of true wisdom (*sophia*), two results follow: first, we will establish a robust connection between proper action and the desire to love God (*amor dei*); second, we will see how theological and non-theological epistemological commitments inform the imperative to love God (a moral commitment). These results will yield a clear picture of the miracle-invocator's

imagination—an account that is sensitive to the theological and moral commitments that buttress the invocator’s imagination. First, we will analyze the epistemic importance of faith.

For Augustine, faith and reason need not be at odds (Rist 2001, 27). Indeed, both faith and reason play an essential role in Christian life, and these modes of understanding often assent to identical propositions. In the *Handbook on Faith, Hope, and Love* (421/422) (hereafter: *Handbook*) Augustine makes it clear to the inquisitive Laurentius that Christianity requires more than justified true belief (*episteme*) in certain propositions; instead, in order to show that one loves God, one must be willing to do more than simply *believe* that something is the case. Christianity, the foundation of a good life, requires action—especially the act of worship (Augustine 1955, 3). Let’s examine the role of faith (and reason) in Augustine’s vision of the good life and proper action.

In the *Handbook*, Augustine begins his analysis of faith by addressing two hallmarks of liturgical life, The Apostle’s Creed and The Lord’s Prayer. Augustine tells Laurentius that faith *believes* (*fides credit*); while hope and love, *pray* (*spes et caritas orant*) (*ibid.*, 7). Concerning the first Grace: What, then, is belief? And what is it that faith believes *in*? The answer to the first question is somewhat easy: Augustine’s conception of belief does not break any new ground, for he holds that belief is a process of the mind/soul in which an individual assents to the truth of a proposition. (Disbelief occurs when one rejects the truth of a proposition.) In *On the Predestination of the Saints* (428/429) Augustine defines belief as “thinking with assent” (1887B II.5). However, as Rist points out (2006, 61), we are then left with the question: What makes us either assent to, or reject, the truth of a proposition? The answer to this question ought not surprise us—the individual human will (*voluntas*) is the faculty that allows us to assent to the truth of a proposition.

So then, what does faith believe *in* exactly? In Chapter 8 of *Handbook* Augustine confidently tells Laurentius that Paul’s Epistle to the Hebrews tells the community that faith can be defined as “the evidence of things not seen” (Hebrews 11:1). Faith applies to beliefs that contain objects or events that we did not see, or could not see. Augustine notes that one can come to have faith in some non-sensible object by: 1) verbal testimony from others (especially Scripture and the Church), 2) one’s own reason (*ratio*), or 3) deducing the non-sensible from one’s own experience (Augustine 1955, 8). That is, an individual may gain evidence for a faith-based belief by trusting in the testimony of others and/or one’s own understanding (*intellegere* or *scire*). Notice how Augustine makes room for the possibility that one can accept the authority of both *ratio* and the Church—reason and faith. We see, again, that natural reason need not encroach upon the realm of the Church and vice versa; both the intellect and ecclesial authorities may be the catalysts for beliefs in things not seen.

Throughout his battles against the Manicheans, Donatists, and Pelagians, Augustine revises many of his opinions; however I can find no evidence that his well-known dictum, “*crede ut intelligas*” (“believe that you may understand”) undergoes any significant revision (Augustine 1888, 6). Augustine holds that belief must precede any understanding of an object of faith; that is, Augustine does not imply, at any stage in his development, that the intellect/understanding has the power to cause an individual’s faith. Instead, when an individual mind (*mens*) comes to an understanding of any spiritual object, faith *preceded* intellectual apprehension. In a Sermon on Matthew 20:30, Augustine connects the requirement of faith with divine reward, saying, “What can be the reward of faith, what can its very name mean if you wish to see now what you believe? You ought not to see in order to believe, *you ought to believe in order to see*; you ought to believe so long as you do not see, lest when you do see you may be put to the blush” (Sermon

38, emphasis added). In this sermon, Augustine lets the faithful know that even if it appears that faith is not rewarded in this life, the properly oriented faith will be rewarded in the *eschaton*. Even when *ratio* fails to assent to the truths of the Christian faith, the Christian should not falter: fundamental truths will, eventually, be made obvious to all humans.

Even though the *Handbook* emphasizes the importance of loving God as a way of life, orthodox beliefs play a central role in this way of life (Augustine 1955, 9). Unlike the Greek, the Christian need not delve into the nature of the physical universe in order to have a proper belief about the *primum movens*: “It is enough for the Christian to believe that the only cause of all created things, whether heavenly or earthly, whether visible or invisible, is the goodness of the Creator the one true God; and that nothing exists but Himself that does not derive its existence from Him; and that He is the Trinity” (*ibid.*). Of course, Christians who wish to unpack this *fundatissima fides* are free to do so, so long as they remain orthodox.

Now that we have seen the ways in which we may come to a faithful belief, we can analyze the *objects* of faith. It is with his emphasis that Augustine begins discussing the relationship between faith, hope, and love. He makes it clear that we can believe in objects and events that we do not hope for (*ibid.*, 8). For example, a Christian believes in the eternal damnation of sinful souls, but she does not hope for this punishment. According to Augustine, we only hope for the sake of something good (for the individual)—we never hope that some misfortune or suffering visit us or those we care about. We also find a temporal element of faith: it concerns the past, the present, and the future. To illustrate this, Augustine points out that *pietas* tells us that Christ was killed and resurrected (past), Christ currently sits at the right hand of God (present), and that Christ will come again as Judge (future) (*ibid.*). However, in the case of hope, we only have hope for the sake of some *future* event. For example, if I were to say, “I hope the

Apollo 11 mission safely reaches the moon,” the listener would assume I misspoke. The listener would be confused because the event I am hoping for has already occurred. Given this temporal distinction, we see that the imaginative process of *pietas* and hope must remain distinct, as they may intend disparate objects and do not always refer to the same temporal aspects.

In What Should the Christian Faithfully Hope?

Let us continue by taking a closer look at Augustine’s notion of hope (*spes*). Augustine supports his conception of hope with Pauline epistles. Citing Romans 8: 24-25, Augustine writes, “Hope that is seen is not hope; for what a man sees, why does he yet hope for? But if we hope for that we see not, then do we with patience wait for it?” (*ibid.*). We see Augustine’s Pauline influence in this emphasis on the *temporal* aspect of hope. But this quote also emphasizes the individual’s perceptive faculty—his ability to see. Here, sight as a metaphor for direct experience, thus distinguishes itself from the testimony of others and *ratio*. Paul also introduces the value of patience. As the Christian waits (for example: for the *parousia*), she ought to wait in a patient manner. The future fruition of some occurrence is entirely independent of any individual’s subjective hope; therefore, fretting over the possibility of an event serves no purpose.

In Augustine’s *Confessions* (397/401) (hereafter: *Conf.*), *spes* plays an important role not only in Augustine’s spiritual formation but also in the conceptual framework of the book *in toto*. Augustine sets up an opposition between the subjective states of hope and fear. While discussing his early encounters with pagan poetry and mythology, he writes, “For a lesson was given me that sufficiently disturbed my soul, for in it there was both hope of praise and fear of shame or stripes. The assignment was that I should declaim the words of Juno, as she raged and

sorrowed...” (Augustine 1991, I:xxvii:27). Both hope and fear exist in the *same* soul toward the *same* event: Augustine hoped that he would be praised for his jeremiad, but also feared the possibility of failing. Augustine admits that he should not have wanted praise from his schoolteachers and peers—he labels hopes for praise “vain (*vanae*) hopes” (*ibid.*, III:iv:7). Throughout *Conf.* we find Augustine chiding himself for hoping for the sake of vanity rather than for the love of God. Augustine excoriates his past self for treating wealth and honor as objects to be hoped-for (*ibid.*, II:v:11). Money, political clout, *episteme*, and bodily gratification are all “worldly” (*mundi* or *saeculi*) and vain hopes Augustine once held (e.g., *ibid.*, VI:x:17).

Augustine contrasts vain and worldly hopes, with *faithful* hopes. Faithful hope occurs when an individual places hope in an object that *ought to be* hoped for. But how does one know that one’s hope is faithful rather than vain—that one’s intended object is proper? In most cases one couldn’t be certain, given the future-oriented nature of hope; nonetheless, if you honestly believe that you base your hope in love (*caritas*) of God and Neighbor rather than love of self, then it is likely that your hope is faithful, not vain (see, especially, *ibid.*, VI:viii:13). The hopes of Augustine’s mother, Monica, can help illuminate this distinction.

Monica hoped that her son would relinquish his ties to Academic philosophy and Manichaeism to join her in Roman Christianity (*ibid.*, IIX). Augustine heard these cries, but could not simply will himself into Roman Christianity’s Church. (He had to wait for God’s grace to quicken his soul.) Monica hoped Augustine would convert not because his conversion would be beneficial *to her*, but her son’s conversion would benefit her son’s soul. Augustine, according to Monica, would now have the chance to properly love God rather than himself. Augustine describes Monica’s reaction to the news of his conversion thusly:

and she leaped for joy triumphant; and she blessed thee, who art ‘able to do exceedingly abundantly above all that we ask or think.’ For she saw that thou hadst granted her far

more than she had ever asked for in all her pitiful and doleful lamentations. For thou didst so convert me to thee that I sought neither a wife nor any other of this world's hopes, but set my feet on that rule of faith which so many years before thou hadst showed her in her dream about me. (*ibid.*, VIII:xii:30)

Monica's hope that her son would be saved was faithful, not worldly, because it sprang from her love of God and God's plan, not love of self, according to Augustine.

Monica's trials also display the interaction Augustine finds between hope and hopelessness (*exspes*). We can experience both faithful hope and hopelessness at the same time, even though the object of such hope and hopelessness would not be the same. In Monica's case, while she hoped for her son's conversion, she felt dismay over her son's love of decadence, astrology, and pagan *sophia*. We can envision Monica being hopeful that God will save her son, but greatly distressed over her son's temerity. Therefore, even when hope is properly oriented in God's love and Providence, we are not necessarily living in happiness, or even contentment. One need only recall the Agony in the Garden (Luke 22:39-46) or Jesus' "My God, my God, why hast thou forsake me?" (Matthew 27:46, Mark 15:34) to find biblical precedents where both hope and hopelessness reside in the same person, at the same time.

Can we freely choose to have hope in God? What is the relationship between free choice (*voluntas*) and hope? In Book IV of *Conf.*, we find Augustine at his most miserable, as he laments for an anonymous dead friend. Everywhere he looks, Augustine sees death. Neither his childhood home, nor once-comforting books, nor family can steer his thoughts away from his deceased friend. During this time, Augustine (at the time, a practicing Manichean) writes, "I became a hard riddle to myself, and I asked my soul why she was so downcast and why this disquieted me so sorely. But she did not know how to answer me. And if I said, 'Hope thou in God,' *she very properly disobeyed me*, because that dearest friend she had lost was as an actual man, both truer and better than the imagined deity she was ordered to put her hope in"

(Augustine 1991, IV:iv:9, emphasis added). Love of God, at this time in Augustine's life, seemed so abstract and far-off; the love he felt for his recently dead companion overwhelmed any latent love of God. As we saw in our discussion of faith, Augustine draws a distinction between *assenting* to the truth of some proposition and *living through* such truth. Again we see this distinction with his conception of *spes*. Augustine tries to will his soul into a faith-based hope in the true God. We assume that this imperative to hope in God is rationally understood (*ratio*) by his mind; that is, when he tells himself to hope, he *assents* to the truth of such a proposition. However, hope in God requires more than voluntary, cognitive acceptance of God's Being. Even before his conflicts with Pelagius, Augustine realizes that humans need something beyond voluntary belief if we wish to place hope properly in God. Specifically, he sees that faithful hope in God requires God's unearned grace (*gratia*) (Augustine 1955, 76). Without God's grace, we cannot (as Augustine could not) properly hope in God.

Love of God and Charity (*caritas*)

Early in *Handbook*, Augustine summarizes the relationship between faith, hope, and love: "Without it [love], faith profits nothing; and in its absence, hope cannot exist. Wherefore there is no love without hope, no hope without love, and neither love nor hope without faith" (Augustine 1955, 8). While we find a symbiotic and circular relationship between these virtues, in the final chapters of the *Handbook* he argues that *caritas* ("love" or "charity") is the greatest of the three modes of *pietas* (*ibid.*, 117). Like hope, Augustine dedicates only a few chapters to love/charity, but his asymmetrical distribution does not reflect its importance in Augustine's conception of a proper Christian life.

Paul writes to the Corinthians (1 Cor. 13:13) that love is the greatest of the three modes of wisdom (*ibid.*). Concerning proper belief, the Apostle writes that true belief “works by love”—rendering any true faith founded in *caritas* (*ibid.*); furthermore, Augustine writes in *Contra Faustum*, “one does not enter into truth except through love” (Augustine 2007, 32.18). Quoting 1 Timothy 1:5 to Laurentius, Augustine reiterates the essential nature of love: “Now the end [*finis*] of the Commandment is charity [*caritas*], out of a pure heart, and of a good conscience, and of faith unfeigned” (c.f., Augustine 1955, 121). Here we find Augustine positing a vision of proper-living. When we ask whether or not someone lives a good life, we are not asking what this person *believes*, or for what she *hopes*—these are merely cognitive states—instead, we ask what she *loves* and how she acts. When one loves correctly, one also has faith-in and hope-for the proper objects. If one does not have love, then one’s hopes and beliefs would be in vain. An example regarding hope: an individual can place his hope in God’s promise that those who act with righteousness will receive eternal life. However, if he does not love righteousness—and live through this love—this hope will come to naught (*ibid.*, 117).

The association between *caritas* and God’s Word also displays a notable aspect of Augustine’s conception of proper living. God has shown love for humanity, through time, in four stages. God has: 1) endowed humans with an intelligence that can apprehend God’s Natural Law, 2) given us the Law of Moses, 3) sacrificed God’s only Son to show the possibility of grace, and 4) provided eternal grace to the Saved in Heaven (*ibid.*, 118-119). In each of these four stages of history, it has been possible to love God properly. Before Moses, we had reason—a faculty that can understand God’s natural laws. The Universe proclaims it has been made and sustained by a Divine Intelligence. During the time of Moses, the Law (in conjunction with *ratio*) told us how to love. Since the time of Jesus’ life and death we have had the Scriptures and the Church

showing us the way toward love of God. Finally, after the Second Coming, the soul that has loved properly (thanks to God's grace) will be at peace. Proper action at each stage requires properly loving God (*ibid.*, 121; Augustine 1887A, 57.67). If the individual soul voluntarily acts for the sake of either love of God or love of others, then one's motive is both virtuous and grace-filled.

Let us return to *OFCW* before tying this analysis to Augustine's conception of the miraculous. In various sections of this dialogue we find Augustine and Evodius discussing *voluntas* as it relates to love, God, and God's Creation. His revolutionary discussion of the free choice of the will can help us understand what the love of God requires. We saw that he places the human soul below spiritual beings (e.g., God and angels) but above merely material things such as human bodies, animals, inanimate things, and images—the propriety or viciousness of one's love depends not merely on motive and desire, but also the intended object. When we act virtuously, our God-given motives result in love of God or neighbor. Ontologically, this occurs when the object of our love is found *above* the soul's station in the hierarchy. As Augustine says in *City of God* (c. 413, 427) (hereafter: *CoG*) “hence, as it seems to me, a brief and true definition of virtue (*virtus*) is ‘rightly ordered love’” (*ordo amoris*) (Augustine 2003, XV.22). Not surprisingly, we sin (*cupiditas*) each time we “love” something placed ontologically beneath the individual soul (see, e.g., Augustine 1998, III.9-10 and Augustine 1991, VIII:3.8). In these cases, our motives are not God-given, but instead rely on self-love. When God causes us to love properly, the object of our love must be God. Concerning responsibility, recall that *cupiditas* (“inordinate desire”) results from our own selfishness, while love oriented in a proper manner has been caused by God's grace. Therefore, Augustine would have us believe that the

mechanism of both proper and improper (*caritas* and *cupiditas*) use of one's *voluntas*, is love (e.g., Augustine 1998, I.14).

In *Handbook*, love is the central motive in the life of any person to whom God has favored with God's all-powerful grace. Her proper beliefs and faithful hope would be non-virtuous if it were not for *caritas*. Throughout the span of history, the desideratum of a proper life has remained (and will always be) the love of God. As we have seen, Augustine's conception of *caritas* greatly colors his ideas on virtue/proper action. Hannah Arendt argues that Augustine's theology of history orients life here on earth toward the fourth, enduring, and final stage of God's relationship to Creation (what I described as "stage four" above) (1996, 36-44). If this is right, then, according to Augustine, virtuous people are those who look forward (and upward) when deciding how to act and what to believe. They are open to God's grace. However, even with the gifts of *ratio*, Scripture, and the Church, an answer to the question "How ought I act?" can be turbid. Most important for our purposes is a more specific question: Could hope for a miracle ever be consistent with the proper love of God and neighbor? If we hope to adequately answer this question—thereby creating a sensitive portrait of miracle-invocations—we should take a closer look at Augustine's notions of the miraculous.

From Morals to Miracles

In order to use to get a better sense of the religious imagination that accompanies miracle-invocations, let us say a word on the ontological and metaphysical aspects of Augustine's miracle-concept. In two anti-Manichean works from around 390, we find Augustine's earliest descriptions of *miraculum*. In the tract *On the Profit of Believing* (c.391), he defines "miracle" as "anything which appears arduous or unusual, beyond the expectation or

ability of the one who marvels at it” (Augustine 1953, 34). Augustine identifies two species of miracle-events: 1) miracles that cause wonder, 2) miracles that not only cause wonder, but also provide a direct benefit to an individual (*ibid.*). This benefit can be physical, spiritual, or both. A man flying through the air would be an example of the former; while Jesus’ healing of the blind man at Siloam (John 9) is an example for the latter. Augustine emphasizes the psychological effect that miracles have on the mind of those who witness them—miracles must be both unusual (*insolitum*) and beyond what one would expect (*supra spem*). In *On True Religion* (390/91) he argues that the psychology of humans in Bible-times required miracles in order to point them toward the one true God (Augustine 1887C, xxv.47). The human mind craves spectacle.

Augustine’s discussion of the miraculous has an essential moral facet as well as this psychological aspect. He makes an important observation regarding happiness and living-well; he contends that we simply cannot live good or happy lives if we are mistaken in our beliefs (Augustine 1953, 33). If this is the case, Truth becomes a paramount moral requirement. Augustine sets up a distinction between the authority engendered by Jesus’ miracle-events, and the unadulterated Truth that reason provides. It is through reason (*ratio*) that the “wise man” (*sapiens*) “is so joined to God in mind, as that there is nothing set between to separate; for God is Truth” (Augustine 1887D, 33). However, not all are wise; some are “foolish” (*stulte*) and need something other than reason to uncover God/Truth. This is where miracles arise in the moral life. Witnessing a miracle does not require the hard work of rational thought; instead, miracles engender proper belief (here: the divinity of Christ) because they are unambiguous displays of authority. In the past, miracle events were needed to engender a loving attitude toward the Divine (Augustine 1953, xxv.47). Since all humans seek Truth—trying to purge their souls of error and filth—and not all humans are wise, not all humans follow God’s natural law

toward truth (Augustine 1887D, 34). Mercifully, God has given the fools a shortcut to Truth through the non-rational authority that miracles provide. For those of us who were not invited to the wedding at Canaan, God has appointed the Catholic Church to carry on instilling Truth; given, that the Catholic Church has spread the Good News throughout the Earth, Augustine claims that had God continued performing spectacular and revelatory events, our fragile, fallen psyches would have become accustomed to the miraculous, leaving us fixated on wonders rather than truth (Augustine 1953, xxv.47; Augustine 1887D, 34).

In Augustine's point-by-point refutation of the beliefs of Faustus the Manichean, *Answer to Faustus, the Manichean*, (c.386-90) he explicitly addresses the ontological, metaphysical, and theological aspects of the miraculous. Faustus argues that many of the miraculous occurrences we find in the Hebrew Bible—such as the immortality of Elijah, Moses, and Enoch—are “contrary to nature” [*contra naturam*] (Augustine 2007, XXVI.3). Nature sets up the boundaries of what is possible, and it would be contrary to nature to believe that these figures could still be alive, according to Faustus. Augustine responds with a distinction between what is contrary to nature and what is contrary to nature *as we experience it*. Using Romans 11:24 as a proof-text, Augustine writes “God, the Author and Creator of all natures, does nothing contrary to nature; for whatever is done by Him who appoints all natural order and measure and proportion must be natural in every case” (*ibid.*). Any action God takes in the world must, by definition, be natural. Miracles are events that cause wonder because the event goes against what we commonly think of as a nature; nonetheless, it makes sense to say that “God causes miracles that are contrary to nature” if, and only if, we mean that “God causes miracles that are contrary to *what we know* of nature” (*ibid.*). Of course, we should accept the truth of the miracles we find in

the Scripture because both reason (through natural law) and authority (through the Church) assent to them.

St. Stephen's Relics and Their Effect on Augustine's Miracle-Concept

However, Augustine faced a problem later in his career, after being made a bishop in Hippo Regis. Across the Mediterranean, the faithful began reporting miraculous cures attached to the relics and reliquaries of St. Stephen, the first Christian martyr. These wonders (*prodigia*) posed a theological problem for Augustine, given that he believed Gospel-like miracles had ceased. With these concrete experiences to account for, Augustine began clarifying and revising his ideas regarding both miracle as a concept and as an event. In Chapter 8-10, book XXII of *CoG* Augustine describes approximately thirty contemporaneous miraculous healings that took place in or around his bishopric in Hippo Regis. (The table at the end of this chapter gives a summation of these cures.) While some cures warrant no more than a brief note, Augustine dedicates a full narrative to others. An example of the latter would be Augustine's first-hand account of Innocentius of Carthage (Augustine 2003, XXII.8). While in Carthage early on in his career, Augustine and his friend Alypius stayed with Innocentius while traveling. Augustine describes Innocentius as a faithful man with rectal and lower intestinal fistulas. Before Augustine's arrival, Innocentius had undergone a surgery, hoping for repair and restoration; however, the surgery failed to remedy the painful situation. The afflicted patient (*aegrotus*) consulted other doctors; they promised to cure him with pharmaceuticals rather than another surgery. After a few days, it became clear that drugs would not work, and all consulted physicians agreed that another surgery would be necessary. Once this was decided, Innocentius (and other Roman Catholic clergy members) spent the night before the surgery praying.

Innocentius' prayer involved throwing himself to the ground, shrieking, and begging God for relief from the surgery. Augustine was so surprised and overwhelmed by this clamor, that he was unable to pray—aside from saying “O Lord, what prayers of Thy people dost Thou hear if Thou hearest not these?” (*ibid.*). The next morning, the surgeon began probing, only to find Innocentius completely healed of any fistula, his sores replaced with scar tissue. In response to this miraculous healing, Augustine, Innocentius, and the clergy began praising and thanking God.

Notice the process Innocentius went through. First, we see the problem Innocentius is suffering through; next, with surgery and drugs, traditional medicine fails to allay the affliction. After this, the patient earnestly prays to God for a cure—so fervently it distracts Augustine. God responds with a miraculous healing. Finally, the patient (and those around him) gives thanks to God for the miracle-event. This process is repeated in the stories of Innocentia of Cathage, Petronilla of Carthage, and Lucullus, the bishop of Sinita. In each of these stories, a sincere petition to God is the catalyst for healing, not the medical profession. However, the majority of the cases do not feature medical professionals in such a prominent way.

In a five of these stories Augustine relates, sending for a physician or surgeon would be futile because the patient is already dead. In each of these stories Augustine mentions direct contact with one of St. Stephen's reliquaries. For example, a father named Bassus prayed at Hippo's reliquary with his daughter's dress. Upon his return home, he found his daughter dead. During his lamenting, he tossed the dress onto his daughter's corpse, and she returned to life (*ibid.*). There are noteworthy metaphysics at play in these stories; as Augustine has to address the relationship between the individual, an intermediate party (St. Stephen), and God. Augustine identifies a few possibilities for the actual logistical working-out of such a miracle. First, it could

be the case that God is the direct cause of a miraculous healing (*ibid.*, XXII.9). If this were true, then the efficient cause of the revivification of Bassus' daughter would be the eternal God working in time (*tempus*). Or, secondly, God might be working indirectly through either martyrs or angels. Since God has power over all spiritual beings, angels could be performing these miracles—thereby making God the indirect cause of such events. Or humans could be praying to a martyr who, in turn, intercedes on behalf of the faithful. From that point God might take over as the direct cause, or allow the spirit of the martyr to perform the miracle. Or, thirdly, Augustine floats the possibility that we humans might not really comprehend the metaphysics behind these miracles. In any case, what we do know is this: that miracles are incredible displays of Divine power that witness or testify (*testis*) to the truths of Roman Catholic Christianity (*ibid.*).

We also know, according to Augustine, that petitions to St. Stephen work—Bassus' daughter was healed for example (*ibid.*, XXII.8). In a victory over the forces of evil, St. Stephen and others martyrs died for their belief that Jesus was God on earth. These disciples displayed *caritas* even when tortured and killed, thereby gaining a place in heaven after death. The souls of the martyrs are in a privileged position—as Christians at this time did not believe that God separated souls between heaven and hell at the moment of death. (This separation would have to wait until the Second Coming.) The fact that these martyrs are in heaven gives them the chance to reap benefits (*beneficia*) from God (*ibid.*, XXII.9). Had these martyrs died for a false belief, they would not have God's ear; these martyrs would not have powers of intercession. Again, these miracles manifest the power of Roman Catholic Christianity (*ibid.*).

We might fruitfully put Augustine in conversation with contemporary miracle-invocators. For Augustine, hoping for a miracle can be part of a good Christian life, but this kind of hoping must reach a high bar to be considered it a proper action. The desire for a miracle must be

motivated by love of God or neighbor; that is, the hope for a miracle must be properly oriented toward the spiritual, intelligible goods and not the lesser, tangible goods. Augustine would reject the possibility that a selfish (improperly oriented) desire could ever orient an authentic Christian hope for a miracle. In our case, if Maria is using miracle-language to gain power over her brother or Vanderbilt's health-care workers, then her motivation would be pride (*superbia*) or love of self (*amor sui*), not love of God and neighbor. Her desires are disordered and improper; Augustine would call her actions *aversio*. Maria's hope for a miracle would be an action that is based in self-love, rendering it vicious rather than virtuous. However, if Maria—like Innocentius—hopes for a miracle in an orderly fashion, then her action would be virtuous. The point we must remember is that Augustine would sanction hoping for a miracle, if one's desire for the miracle is based in ordinate love.

It can be hard to distinguish a faithful plea for intercession from a selfish one, for an external observer at least. Innocentius' pain seems acute, and I imagine alleviation of this pain would be a priority for him. Accordingly, Innocentius' story seems to have the hallmark of self-love: desire for one's own *bodily* good over all else. However, according to Augustine, we would be mistaken with this conclusion, for it seems quite clear that Augustine believes Innocentius deserved to be healed (*ibid.*, XXII.8). In *Conf.*, Augustine prays for relief from a toothache that pained him so much he stopped speaking, instead, communicating with a wax tablet (Augustine 1991, IX.vi.12). Augustine beseeched his friends to pray with him and, as soon as Augustine fell to his knees in supplication, God healed his toothache with "miraculous rapidity" (*ibid.*). Given the tone of the book, we might expect Augustine to begin chastising himself for pleading for something trivial, but he does not do so. Rather, we find Augustine simply praising God: emphasizing God's ability to heal both the body and the soul (*ibid.*).

One possible explanation: Augustine might tell us that those who pray for bodily health are asking to restore proper order. Although our postlapsarian bodies must decay and die, perhaps Augustine would tell us that hoping for a miracle-cure can be based in *caritas* because a properly ordered body must be free of chronic pain. Although our fallen bodies are weak—and our souls are disordered without God’s grace—God does not intend humans to experience chronic tooth pain or broken bones that inhibit one’s daily life. Augustine, Innocentius, and the others are requesting what God has ordained. Therefore, a properly functioning body becomes a necessary condition of living a happy Christian life. In any case, two points stand out: 1) asking God for an alleviation of pain can be consistent with proper action, and 2) it is hard for outsiders to evaluate the appropriateness of such pleas—at least until God either grants or gainsays the petition. If God (directly or indirectly) causes a miraculous healing we know, *post facto*, that the petition must have been founded in the desire to love God, in *caritas*.

Making it Explicit: How Augustine Illuminates Clinical Miracle-Invocations

How does Augustine’s thought help the clinical ethicist better understand the miracle-invocator’s religious imagination? My readers may have ideas of their own, but in this final section, I will make a few connections explicit. First, Augustine’s ontological commitments place God above all Creation—at the summit of all that exists. In a word, the values we find underlying the arguments presented in chapter two are arguments based on secular principles, values, and concepts. Neither the “argument from well-being” nor the “argument from self-determination” requires a God-concept in order to promote a conception of proper action. Neither do these arguments *orient* their conceptions of proper action or proper living around a God-image. Indeed, all of the arguments we encountered in chapter two assume a materialistic ontology: a

view of the world that functions without any supernatural/non-material entities. Therefore, a conceptual scheme that harbors a traditionally monotheistic God-image (a God who is omnipotent, omniscient, all-good) must contain different entities than a world-view that does not require a tri-omni God. What is important for the clinical ethics consultant, however, is not merely the fact that disparate images, values, and concepts furnish the clinical imagination and the invocator's religious imagination, but the impact this disagreement has on moral commitments and clinical actions.

It is obvious that God has great power within Augustine's scheme. Concerning metaphysics, we have seen that God has the ability not only to sustain Creation, but also cause miracles. Grace—an operative force that the clinical imagination does without—figures heavily into Augustine's moral-world. As we saw, God's grace is a necessary requisite to any good life and any proper action. Without God's grace we can neither be happy nor act virtuously, making God's grace a necessary condition for the possibility of any proper action, good life, or salvation. Indeed, recall that for Augustine each desire and each voluntary act of the will actually *lacks existence* until God's supererogatory grace causes one's proper desire and action (Augustine 1887A, 22.29). Think of an old-fashioned, key stroke typewriter. Let us say you want to write a letter to the President because you disagree with some aspect of his or her health care agenda. In a fury, you draft the note without looking at the page. When finished, you pull the paper from the machine, and you realize you forgot to replace your ink ribbon. Your jeremiad remains unwritten. For the sake of this analogy, the typewriter represents the actions an individual soul takes *without* God's grace and love. The machine appears to be functioning properly (you kept writing), but without the ink ribbon, the machine's movements are empty and pointless. Nothing comes of the typewriter's motions. The same is true of the soul that acts without God's grace: it

might function, but only in a hollow sense. Without God's grace, the individual person can do no right—only nothing. Virtuous action is here contingent upon God's action; therefore, God's ability is an essential part of the religious imagination.

Although notions of “freedom” and “autonomy” make up a critical part of practical responses to miracle-language, the “soul” plays no significant role in these responses. The eternal soul, however, is of great importance to Augustinian notions of selfhood, autonomy, and proper living. Each human soul (*animus* or *mens*) has become vivified in a single physical body (*corpus*) and endowed with the ability to freely choose. However, due to Adam's decision to place pride before true love, we are also born dead in *spirit* and bound for Perdition (Augustine 1887A, 39.48). In bodily death, the material body and the soul (be it renewed through Christ or otherwise) separate, with the soul remaining vivified—to be judged by God/Christ during the *eschaton* (e.g., Augustine 1991, XX.1). Without the salvific grace of God (and our cooperation with unwarranted gift), Christ will judge our souls harshly and damn us to Hell (Augustine 1998, III.5). With Augustine, proper desire (in the form of *caritas*) comes before any truly free choice of the will, without such a desire, our actions are doomed to disorder and selfishness. In the clinical imagination, the ability to responsibly choose between options that best fit one's worldview (recall **A: Self-determination**) centers notions of freedom and autonomy. So then, we see that in the clinical imagination, neither God nor God's grace plays a role in determining the freedom of one's clinical decisions, but with Augustine's thought, we find a worldview that puts God's power to dole out grace at the center of any morally-relevant desire, decision, or action.

In addition to these ontological and metaphysical considerations, Augustine's notion of general well-being differs considerably from the notions of well-being we see bioethicists and

scholars of religion and medicine promoting. For Augustine, a life well-lived requires accurate beliefs, especially religious beliefs. Faith (*fides*), we have seen, involves belief in something that one has not (or cannot) experience (Augustine 1955, 8). One must have faith in the God of the Roman Catholic Church if one lives and loves properly. Even with the original guilt deadening the individual soul, humans have an “inward consciousness” (*interior conscientia*) that pushes them to seek accurate beliefs about themselves and the world (Augustine 1887D, 33; Col 3:1-3). Without true beliefs, the individual misapprehends the nature of the world—thereby orienting herself toward the impermanent, Lesser goods. Although God’s grace is responsible for any properly oriented action, we nonetheless must train our souls to choose properly; we must instill in ourselves ordinate habits if we hope to desire and act virtuously (*conversio*). Therefore, without proper religious beliefs, ordered love, and virtuous action, it is impossible to live well. Within the clinical imagination, however, proper action does not depend on true religious beliefs. This makes sense, as medicine’s methods do not extend into the study of God’s nature. A proper response to miracle-invocations involves, *cet. par.*, respecting the patient’s right to make autonomous decisions, independent of the truth-value of the patient’s religious beliefs. This means that proper medical care ignores the truth or falsity of a religious belief, it instead concentrates on the coherence of the patient’s individual conception of well-being (see **A:Well-being**). This concentration makes sense given that designating one religious belief “true” and another “false” would be far outside medicine’s methodological scope. Nonetheless, we have seen that medicine does indeed judge religious worldviews as either “syncretic” or “idiosyncratic”. In doing so, the clinical imagination reorients the question from propositional truth-value to fidelity between a stated belief and the beliefs codified in the invocator’s community. My point is this: while a religious imagination might believe proper action is

contingent upon true religious beliefs, the clinical imagination's conception of proper action relies on other values, such as coherence between propositions and fidelity to communal beliefs.

Augustine's discussion of faithfully hoping for a miracle is especially important for our purposes. From Conners, Jr. and Smith, one gets the sense that hoping for a miracle—and orienting one's conception of the Divine around such a hope—is bad theology. But Augustine would have us believe that a Christian might faithfully hope for the possibility of a miraculous bodily healing. As we have seen, Augustine did so himself without regret. One's hope for a miracle may be faithful when this hope stems from love of God and neighbor. In Augustine's thought, we see that both reason and authority agree that praying for a miracle can be proper and faithful—founded in love of God. The appropriateness of hoping for a miracle is founded in the preservation of the order God created and sustained. A faithful Christian can feel dismay at the possibility of undergoing a painful medical procedure and hope that God will rescue her from her suffering. Augustine's thought shows that belief in the possibility of a miracle-event can form part of a complex system of theologico-moral commitments. Therefore, Augustine shows us that complex notions of faith, hope, love, and miracle may undergird the invocator's hope for a miracle. Augustine would have us question a theology that curtails God's power to cause health and revivification. The clinical ethicist should be open to the possibility that good, astute, and complex religious commitments undergird a patient's hope for a miracle-event.

The Augustine we find in *OPB* views miracle stories as heuristic methods to *caritas*, truth, and proper action. He had to account for the (apparent) discrepancy between the numerous signs and wonders Jesus and his disciples worked in the New Testament with the (apparent) fact that miracles no longer occurred. His answer (that the human mind would become accustomed to these events—rendering them banal) shows that Augustine finds these stories pedagogical. New

Testament miracle stories teach us: 1) the brute fact that God has power, and 2) we should orient our lives toward this power. Augustine accepts this psychological observation throughout his life. Some people need fireworks to force their gaze upward. In the clinic, a responsible practical response must take biblical hermeneutics into account. That is, some invocators may have come to their belief in the possibility of a miracle from the stories we find in the New Testament and/or Hebrew Bible. In these situations, biblical authority plays an essential role in the invocator's imagination. When these patients hope for a miracle, they believe they have good reason for belief: God's inspired Word.

Augustine's thought contains a God-image that always has the possibility of working a miracle. Even post mortem, Augustine has evidence (personal and Scriptural) that God might enliven a la Lazarus. However, the Augustine we find in *OFCW* places sin in the love of things that can be lost (recall the slave quote above), and virtue in the love of permanent, immaterial things (Augustine 1998, I.9, I.12, and II.9). Our bodies surely fall into the category of the impermanent, mutable goods. Thus, in order for Augustine to deem the hope for a miracle "ordinate," the invocator must find a balance between faithfully hoping for the restoration of bodily well-being and selfishly clinging onto an object destined to decay. As I mentioned above, when discussing Innocentius' plea, this distinction may be impossible for an outsider to assess, making any practical response based in an assessment of religious motivation suspect. Given the opacity of these mental processes, an adequate practical response to miracle-language must tread lightly when assessing the invocator's motivation or intention.

Even when medicine tries to account for the disparity between the religious imagination and the clinical imagination by integrating the patient's religious values into clinical decision making, conflict continues. And conflict must occur: a value scheme anchored in the existence of

an all-good, all-powerful, all-knowing God who can work miracles will be vastly different from a value scheme that rejects (or, minimally, ignores) this kind of entity and its powers. When the clinical imagination says that Mrs. O'Shay will never return to baseline, Augustine would tell us that restoration of physical health is always possible because he ascribes to a distinct metaphysics: a metaphysics where divine causation can heal the faithful. While the clinical imagination prizes a naturalistic epistemology based on material states of affairs, the religious imagination places epistemic authority in 1) reason, 2) Scripture, and 3) the Church. The notions of selfhood scholars of religion and medicine promote emphasize the ability to make decisions that can be justified with evidence available to all rational beings; or, when the justification for one's decision involves religious tenets, one must appeal to her religious community (see **A: Self-Determination**).

Concluding and Transitioning

We have seen that a complex framework may very well found a patient's hope for a miracle. Although Augustine's thought has proved helpful in numerous ways, the clinical ethicist would be mistaken if he thought that every miracle-invocation stems from a strictly Augustinian notion of the world and self. Augustine shows us how miracle-invocations, moral ontologies, and proper actions can interact and cohere. However, to assume that *all* miracle-invocations follow a complex Augustinian theology would be committing the same error we saw in chapter two, the reduction of a complex phenomenon to a monolithic notion. As we hope to ground the clinical ethicist's response in the concrete and nuanced use of the concept "miracle," we must excavate and analyze the moral, epistemic, political, and ontological values we find beneath miracle-invocations if we hope to hone in on a morally adequate response for the clinical ethicist.

Toward that goal, in the next chapter I will introduce a taxonomy of clinical miracle-invocations. I will divide this taxonomy between existential and unshaken invocations. Existential invocations occur when the invocator uses miracle-language while struggling with her interpretation of herself and her world. Here, the invocator hopes for a miracle—of some kind—as she attempts to live-through and reconcile clinical suffering with past conceptions of self, world, and God. The invocator may form a new conception of herself, or she may return to a previously held worldview; in either case, clinical experiences have had an effect on her world. Patients or surrogate decision makers who use miracle-language, but remain unaffected by clinical experiences, evoke God’s power in an unshaken manner. This kind of invocator might use religious language in an attempt to wrest decision making power away from another person (family or clinician), or she might be placid and confident that her worldview completely accounts for the pain or suffering she finds in end of life scenarios. In these latter instances, the clinical ethicist cannot discern any trouble between the invocator’s conception of the world and her clinical experiences. In chapter four, I will continue to use Augustine, but integrate the thought the Czech phenomenologist Jan Patočka (1907-77) in order to justify this distinction between existential and unshaken invocations.

CHAPTER IV

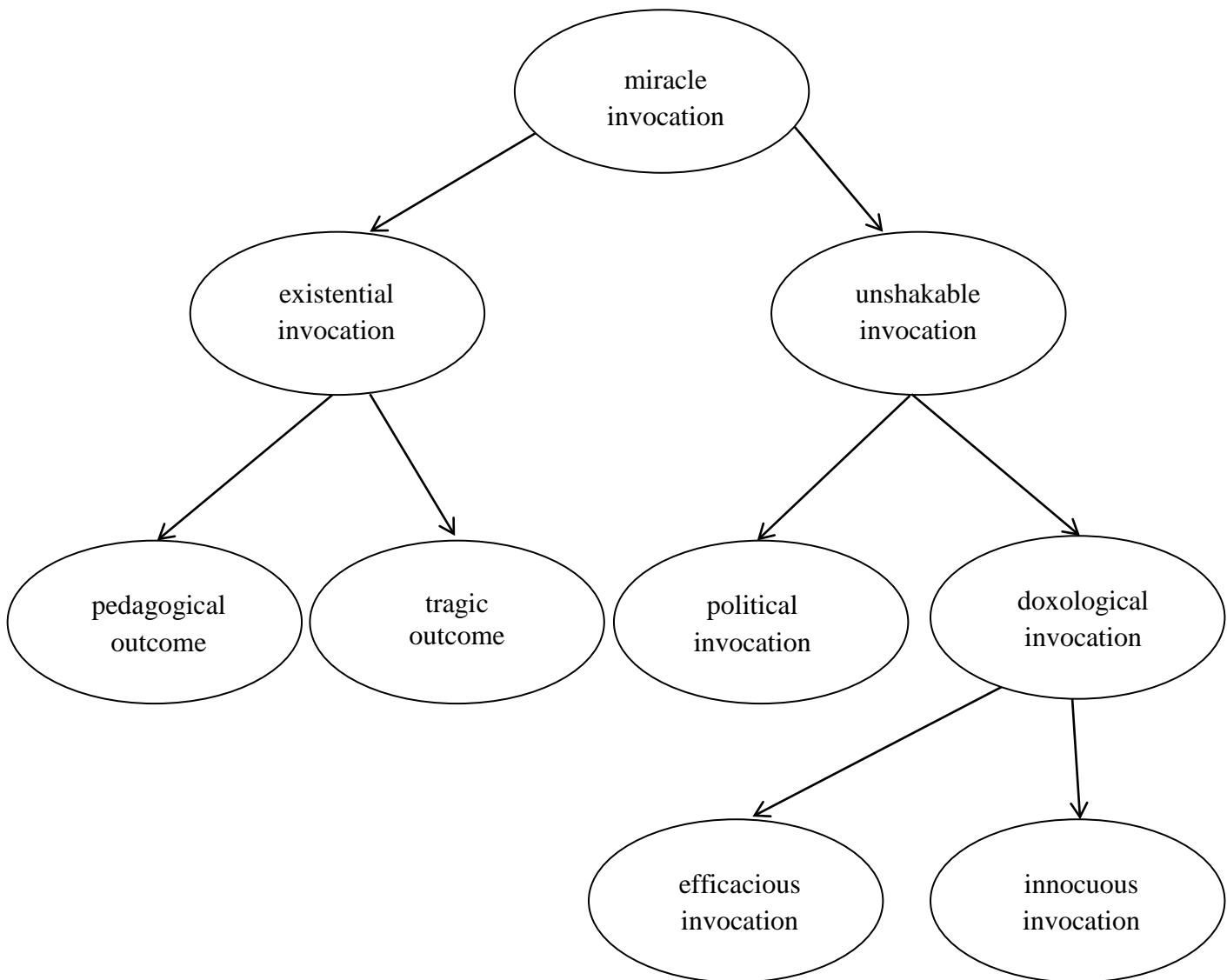
A TAXONOMY OF MIRACLE-LANGUAGE: THE WORKINGS OF RELIGIOUS IMAGINATIONS

In the first two chapters of this dissertation, I discussed practical responses to miracle-invocations, and analyzed the moral, epistemic, ontological, and metaphysical values found therein. As we have seen, there is a notable shortcoming shared by these practical responses: the authors fail to account for the complexity and uniqueness that accompanies miracle-invocations. To rectify this shortcoming, in chapter three I offered a more nuanced and accurate portrait of the invocator's religious imagination by analyzing Augustine's conceptions of God, the world, and personhood. Specifically, this portrait exemplifies how a miracle-concept and a God-image might interact and intertwine. Miracle-language can reflect a complex structure wherein morality, metaphysics, and epistemology connect to form a cohesive image of self, community, and world. While Augustine's work has helped us uncover the intricate nature of miracle-invocations, his thought cannot fully account for the workings of the imagination behind contemporary miracle invocations. If I hope to proffer my own practical responses—justified by a more astute account of the concepts, metaphors, and images that guide miracle-invocations—our next goal should be providing a better description of the political, moral, and theological concepts, values, and images that occur in concrete clinical situations.

A taxonomic analysis of clinical miracle-language will not only reveal the complex theological systems that undergird miracle-invocations, but also help to correct the less-than-

justified strategies we find in popular practical responses. At the broadest level of analysis, my taxonomy divides miracle invocations between unshaken and existential invocations. I then subdivide each of these categories: the unshaken containing 1) doxological and 2) political invocations, while the existential division includes 3) pedagogical and 4) tragic invocations. The taxonomy looks like this:

Diagram IV.1. Taxonomy of Miracle-Language



The cardinal distinction between unshaken and existential invocations revolves around, what I will call, being “open.” Being open has to do with an individual invocator’s will, psychological disposition, and intention. The existential invocator is open to the possibility that her previously held worldview might not adequately account for the stress and suffering she experiences during the end of life—either her own or another’s. The existential invocator displays a willingness to discuss her thoughts about herself and her world. When the ethicist asks her, “Can you tell me a little more about how you think about miracles?” she not only shares her beliefs, but also reflects upon them. The clinic has had an effect on the ways they think about themselves, their communities, and their worlds. Compared to the existential invocator, the unshaken invocator refuses to discuss his beliefs and commitments. Instead of being shaken by the processes dying and the possibility of death, the unshaken invocator’s worldview remains solid and untroubled. For the unshaken invocator, when asked to talk about his miracle-term, he confidently tells the ethicist about the power of God and the power of religious belief. If asked, “Has the time you have spent in the hospital changed your view of the world?” the “solid” disposition will respond, “No. I know what I believe.” This is an important distinction for the clinical ethics consultant, as a proper response to miracle-language is contingent upon the ethicist’s ability to discuss what is important for the invocator.²⁵

Before delving further into the distinctions between existential and unshaken invocations, I should make a few additional observations about my distinction between an “open”

²⁵ I should impress upon my reader, right at the beginning of this chapter, the *descriptive* rather than *prescriptive* nature of this taxonomy. I will not be arguing that miracle-invocators who show openness have superior dispositions or correct worldviews when compared to those who are not open. I am describing this difference because the degree of openness the invocator shows matters for the clinical ethicist’s practical response. Simply put, a miracle-invocator who is reinterpreting himself and his surroundings should be treated differently than an invocator who closes himself off from discussing his view of the world.

(exemplified by the existential invocator) and a “solid” disposition (the unshaken invocator). A number of theorists of moral development come to mind when I think about how to best explain the distinction I am here trying to establish. James Fowler’s *Stages of Faith* (1995), Carol Gilligan’s *In a Different Voice* (1998), or Judith Andre’s virtue theory of adult development (2002) could each be of service as we try to understand the variations and fluctuations of the miracle-invocator’s religious imagination. All of these scholars have done interesting work on the ways individuals employ religious and philosophical concepts as they attempt to act in accord with some sense of self. However, I will choose to concentrate on the work of Czech phenomenologist Jan Patočka before these other thinkers. Although he is considered a philosopher, historian, and politician before a scholar of moral development, we will see that Patočka’s readings of Greek and Latin philosophers will illuminate the miracle-invocator’s moral and religious imagination.

Returning to Mrs. O’Shay

Let us return to Mrs. O’Shay’s tribulations to anchor our analysis. To review, Mrs. Judith O’Shay (a pseudonym) suffered a hemorrhagic stroke in the spring of 2013. She recovered to some degree, and returned home to live with her son Steve in Nashville TN, with her daughter April nearby. Mrs. O’Shay also had a second daughter (I’ll call her Maria) who lived in Tennessee, but not near Nashville. A few months after her first stroke, Steve found his mother unconscious in their kitchen. At VUMC, Mrs. O’Shay was diagnosed with status epilepticus, a neurological condition that left her experiencing constant brain seizures. She was unconscious, on ventilator support, and not responsive to her surroundings.

Within the first week of Mrs. O’Shay’s admission, the Neuro-ICU attending saw two possible paths ahead for Mrs. O’Shay: aggressive care or palliative care. The aggressive path included a tracheotomy, surgical debridement, a feeding tube, and burst-suppression therapy (BST). A controversial therapy, BST employs numerous anesthetics (in this case, propofol) to place Mrs. O’Shay in a drug-induced coma, with the hope of stopping her constant seizures. It’s a dramatic and impressive therapy when successful, and, initially, the Neuro-ICU team estimated Mrs. O’Shay’s chance of surviving the aggressive course and returning to baseline at about sixty percent (60%). Midway through her second week in the Neuro-ICU, however, the team revises their prognosis, believing Mrs. O’Shay has deteriorated to such a degree that there is now less than a one percent (1%) chance of surviving the propofol coma. As the BST would be the lynchpin of the aggressive course, all ICU teams agreed that the best way forward would be a transfer to VUMC’s Palliative Care Unit, where she would be extubated. While she may survive extubation, the clinicians believe that she would die soon after.

The Neuro-ICU team sets up a meeting to discuss their revised prognosis. During this meeting, April says that she is hoping and praying for a miracle, but she understands the Neuro-ICU team’s reasons for a transfer to palliative care. April tells the team that she is a good Christian—she believes God’s Will will be done. She tells the team, “We humans can’t stop God’s will from happening. No matter how hard we try, God’s will prevails.” Steve agrees; while Maria remains silent. “I will keep praying, and have faith—I *know*—that Mom is in God’s hands now. Deacon Remus reminds us every Easter that all humans die, and if Jesus is calling Mom back to Zion...well...that’s His will.”

Steve again agrees, and says “Mom had a sister who was on dialysis—Aunt Jeanie—and Mom said to me that she would never want to spend so much time in the hospital. I don’t think she would want to continue suffering like this.”

While April and Steve agreed that their mother would not want the aggressive path, on the morning of the transfer, Maria refused to have her mother taken from the Neuro-ICU, saying “my mother would want every possible thing done in order to give God time to work a miracle. So BST should be back on the table.”

In a heated meeting later that day, Maria explains further: “I know my rights as an American. Both my mother and I believe in the true Gospel of Jesus Christ. We believe that the all-powerful hand of God can come down and heal the sick—heal my mother. So we have to give God more time. We need time to pray. We can’t give up so quickly. You have no right to deny my mother her freedom of religion, and I’m not afraid to sue if Vanderbilt continues to treat me and my mother in this way.”

I imagine Maria delivering this message with quick confidence and eye contact. After this conversation, the resolve of the Neuro-ICU team wavers. They say, “Well...we were going to offer BST at first anyway...” and “Who are we to get in the way of a miracle?” and “Patients do have rights, and Maria seems to know what her mom would want.”

The team has another meeting with the entire family. It becomes quite clear that that April and Maria disagree about what their mother would have wanted. There also appears to be a great deal of tension between siblings. April and Maria accuse one another of not properly caring for their mother. April tells her sister that she should have spent more time with their mother after her first stroke; Maria accuses April and Steve of neglecting Mrs. O’Shay. April becomes insulted by Maria’s claim that she should be the one making decisions for their mother—April

says to Maria, “You aren’t the one who cares for Mom. You aren’t the one who gets her out of the bathtub, or takes her shopping, or attends church.”

Throughout meeting, Maria adheres to her assertion that God will work a miraculous healing of her mother if given enough time. The ethicist, inspired by the complexity of miracle-language, asks, “Maria, is it possible that your mother’s bravery in the face of suffering is the miracle you are looking for? Or maybe the fact that your family has been brought together by this experience is the miracle? Or what about your mother’s life overall: all the love she has shown and lived-through...maybe that is the miracle?”

Maria’s response, “I know what I believe. You can’t tell me what I think about God, heaven, and earth. And my mom is free to exercise her religion as she sees fit. We believe God will work a miracle—nothing you can say will ever change that.”

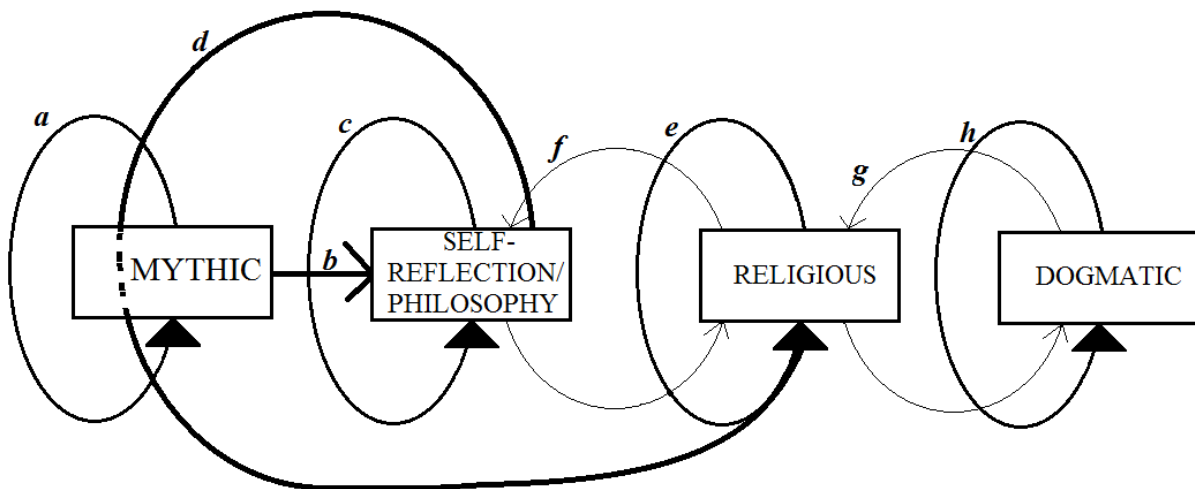
The ethicist responds, “I understand and respect your beliefs. But we need to remember what your mom would have wanted—” Maria interrupts, “I know what my mom would have wanted: she wants to give God time to display His powers!” When asked if she would like to talk with a chaplain or the pastor from her home congregation, she declines, saying “I don’t need anyone to tell me what I believe, I know; both my mother and I have the right to have our beliefs respected.”

In this scenario, I find both April and Maria using miracle-language in an unshaken sense. Neither party shows openness to the possibility of reevaluating their conceptual schemes; clinical events do not cause either party to reevaluate their worldviews: both April and Maria are confident that their systems can account for their mother’s deterioration, current condition, and possible death.

Jan Patočka's Ways of Believing

We need to understand how being open to the possibility of a new conceptual scheme plays into clinical decision making near the end of life. Broadly speaking, invocators who use miracle-language in its existential sense are searching for truth in the world. Those who use “miracle” in the unshaken sense believe that they have *already found* truth, giving them no reason to reevaluate their worldviews. In my attempt at categorizing miracle-language, I will appropriate facets of Jan Patočka's four modes of belief: 1) myth, 2) philosophical inquiry/self-reflection, 3) religious faith, and 4) dogma. Each of these four modes will help us see the underlying epistemic and moral assumptions miracle-invocators harbor.

Diagram IV.2. Patočka's Four Modes of Belief



Myths are those stories our guardian tells us when we are growing up. Each of us was born into a particular culture, at a particular time, within a particular family. Myth affords a view of the world in its entirety, instantaneously. *See arrow a.* As the world presents itself to each of us, we use our learned myth to interpret what we encounter: we appeal to the past, to history, to

tradition (2002; 57, 59). Notably, myth accounts for the *entirety* of experience, so we have nothing more to ask of the world. For Augustine: Roman and Greek myth, North African ancestor cults, and Catholic myth were intertwined to form a mythic conception of self and the world. Additionally, it is possible that April and Maria share similar mythical accounts of the world, given they shared a mother and grew up together. Perhaps they were raised in an evangelical Protestant church where healings or speaking in tongues (*glossolalia*) often occurred. A conversation with both Maria and April about their spiritual upbringings would be a fruitful place to begin understanding what “miracle” might mean for both of them—but more on this later in the chapter.

According to Patočka, Democritus and Socrates were the first Greeks to realize that we can move beyond myth, even as we are indebted to it (*ibid.*, 69). *See arrow b.* Socratic philosophy, according to Patočka, agrees that the world presents itself wholly and in alignment with an individual’s perspective; however, philosophy/self-reflection enables us to see that the world presents itself to people in different ways. We perceive differently; we grow up in different places at different times; we have different cognitive abilities; our parents tell us different stories. Our views of the world are necessarily perspectival. However, if we engage in reflection/philosophy, we can step outside our unique, merely temporal perspectives to see the structures that lie beneath what we experience through a mythical understanding of the world (*ibid.*, 58). Philosophy wants the eternal, not that which quickly moves on (*ibid.*, 74). While myth transcends what is immediate by appealing to the past, philosophy tries to find the permanent in the present. Augustine displays a similar concern for escaping from the ephemeral to the permanent when he writes:

Let these transient things be the ground on which my soul praises you 'God creator of all' [Ps. 145: 2)]. But let it not become stuck in them and glued to them with love through

the physical senses. For these things pass along the path of things that move towards non-existence. They rend the soul with pestilential desires; for the soul loves to be in them and take its repose among the objects of its love. But in these things there is no point of rest: they lack permanence. They flee away and cannot be followed with the bodily senses. (IV.x.15)

This philosophical way of knowing the world insists that the world has a discernible structure that makes manifest (or “shows”) what is (*ibid.*, 60). Despite our limiting perspectives on the world, we may, possibly, get at the more permanent and common structures that allow the world to be shown in the first place. In *Plato and Europe*, Patočka calls this process of reflecting upon the foundation from which one acts and experiences the world “care of the soul” (“*péče o duši*” in Patočka’s native Czech and “*tes psykes epimeleisthai*” in Greek) (*ibid.*, 77 especially). *See arrow c.* Caring for the soul is the axial process of philosophy, as it connects ontology, psychology, moral thought, and perception without reducing philosophical endeavor to merely epistemic concerns. I believe that care for the soul for Augustine begins in 373, at age nineteen, when he reads Cicero’s *Hortensius* (c. 45 b.c.e.). After reading Cicero, he writes, speaking to God, “Every vain hope at once became worthless to me; and I longed with an incredibly burning desire for an immortality of wisdom, and began to arise, that I might return to Thee” (Augustine 1991, III.iv.7). We will see that some who use miracle-language—who I call “existential invocators”—are participating in this process of caring for the soul as they struggle to reconcile their conceptions of self and God with the suffering they experience in the clinic.

So how does one find such solidity? Socrates searched for solidity in coherence of thought (2002, 92). In the dialogues that Plato has left behind, we see Socrates inviting his interlocutors to reject the faux-foundation that myth provides and instead orient themselves toward a true solidity based on self-reflective philosophy. Patočka writes that Socrates “does not say what is good, he only invites people to think, that they think like him, that they search, that

everyone responsibly examine their every thought. This means that they should not accept mere opinion as if it were insight, as if it were a looking-in—to live from true insight into what is here, what is present” (*ibid.*, 85). Socrates hopes for harmony, synthesis, and order within the soul’s conception of itself (its functions and parts) as it encounters the manifested world. The heart of his philosophical method is this invitation to coherent thought. When philosophizing in a Socratic manner, one relentlessly questions what one assumes, asserts, and performs. Solidity is the foundation from which the soul functions, and, with hope, precedes our understanding of the ways in which the soul relates to itself and other things. Thoughts can be “bound together” without myth (*ibid.*, 93).

Augustine’s most essential shifts in thought and habit result from philosophical self-reflection. Like Socrates and Plato, Augustine wants to find an anchor from which to live, think, and act rightly. Speaking again directly to God:

When you are our firm support, then it is firm indeed. But when our support rests on our own strength, it is infirmity. Our good is life with you forever, and because we turned away from that, we became twisted. Let us now return to you that we may not be overturned. (Augustine 1991, IV.xvi.31)

This desire for rest (*quiesco*) and a coherent conception of the self aligns Augustine in the Socratic tradition of caring for the soul. Most important for our purposes, invocators who use miracle-language in an existential fashion follow Socrates and Augustine in their willingness to search for a coherent conception of one’s self and one’s world. Our existential invocators use miracle-invocations when wrestling with the realization that their previously held accounts of the world are inadequate.

We should not equate a Socratic or Augustinian (or existential) search for a coherent conception self and world with certainty; after all, we are already confident—certain—in our worldviews when dwelling in myth. Socrates shows us that suspending our judgments about the

ultimate structure of nature (or aspects of the world) need not be a detriment when caring for the soul. In *Phaedo*, Socrates reflects on, and converse about, topics such as the nature of the soul without providing a final answer. We may want to establish propositional certainty, but more important for self-reflection: the constant attempt at finding the eternal. Patočka calls this “*the ideal of the truthful*” life, that is a life that, as much as in praxis as in its activity of thinking, always directs itself by *looking-in*” (*ibid.*, 107). Within our taxonomy, an existential invocator struggles with questions of utmost importance for her view of the world.

But what’s the point of such self-reflection (or conversation) if we fail to find an answer to the question at hand? What comes next? Patočka’s answer: Plato (424/423–348/347 b.c.e.) invents the possibility of religious faith (*ibid.*, 127). Religion entered Athens when the philosopher, who has rejected myth as an acceptable means of gaining an orientation for the soul, *returns* to mythic accounts for his orientation. *See arrow d.* Let’s take an example. In *Phaedo*, Socrates tells his interlocutors that two scenarios can happen after he is executed: either 1) his soul will no longer experience sense perception, or 2) he will go down to Hades. If the former occurs then the dissolution of the soul is nothing to fear because all of eternity will be like a peaceful nap. And if Socrates’ soul journeys to the underworld, then he can continue his divinely-sanctioned quest to find someone wiser than he. In either case, Socrates has returned to a mythic interpretation of the soul’s life post-mortem.

When we gain religious faith, we engage in a conscious effort (unlike myth), we actively accept the truth of something. Augustine’s conversions first to Manicheism and then Roman Christianity would be examples of the acquisition of religious faith after he reached a limit with self-reflection and *returned to myth*. The Manichean system provided religious beliefs concerning the nature of the soul and the divine. However, Augustine eventually comes to realize

that this system does not sufficiently lay the groundwork for a proper account of the *person* in relation to the world. Augustine interrogates himself, Manichean sacred texts, as well as a renowned member of the Manichean elect while searching for solidity. *See arrow e*. Let me give another example. A hallmark proposition for Augustine the Manichean: “All in the world is material, and these materials are either made up of a good or evil substance.” But he eventually came to question these fundamental religious propositions. He confesses,

I should have lifted myself to you, Lord, to find a cure. I knew that, but did not wish it or have the strength for it. When I thought of you, my mental image was not of anything solid and firm; it was not you but a vain phantom. My error was my god. If I attempted to find rest there for my soul, it slipped through a void and again came falling back upon me. (IV.vii.12)

After reading the books of the Neo-Platonists Augustine discovered that his Manichean religious beliefs could not properly account for the nature of his soul in the onto-cosmological scheme. *See arrow f*. Augustine comes to realize that he “was unaware of another reality [...] spirit” (Augustine 1991, III.vii.12). With the kind of clarity only retrospection can provide, Augustine chastises himself for failure to “look inward” in order to discern the true nature of the world as containing both material and spirit (*ibid.*, X.vii.10). Once Neo-Platonic doctrines afforded Augustine the possibility of a new understanding of non-material things, the materialism the Manicheans offered could no longer provide a coherent account, as the introduction of a spiritual substance provided the groundwork for a new way of unifying or solidifying Augustine’s conception of the soul.

Perhaps, like Augustine, April and Maria have both gone-through a similar process. Born into myths about the salvific power of Christ, perhaps they have spent years asking themselves, “What does it mean to be saved?” “How do I love God properly?” and “What is Heaven like?” If this is the case, then they have done a great deal of philosophical inquiry, with the upshot being a

return to the myths they were born into. The language of being a “born again Christian” might apply, insofar as one returns to the myths of one’s childhood, but this time, *actively* accepting these stories. Or, perhaps the invocator was born into a non-Christian mythical narrative, but, later in life, converted to a conceptual scheme that includes the belief in the possibility of the miraculous. After engaging in philosophical inquiry, the invocator realized that the myths he was born into cannot account for the world as he encounters it. After diligently questioning all that she believes, she converts to a new conceptual scheme.

Augustine’s conversion to Roman Catholicism marks perhaps the most radical step in the process of caring for his soul. With his conversion, Augustine *chooses* to accept certain fundamental propositions as indubitable: *fundatissima fides*, e.g., God creates and sustains individual, non-material human souls. When religious beliefs are cordoned off from the possibility of reflective skepticism, they become dogmata. *See arrow g.*

Dogmata are beliefs that 1) are no longer open to direct rational inquiry, and 2) provide a fundamental moral and epistemic foundation from which to think and act. Patočka emphasizes that dogmata (what Augustine calls *fundatissima fides*) are “not mere myth,” but are indeed “*justified*” (90, Patočka’s emphasis). For our purposes, these distinctions between myth, philosophy as care of the soul, religious belief, and dogmata can be helpful ways of tracking the epistemic processes miracle-invocators undergo. These modes of understanding can also serve the ethicist when determining the importance of miracle-language for the invocator’s overall worldview.

Categorizing Miracle-Invocations

Unshaken Invocations: Doxological

With my adaptation of Patočka's four modes of inquiry in mind, let us return to April's use of religious-language. She represents a kind of unshaken invocation I call "doxological." In this section, we will demarcate and analyze a number of propositions the doxological imagination holds true, using April as a representative. I am using the term "doxological" in a simple sense: "doxa" (Greek: *doxa*) meaning "glory" and the common suffix "-logical" (*logos*) meaning "word" or "saying." So, the invocator who uses "miracle" in a doxological sense centers his imagination on praising God and God's plan (Providence). The central characteristic of the doxological imagination is this: the preservation of God's glory in the face of any and all clinical suffering. This kind of invocator shows no willingness to interrogate the worldview that has brought him to this point—believing that his conception of the world adequately accounts for the clinical events his witnesses.

A number of theological expressions can signal a doxological invocation. We find herein a common Christian (and masculine) image of God. The doxological imagination's God knows the afflicted suffer (an aspect of His omniscience), God has power to work healings (an aspect of His omnipotence), and God's sustains His creation with love (an aspect of His all-loving nature). For April, the suffering Mrs. O'Shay experiences should be accepted because of the fact that God allows it to happen. God could have willed that Mrs. O'Shay recover instantly from her status epilepticus; or God could have willed that the patient had died on the floor of Steve's kitchen. Like Augustine, April believes that God's love for His creation means that God would allow neither injustice nor the triumph of evil; therefore, if we deem something "bad," "evil," or "unjust" (e.g., the hospitalization of a loved-one), this is due to the fact that we are corporeal humans with limited perspectives (see Augustine 1998, III.24). Had we the ability to understand Creation in the same manner God understands Creation we would be able to understand that all

events—even those that appear unjust or evil—contribute to the goodness of God’s creation.

Clinical events never disturb the soil from which doxological invocations sprout. Above all else, God’s goodness will be upheld.

As the reader has noticed, the doxological imagination’s conception of proper action and good-living revolves around loving God in a particular manner—a manner that reminds me of our analysis of Augustine’s *caritas*. For both Augustine and the doxological invocator, the desire to love God must orient any proper action and any well-lived life. April may not have a complex theological apparatus like Augustine, but we can tell that she places love of God above any competing moral responsibilities when she says, “A life well-lived involves living *through* the truth of the Good News (*euangelion*) that Christ has rectified the death Adam wrought, and, this means, that even within the walls of a hospital one must express fidelity to Christ’s message. Love of God requires making hard decisions.”

The clinical ethicist should differentiate two sorts of the doxological invocator. With the first, the invocator’s belief in the possibility of a miracle does not have an impact on medical care. April can serve as an example of this kind of doxological invocator. The conceptual scheme wherein her conception of “miracle” exists does not have an effect on medical care. Both the clinical imagination and her religious imagination coexist without conflict. This kind of invocator labels an event *other than* a spontaneous recovery a “miracle.” Perhaps a miracle can be found in Mrs. O’Shay’s long and peaceful life; or in the lives of those she raised; or maybe the miracle can be found in the gathering together of her children—despite their disagreements. This kind of doxological exclamation appears innocuous from the point of view of the institution because the invocator’s beliefs do not inhibit the course of care deemed appropriate by the health

care team. The clinical imagination thinks, “If the patient wants to interpret clinical events as God’s will, who are we to judge? These beliefs do no harm.”

Controversy arises when patient or surrogate employs miracle-language in a doxological sense, but he uses this belief in the possibility of a miracle to affect clinical care. I will call this kind of doxological invocation “efficacious.”²⁶ The efficacious doxological invocator has a specific miracle-event imagined and projected into the future. Another example will bring this distinction into focus.

Consider: Colby is an anencephalic infant born to Mrs. Montmartre. The neonatal ICU team places Colby on respiratory support systems, but quickly regrets their decision. Despite Colby’s birth defects, Mrs. Montmartre insists her baby remain on ventilator support for his respiratory failure. The NICU team tells Mrs. Montmartre that they believe life support should be withdrawn, as Colby has no chance of improving or ever going home. Mrs. Montmartre disagrees: firmly believing that all life is sacred and should be protected. In so many words, she lets the ICU team know that independent of any quality of life assessment others might perform, Colby should remain on the most aggressive therapies possible. Mrs. Montmartre also believes respiratory support should continue because God might work a miracle—healing her baby’s respiratory system. Colby’s attending pediatrician calls in the hospital’s clinical ethicist to help decide what to do next. The ethicist has a long conversation with Mrs. Montmartre; wherein she repeats the mantra that all life is sacred, even Colby’s—therefore—Colby should remain on ventilator support to give God time to work a miracle. She says, “God loves all creation, and to say to some part of His creation that is not good enough to be alive is unfathomable. I have

²⁶ This label does not imply that the doxological invocation is efficacious because the invocation *will* have an effect on the care the patient receives, but rather because it *intends* to have an effect.

believed this for my whole life. And I *know* that God will work a miracle if we hang on long enough.”

In this example, we find an unshaken miracle-invocation, since it appears Mrs. Montmartre’s unwavering position stems from a codified worldview and a strong sense of self. Next, we ask ourselves, “Is she using the term in a doxological or political manner?” Doxological, I believe. Although we will see this distinction more clearly after we discuss political invocations, for now, we should note that the political invocator will not have a community to appeal to as she proclaims her worldview. The political invocator lacks a support community because his conceptual vocabulary has only recently included a concept of the miraculous. Maria, for example, might eventually find a congregation where she feels at home, but, during her mother’s hospitalization at least, she has no congregational home. Unlike the doxological invocator—whose belief in the miraculous predates her experiences in the clinic—the political invocator has no direct social support from a community of believers.

Mrs. Montmartre’s theological beliefs are impeding the institution’s regular course of care; therefore, we would categorize her invocation as efficacious. The doxological invocator (whether “innocuous” or “efficacious”) displays a certain kind of love of God: an unwavering faith in the goodness of God’s plan. Both April and Mrs. Montmartre have firm convictions that *preceded* the struggles they encountered in clinical settings. Doxological invocators are members of communities: they attend worship services, know their denomination’s sacred texts well, and show respect to their spiritual authorities. Whether the doxological invocator’s miracle-concept includes events outside Gospel-like healings (like April), or a monolithic conception of the miraculous (like Mrs. Montmartre), both sets of doxological invocators came to the clinic with

an internally coherent conception of God, world, and self. The doxological invocator finds no reason to reevaluate his conceptual scheme even when faced with clinical adversity.

We see that, according to the doxological imagination, sincere prayer can influence God's power to work miracles. This aspect of the doxological imagination reminds us of Augustine's stories in *City of God*—recall Innocentius' pleading for his suffering to cease (Augustine 2003, XXII.8). With both the innocuous and the efficacious doxological invocations, God responds (or, at least, *could* respond) when provoked by prayer. This kind of theological imagination finds both quality and quantity important when praying for a miracle. Sincerity and intensity signify the proper quality of one's prayer. A half-hearted, unfeeling request would not serve to provoke God's loving grace. Concerning quantity, the amount of prayers sent appears to affect Divine action as well. An entire congregation praying for a miracle has more power than a single congregant's prayer.

A number of questions about metaphysical coherence arise from holding that this kind of prayer can be a proper action. Why would the quantity of the prayers offered to God have an effect on God's distribution of grace? Does God really need convincing? Would God have caused the miracle-event had the prayer never been uttered? The doxological imagination may not have finessed answers to these questions. Indeed, perhaps this imagination—in both its efficacious and innocuous modes—finds these questions inessential for living a proper Christian life. We find an Augustinian sentiment: when diving into the muddy waters of theology, if you find yourself in a heterodoxical current, the Christian should come up for air (see Augustine 1955, 1). No need to drown; biblical orthodoxy provides a firm sandbank on which to stand. Firmly ensconced in certainty, the doxological imagination finds no reason to translate a question about metaphysics into a critique of the efficacy of prayer and Divine Action.

The epistemic structure of the doxological imagination prizes revelation over reason—the truths of the Gospels will win-out over any concern regarding external validity. The red letters of the Bible provide an indelible, and unquestionable, foundation for a true belief and proper living. If the clinical imagination, the ethicist, or the theologian finds the invocator’s position inconsistent or even incoherent—perhaps arguing that Revelation can be ambiguous and contradictory—the doxological imagination has no problem dismissing the critique. The impetus behind this dismissal can be found in three sources that influence the doxological imagination’s conception of the miraculous: 1) the Christian myth into which the invocator was born and raised, 2) the invocator’s *individual* interpretation of the Bible, and 3) the Christian community to which the invocator belongs at this point in her intellectual journey. All of these sources point toward the epistemic fact that God’s Revelation contains the truths from which one ought to orient one’s life. As we saw in chapter three, Augustine would support ranking revelation above reason as a mode of knowing; however, Augustine would also insist that revelation and reason must agree (Augustine 1998, III.3). The rational, ordered structure of Creation proclaims that God is a rational agent; therefore, if we sons and daughters of Adam cannot see how Revelation could be rational, we should accept ignorance before questioning the validity of God’s Word (*ibid.*, II.19).

Doxological invocations spring from two epistemic sources. First, doxological invocators may be born and raised into Christian conceptions of the world. They have accepted the worldview that their guardians and community have instilled in them; therefore, we should not be surprised when the authority of the community plays a substantial and formative role in the doxological invocator’s imagination. It goes without saying that each doxological invocator will come from a different background, with a unique theological imagination, but, speaking broadly,

we should notice that doxological invocators will hold the opinion of their community in high regard. The community functions as: 1) an interpreter of revelation, 2) a social support system, and 3) an authoritative voice on matters of life and death. The doxological invocator lends his community this kind of authority because he is indebted to this community for his worldview. The doxological invocator finds a tight connection between the good of the community in which he lives, and the good of himself as an individual.

However, to identify conversion with a mythical mode of belief would be a mistake. The second path to doxological invocation: conversion to a Christian world-view. Conversion, by definition, requires the believer to consciously accept a new conceptual scheme; or, in the case of “born again” Christians, the convert willfully returns to the mythical account of the world with which he grew up. In Patočka’s terms, conversion includes two possible routes 1) a journey from myth, to philosophy, and then back to myth (*arrow d*), or 2) myth, to philosophy, and then acceptance of another mythological account of the world (*arrow f*). In either case—following Patočka—we would categorize the return to myth as “religious belief” since the invocator has reflected upon the nature of herself and the world—she performs self-reflection/philosophy.

Before moving on to the political invocations, we should take a moment to discuss another source for the doxological imagination: popular evangelical media. Both fiction and nonfiction can influence the doxological imagination’s conceptions of God and miracle. One need only visit the “spiritual” section of a local bookstore to see how often Christian memoirs and self-help books employ miracle language and a doxological theology when analyzing illness, dying, and death. Mary Self’s autobiography has the eye-catching title, *From Medicine to Miracle: How my Faith Overcame Cancer* (2001). After noticing muscle pain, Self was diagnosed with bone cancer at the age of seventeen. Self obdurately told her oncologist that a

miracle would occur: God would very soon cure her of the cancer found in her left leg. This miracle would make the anticipated knee-down amputation of her left leg unnecessary, and she believed she would continue her life as if no illness ever visited her body. Self's place in the world, conception of God, and sense of community remain untouched, despite her illness. Using our taxonomy, we would call such an invocation: unshaken, doxological, and efficacious. Nonetheless, Self's doxological invocation is short-lived. She questions the wisdom of Providence once chemotherapy begins; that is, when she realizes the miracles that she has been praying have not been realized. If the ethicist were to talk with her at this point in her struggle, she would categorize her as an existential invocator, as she is trying to reconcile her conception of God with her suffering—but more on the existential mode later.

We also find books employing a doxological theology in order to inspire a similar disposition in the reader. In *Miracles are for Real: What Happens when Heaven Touches Earth* the authors, Jim Garlow and Keith Wall, use a number of trauma and illness related short narratives to build their case that God continues to perform miracles for those who petition the Divine (2011, 206). For example, in the story of Marie Packard, the reader finds a family battling a brain tumor and complications from radiation therapy. Marie and her husband Derek hoped to raise a large family; however, the “medical community” had deemed her infertile. After praying with her congregation (thereby “prompting God’s hand”), Marie became pregnant with a son (141-48). This, and other examples, purportedly show the power of God to the reader, leading the reader to accept the possibility that God continues to act in the world—that God may show favor to me or my loved-ones. Like other books in this genre, *Miracles are for Real* contains a section reminding the reader that God does not work on command. The final chapter “Beware of being a miracle chaser” and the epilogue “When miracles don’t happen” tell the reader that

God's will and our beliefs about what *we* want do not always align. Not every miracle we pray for will occur. The good Christian should concentrate his efforts on living an "authentic life" where he properly develops his character by loving God rightly (Garlow and Wall 2011, 237, 241).

We also find a doxological impetus underlying a recent resurgence of films marketed toward evangelical Christians. In the Spring of 2014, *God's Not Dead* and *Heaven is for Real* premiered in theatres worldwide. *Heaven is for Real* tells the "true story" of a little boy, Colton Burpo, who purportedly died while undergoing an emergency appendectomy at the age of four. Colton claims to have visited Heaven, where he encountered Jesus, Mary, deceased relatives and loved-ones. The film intends to be apologetic: it is supposed to convince the audience that miracles happen, that heaven exists, and it awaits those who deserve entrance. In *God's Not Dead*, a college student enrolls in "Philosophy 150," where he is forced either renounce his faith or defend the proposition that "God is alive." He does so; and converts his class, including his professor. Even though these saccharine films lack nuance and artistic merit, with over \$150,000,000 in ticket sales, the ethicist should be aware that miracle-invocations may have been influenced by these and other popular evangelical media. Specifically, in this genre God performs miracles for those who love God rightly. External critiques of one's Christian beliefs are seen as attacks against not only what the individual's worldview, but also on the sacred. For the doxological miracle-invocator, the hope for a miracle expresses a fundamental truth about the cosmos: humans can petition God for divine assistance.

Unshaken Invocations: Political

Another way patients or family members might use miracle-language is in its political mode of invocation. It is essential to highlight a cardinal difference between the doxological imagination and the political invocator's imagination. Both innocuous and the efficacious doxological invocators have a history of engagement with their Christian communities. These invocators witness (or experience) illness with a firm, Christian conceptual scheme ready to account for the invocator's (or a loved one's) suffering. The political invocator, however, has no readily available miracle-concept—his conceptual scheme is not rooted in the creeds and practices of a Christian community; instead, the political imagination appropriates religious language in an attempt to influence clinical care. The effective doxological invocator (e.g., Mrs. Montmartre) hopes to influence clinical care through miracle-language, so she utilizes a conceptual scheme that has oriented her life *prior* to entering the clinic. The political invocator's past conception of self and world, however, did not include a miracle-term—it is not until he entered clinical spaces that miracle-language became a part of his religious vocabulary. This cardinal difference between the political and efficacious displays the *ad hoc* nature of the political miracle-invocation.

Recall Maria's conversation and experiences. She can serve as an example of the political mode of invocation. Unlike her sister April, Maria has only recently incorporated the term "miracle" into her conceptual scheme. She steadfastly insists that a miracle-event will occur, but the political invocator's miracle-term has not been steeped in years (or even decades) of communally sanctioned usage. Even without the aid of a formal "spiritual assessment," the ethicist can learn of the invocator's past religious commitments. If the invocator does not participate in a Christian community, or, if he does not have a grasp on the sign and wonders

Christ performs, then the ethicist should assume that the invocator has only recently incorporated a miracle-term into his religious lexicon.

The political invocator, like the doxological, efficacious invocator, hopes to use miracle-language to influence clinical care; however, the political invocator's rationale for this influence comes from a different set of *interests* than that of the doxological invocator. While the doxological invocator has an interest in acting in accord with what he believes to be God's divine plan, political invocators use miracle-language in order to display power over others. It will become evident to the ethicist that the political invocator is trying to convince someone of something: be they loved-ones or members of the health care team. This mode of invocation intends to use religious language to further non-religious interests. So then, what might Maria's interests actually be? Maria is trying to manifest her love by claiming to know more about her mother than either her brother or sister. Her audience for this display appears to be both her family and her mother's health care team. Maria is trying to connect the intense love she feels for her mother with aggressive therapy. To cease aggressive therapy is tantamount to "giving up" on Mrs. O'Shay—letting her die when more could be done. Perhaps Maria feels guilty about being absent from her mother's life; or, perhaps, she is jealous of the relationship her siblings have had with Mrs. O'Shay. Whatever her motivations may be, Maria views miracle-language as the key to unlocking the path of aggressive care—a path Maria has come to equate with proper care.

The political invocator will display a number of characteristics as he attempts to wrest decision making control away from another party. As mentioned above, the political invocator will not have the support of his community. It need not be the case that the invocator lacks this support because no congregation would agree with his miracle-concept; rather, since the miraculous played no role in the invocator's conception of the world before he entered the clinic,

he has not had the chance to join a community of like-minded believers. Perhaps the political invocator will connect with a social network after he leaves the clinic, but if the ethicist asks about the political invocator's congregation or parish, the ethicist will not be able to establish a tight connection between the individual invocator and a Christian community.

The political invocator wants to influence medical care by imposing her religious imagination upon the clinical imagination. Unlike the doxological invocator's worldview—sharpened by years of reflection on Providence—the political invocator uses blunt language that emphasizes her *right* to her religious convictions. The political invocator will be unwilling to discuss the details of her miracle-concept. She will instead say, "That's just what I believe." Unlike the doxological invocator—who has a robust understanding of the Bible and the miracle stories found in the Gospels—neither will the political invocator will not have a firm grasp on sacred texts. This is understandable. Since miracles have not furnished this kind of invocator's religious imagination (and since she has not been regularly attending Christian services) it is unlikely that she will have a proficient command of Christianity's sacred texts.

In general, the deep-seated interests of the political invocator will be closed-off from the ethicist and the clinical care team. The ethicist may get a general idea about the invocator's motivations, but we would be fooling ourselves if we expect to know the invocator's *true* motivation. Discerning this kind of foundational interest—an interest that attempts to preserve one's sense of self—is outside the scope of the clinical ethicist, for the most part. I am not suggesting that it would be impossible for the ethicist to hold a conversation in which an invocator opens up to such a degree that she begins discussing these foundational tenets—indeed, something like this happens when the invocator uses "miracle" in an existential sense. Nonetheless, the clinical ethicist should not assume that a deep, intense conversation necessarily

means the ethicist knows the motivations and interests of a patient or a surrogate. Does Maria *really* believe her mother would want aggressive care, or is she being a contrarian out of jealousy? Having an answer to these questions is far less important, for the ethicist, than realizing that the political invocator's interests are oriented by something other than an attempt at loving God properly.

Existential Miracle-Invocations: Pedagogical and Tragic

Our unshaken miracle-invocators come into the clinic with a solid conception of self and world. Whether they have the attributes of a doxological or political invocator, both imaginations are unwilling to reassess their worldview. In this section, we will address those patients and loved-ones who use miracle-language while attempting to understand themselves, their relationships, and their conceptions of the world. I will call these people "existential" invocators. They deserve this label because they are struggling to figure out what it means to *exist*—existential invocators, unlike unshaken invocators, do not have a solid conception of themselves or the world they inhabit. The existential invocator reacts to the suffering she experiences in the clinic with religious language, but she finds that the theological tenets she has believed up until this point cannot account for her experiences. Notice, the doxological invocator employs miracle-language while trying to find answers to questions of great importance. Questions that run through the mind of the existential invocator include: What does it mean to be human? How should I relate to the Divine? Why isn't God answering my prayers for a miracle?

We should return to Patočka's schemata to expediently connect the individual's struggle for proper belief with an account of proper action. The existential invocator is not at the mythic stage of his intellectual journey. Recall, the mythic stage completely accounts of one's place in

the world, leaving the invocator with nothing more to ask of themselves or the cosmos; as such, it would be a mistake to place the existential invocator in this stage. The existential invocator is *searching for* solidity; she has not already found it. She might have had a solid, coherent account of the world before she began experiencing clinical hardships; or, the existential invocator may have given little thought to her relationship with the divine.

As I mentioned above, the clinical care team can distinguish an existential invocator from an unshaken invocator by the existential invocator's openness to discuss his religious imagination. Returning to Mrs. O'Shay's son Bruce might help us flesh out the nature of the existential miracle invocations. We can imagine an ethicist sitting down with Bruce in order to talk about his thoughts on his mother's wishes. The ethicist asks Bruce, "What do you think your mother would want at this point in her life?" He responds, "I don't know. I think April is right—Mom wouldn't want to have a therapy that can't help her in the long run. I don't think Maria is right that Mom would want to keep hanging on just for the sake of a miracle. I believe in God, and I hope a miracle happens, but I don't agree with either of them. Miracles don't just *happen*. I guess I don't really know what's going on—I don't know what to believe anymore."

Bruce, *unlike* his siblings, expresses confusion and uncertainty regarding the nature of miracles. He appears to be struggling not only with his beliefs about miracles, but also with his God-concept as well. This should not surprise us: a reassessment of Divine Action may very well lead to a reassessment of the Divine itself. After questioning the nature of God, interrogating one's conception of the world (God's creation) and oneself (another one of God's creations) might not be far off. Bruce appears to be interrogating himself and his conception of the world. Borrowing Patočka's language, we can say that Bruce is doing philosophy; he is interrogating himself and the world he encounters. The existential invocator participates in the Socratic project

of searching for a solid, foundational sense of self. (The unshaken invocator has no reason to participate in this project, as clinical events have no effect on her worldview.) We will see that *all* existential invocators participate in the activity of self-interrogation; indeed, the process of self-interrogation is a necessary condition of being a miracle invocator in the existential sense.

Self-reflection is the hallmark imaginative process of the existential miracle-invocator; but as we begin to see, the content—if not the method—of inquiry differs between invocators. Bruce struggles with reconciling his turbid conception of the miraculous with his past, present, and future conceptions of himself. His relationship with the Divine lacks clarity. For the existential invocator, old sources of epistemic authority no longer hold the weight they could once bear. We can imagine Bruce leafing through the New Testament; we see him reading about Jesus' birth, death, and resurrection, but this story has become muted and pallid. Seeing his mother reach the apparent end of her life causes a reassessment of his sources of knowledge—both of himself and the world. Bruce talks with the hospital chaplain and the pastor he, April, and his mother share every Sunday. He prays with them, but feels disconnected from the conversation. Pastor Hemingway tells Bruce that all lives have a natural span—that all humans are meant to die. Bruce accepts this statement; however, the trust he used to feel toward the clergy has evaporated. Existential invocators might not reject the teachings of past authorities, but they do not fully integrate these teachings into their lives.

In this search for a solid notion of oneself and one's world, the existential invocator's conception of proper action and virtuous living will be shaken as well. For many existential invocators, beliefs about the salvation of the soul influenced their past, solid conceptions of self. Perhaps the invocator spent her life accepting the myth of her childhood; it is only after her most recent clinical experiences that she began questioning the validity of the myth. Or, it may be that

the invocator entered the clinic after already (at some point in the past) questioned the myth she was taught, i.e., having done philosophy. In such a scenario, the invocator would have *returned* to the myth of her youth or converted to another form of Christianity. Returning to the myth of one's youth (or converting to another myth) transforms one's beliefs about God, the universe, and oneself into "religious beliefs," as we saw in the first section. Therefore, it is possible that the existential invocator enters the clinic with either a mythic or religious set of beliefs. In both cases, clinical experiences cause the invocator to continue using miracle-language, but his conception of how to live his life—and what decisions to make—will be shaken. Whatever route the invocator takes, all existential invocators question the propriety of their conceptual schemes.

If asked to make decisions related to medical care, the existential invocator will likely be indecisive. The inability to make a decision will have a greater impact on the existential invocator when she is the patient, not a loved-one or surrogate decision maker. A surrogate decision maker has the duty to make a good-faith, substituted judgment; therefore, she brackets out her own principles and interests in order to make a decision that the patient would want. We see here the danger of appointing someone like Maria as a surrogate decision maker, given her apparent inability to distinguish her interests from her mother's wishes. The fact that Bruce struggles to understand himself has no effect on the clinical care Mrs. O'Shay receives. Perhaps we need another example—an example of a *patient* who uses miracle-language in an existential fashion.

We imagine a fifty nine (59) year old man who reluctantly enters the emergency room of his local hospital with a distended, tender abdomen, yellowed eyes, stomach pain, and nausea. The patient, I'll call him Mr. Greenfield, exhibits the sign of chronic liver disease. After a liver biopsy, the attending physician diagnoses him with cirrhosis of the liver due to chronic hepatitis

B. Mr. Greenfield admits that he has not visited a doctor's office in decades, and that he should have searched-out medical care before he was seriously ill, still, the diagnosis shocks him. His care team's prognosis: without a liver transplant, Mr. Greenfield will decompensate and die within three to six months.

In the span of thirty-six hours he has gone from feeling sick to envisioning extended hospital stays and, possibly, a liver transplant. Mr. Greenfield's wife and daughter visit, and talk with him about his future. After talking with his family, Mr. Greenfield tells the team that he wants his health to improve, but he is uncertain about being placed on the transplant list. Mr. Greenfield tells his health care team that he would rather wait for God to perform a miracle than wait for a transplant. Mr. Greenfield's attending physician is concerned that if the patient waits much longer, then his chances of post-operative complications will increase drastically; for example, infection might set in, leading to complications and further delay. Dismayed by this possibility, the ICU team asks the ethics consultation team for their input.

During a long conversation with Mr. Greenfield, the ethicist asks him about his skepticism, fear, and reticence. He tells the ethicist, "I think a miracle might happen here. If me and my girls pray hard enough, I think God will provide for me; I believe God will see me through this trial...I'm very scared of getting a liver transplant—I really hate hospitals. I wish I was home...even if that means I don't live as long, I think I would rather just go home." After the ethicist prompts Mr. Greenfield to talk about his religious beliefs, he goes on, "I was born Catholic; confirmed Catholic. For a long time I didn't really pay attention to the Church after I got out of high school. But after John Paul II died, I started attending church almost every week. But now, I don't know. I hope God cures me. I pray for it every minute I am awake, but I don't know how much God really loves me, you know? Father Ryan came in, and we talked, and

prayed, but...I don't know...I don't really know what I believe about God and His works anymore.”

Here, Mr. Greenfield uses miracle-language in its existential form. Clinical events (his illness) have disrupted his past conceptions of self and world. He has begun questioning what it means to be himself—what it means to have a relationship with the Divine. Mr. Greenfield, born into some version of a Roman Catholic mythic description of the world, *returned* to the Catholic faith in 2005 when John Paul II died. The patient has chosen to accept the Catholic faith with which he grew up, resulting in a new mode of epistemic assent: religious belief (not mere myth). This transition shows that Mr. Greenfield is open (or, at least *was* open) to discussing his religious beliefs, unlike the unshaken invocators. Existential invocators have already experienced the process of self-reflection, and have concluded that a system of Christian belief best accounts for the world. Even as we find similarities between invocators (such as their acceptance of a world wherein miracles occur), each existential invocator will have a distinct conception of the world. Once she experiences clinical hardships, however, the existential invocator begins the process of philosophical self-reflection again. It is during this process of discernment that the ethicist can play a central role in promoting the well-being of the patient; but we will go into detail on this topic in chapter five.

I envision a pair of possible outcomes for the existential invocator's struggle to regain a sense of self, community, and cosmos. First, the existential invocator might discover a new sense of self—she might find a solid concept that anchors thought and action. She finds meaning in the suffering she has experienced. Suffering has had a pedagogical effect on her worldview. In Mr. Greenfield's case, we can imagine that after a few more conversations with Father Ryan, he is folded back into Roman Catholicism. Father Ryan convinces the patient that God has a plan for

him and everyone he loves. Mr. Greenfield comes to believe that while miracles do indeed happen, a Catholic should not orient her ideas about life and death around this remote possibility. Instead, he should treat medicine as a collection of tools that can help humans live and die in accord with God's will. Or, we might instead imagine that Mr. Greenfield comes to reject his past Catholic faith, deciding that the world Father Ryan describes does not exist. He decides that life has meaning even without God, and that he can live in the world without orienting his actions toward the divine. In both cases, self-reflection leads to the solidification of one's image of self and world. When this happens, clinical experiences have been a catalyst for coming to a new conception of self.

As such, the doxological invocator who has a pedagogical outcome may have unpleasant experiences, but he leaves the hospital with a revitalized, solid, and coherent sense of self. Undoubtedly, not all existential invocators will find a new, revitalized self-concept. The second possibility: the existential invocator's image of herself remains shattered and diffuse—she leaves the hospital without a satisfactory notion of herself or her world. Perhaps the invocator continues to use miracle-language (and she remains open to discussing her worldview), but she feels ambivalence toward past epistemic authorities. For example, while the miracle stories in John were once a comforting reminder of God's presence, the invocator now becomes confused and frustrated when trying to square her experiences with her interpretation of the text. Her conception of God has been fractured, and attempting to return to the myths of her youth (or the myths of other belief systems) continues to fail. Additionally, no amount of discussion or reflection can alleviate feelings of shattered hopelessness. For the existential invocator whose clinical experiences lead to tragedy, the search for a cohesive self via self-reflection fails to account for the relationship between the individual and the cosmos. The invocator might

continue traveling the path of self-reflection, hoping to *eventually* find a foundation from which to live; or, he might give up on this quest. Instead of continuing the search, he decides that the world is an inscrutable place where humans cannot find truth. As we will see in the next chapter, the ethics consultant should try to obviate a tragic outcome.

Concluding and Transitioning

I will conclude this chapter with a reiteration of the central aspects of this taxonomy of miracle-language. We began this chapter with a discussion of Patočka’s ideas regarding philosophy/self-reflection as “care for the soul.” Using Augustine as an example, we saw how the moral and epistemic processes involved in caring for the soul function in the intellectual and moral development of an individual. In the remainder of this chapter, we saw a taxonomic analysis that reflects the complex and multifaceted nature of the term’s use.

I hope that I have left the clinical ethics consult thinking, “Fine. I could use this taxonomy to distinguish different kinds of miracle-invocators. While this will help me better understand the multifaceted nature of miracle-invocations (and the people behind these invocations), how can this taxonomy inform the way I practice clinical ethics? What happens after I have decided that this patient is using miracle-language in an efficacious, doxological sense?” Chapter five answers these questions by translating this taxonomy into a series of practical responses. It is my sincere hope that the responses I articulate will help the ethicist in her attempt at providing quality clinical ethics consultations. By the end of this final chapter, the ethics consultant will have a better way to address miracle-invocators—a way that is sensitive, justified, and practical.

CHAPTER V

RESPONDING TO MIRACLE-INVOCATIONS:

A NEW APPROACH

The previous chapters have emphasized theoretical concerns regarding values and rights. So far I have offered little in the way of concrete practical responses to clinical miracle language. In chapter two, I have articulated and analyzed six practical responses that attempt to promote a morally-adequate response to miracle-language: 1) epistemic inquiry, 2) theological negotiation, 3) spiritual assessment, 4) empathetic imagining, 5) appealing to professional values, and 6) respectful rejection. As I argued, the clinical imagination contains a number of assumptions about nature, proper living, and proper action (see chapter two, especially pages 87-96). Augustine's thought has, I hope, improved our understanding of the complex ontological, moral, and epistemic commitments that can be found in religious imaginations. In the previous chapter, we put this insight into practice by describing different kinds of miracle-invocations. By offering a taxonomy of miracle invocation, we can appreciate its nuance and complexity. Now that we have this theoretical structure, I will move on to offer some practical suggestions for clinical ethicists.

The clinical ethics consultant, as we know, is called upon to alleviate concrete, real-world moral distress; therefore, ending our conversation with practical suggestions follows from the goals of this manuscript. We have seen other practical responses and where they fall short. Our question becomes, "Should the clinical ethics consultant promote the practical strategies offered by the clinical imagination?" We are in a privileged position. Since we have explored and

critiqued the values that found these practical responses, we can decide if we want to accept, promote, modify, or reject these values. Our answer to this question will be informed by our previous analysis of the clinical and religious imaginations. Different religious imaginations function in different manners, as we have seen; therefore, our practical responses will be tailored to the taxonomy created in the previous chapter. In this chapter, I hope to achieve this dissertation's final goal: providing morally appropriate and sensitive responses to clinical miracle-language.²⁷

Now that we are exploring specific aspects of clinical experience (not general remarks about the nature of religious language), we should attend to the distinctions between the miracle-invocator who is a patient, a surrogate decision maker (hereafter: "surrogate"), and a loved-one. What the ethicist (and the medical establishment) owes a person depends on what role the person inhabits. Invocators have different interests in the clinical endeavor. patient who uses miracle-language (Mr. Greenfield), a loved-one who uses miracle-language (Maria), and a surrogate who uses miracle-language (April) The patient will be the focus of clinical attention because he is the individual seeking medical care, while the personal interests of the surrogate and loved-ones will be treated as auxiliary. In short, the ethicist will have to tailor her practical responses to the invocator's role in the clinic, be he the patient, surrogate, or loved-one.

The Goals, Tasks, and Skills of the Clinical Ethics Consultant

²⁷ While on this topic of rejecting or accepting practical responses, allow me to provide a quick defense for the exclusion of "respectful rejection" from this chapter. As we saw in the second chapter, Savulescu and Clarke justify this response with the assumption that all patients who use a religious justification for the acceptance of a therapy *necessarily* receive preferential treatment. This is a skeletal (and probably incorrect) conception of the religious imagination. This sentiment ignores the fact that 1) the clinical imagination and the religious imagination can agree about the appropriateness of an intervention, and 2) there are gray areas where medicine looks to the patient's preferences to determine what course of action to take. Most importantly, the ethicist should not reject wholesale religious conceptual schemes if she hopes to promote the *overall* well-being of the patient—rather than merely the physical well-being.

We should begin with a few words on the goals, tasks, and skills necessary for practicing clinical ethics consultations. The goal/end of clinical ethics consultation should be promoting the well-being of those who find themselves in clinical settings, especially high-tech hospitals. While true, this description tells us nothing about the uniqueness of ethics consultation in contrast with other clinical services. After all, the pulmonologist, lawyer, X-ray technician, and ethicist all work toward this goal. What distinguishes the clinical ethicist from these other professionals is the ethicist's correlated goals. They include: identifying moral values at play, analyzing the issues that arise from the values, facilitating understanding of the moral values and issues, and making prescriptive recommendations founded in moral analysis. In order to meet these goals, the ethicist must have a unique set of skills and a unique knowledge base; however, the best way to go about acquiring and employing these skills and knowledge is a matter of controversy within the field. Indeed, within my description of the correlated goals, ethicists disagree about the nature of moral values, prescriptions, recommendations, and moral analyses; furthermore, we should not be surprised that the conceptual and practical makeup of both "skills" and "knowledge" is a matter of dispute.

The American Society for Bioethics and Humanities' *Core Competencies for Healthcare Ethics Consultation* identifies a number of skills the clinical ethics consultants should have in order to achieve the goal of "improv[ing] the quality of health care through the identification, analysis, and resolution of ethical questions or concerns (American Society for Bioethics and Humanities 2011, 3). In order to do so, Tarzian identifies a number of skills, including: 1) ethical assessment, 2) process skills, 3) facilitation, and 4) interpersonal skills. Additionally, the clinical ethicist must be familiar with: 1) ethical theory, 2) health care systems, 3) institutional policies, and 4) spiritual and cultural beliefs (*ibid.*, 2011, 3-5). Although a number of thinkers have put

forward critiques of this document, it can serve to initiate our conversation on the scope and task of the clinical ethicist. So then, the skills the ethicist acquires leads to an ability to perform discrete tasks, and these tasks point toward the fulfillment of the consultant's goals/ends. The overarching goal of the ethicist includes promoting the health and well-being of the sick and afflicted by ensuring that morally relevant clinical issues are addressed. Now, I hope that my analysis has pointed toward another goal: facilitating self-reflection, when the invocator is willing to discuss her beliefs.

When addressing different kinds of miracle-invocators, can clinical ethics as traditionally conceived adequately account for the modes of religious imagination? Although the traditional tools and tasks of the ethicist work quite well when addressing unshaken invocators, I hope to show that more is needed for a proper response to *existential* miracle-invocations. We have seen that people who use miracle language in an unshaken manner have not been shaken by their clinical experiences—they have solid conceptions of themselves and their worlds; however, existential miracle-invocators lack such a foundation. Their conceptions of self, of God, of their communities, and their worlds have been shaken by their clinical experiences. The ethicist, in such circumstances, ought to help the existential invocator shore up their moral worlds by facilitating self-reflection. To ignore the existential invocator's uncertainty would involve saying to oneself, "This person's world is crumbling, and that's too bad, but there is nothing I can do about it." The ethicist, however, has the skills to alleviate this kind of suffering by facilitating self-reflection through candid discussion.

This phrase, "facilitating self-reflection," seems like an oxymoron at first glance. How could one person (the ethicist) facilitate another person's (the invocator) *self*-reflection? We should make two notes about this. First, as we saw in the thought of Augustine and Patočka's

Socrates, self-reflection can take an inward-looking direction. We saw Augustine chastising himself for a constant failure to look inward toward the permanent, spiritual substance of the soul—to turn back to himself. Instead of looking inward, Augustine looked *away* from his true self, focusing on what he came to understand as the lies of the Manicheans. And we must not forget Socrates' *daimon*: the unrelenting internal voice that oriented his search for truth, knowledge, and understanding (see Vlastos 157-78, 1991). For both of these philosophers, self-reflection involves searching for truth by looking inward—by searching for the permanent within their own selves. However, secondly, self-reflection is not a hermetic, closed-off process, but a process that occurs in dialogue. Augustine left the myth of his upbringing only after many hours of conversation with his living friends and past philosophers. And Socrates' method of self-reflection took place amid conversation in public spaces—often with friends. The Socrates we find in Plato's dialogues heads for the agora when perplexed; he thinks out loud. My point is this: self-analysis plays a critical role in self-reflection, but we would be mistaken to think dialogue with others plays an inessential role in the search for a solid conception of self. Indeed, we may go so far as to say that if we had no conversation partners we would be unable to go beyond myth. When conversing with an existential miracle-invocator, philosophy/self-reflection can help the ethicist understand the invocator's worldview.

The responses of “empathetic imagining” and “epistemic inquiry” can provide a foundation for the ethicist's response. In fact, whether the invocator uses miracle-language in an existential or unshaken fashion, the ethicist should always *begin* her response with empathy and inquiry. We will analyze these two foundational responses; after this analysis, we will tailor our approach to the distinctions between the various kinds of miracle-invocations we explored in chapter four.

The First Foundational Response: “Empathetic Imagining”

Empathetic imagining is the first action the ethicist will take if she hopes to facilitate a proper response to miracle-invocations. This set of skills gives the ethicist a foundation from which to build an adequate response—without this skill, a proper response would be nearly impossible. In chapter two, we discussed the moral and metaphysical values that support empathetic imagining. For Dugan, we saw that empathy had extrinsic value because it can establish trust, which leads to better patient care through open discussion of wishes and preferences (1995, 325-28). Schenck and Churchill incorporated empathy into their set of Eight Healing Skills; while Schneiderman connected empathy with the ability to set aside one’s own interests and inhabit the worldview of another person. The *Core Competencies* pay little attention to empathy, unfortunately. In a section on the “attributes, attitudes, and behaviors” of ethics consultants, the authors associate the virtues (my word, not theirs) of tolerance, patience, and compassion with “traits that would enable the consultant to listen well and communicate interest, respect, support, and empathy.” They go on to say that the virtues of tolerance and patience serve to “welcome people” who are “emotionally distraught or [...] hold minority view so they can be fully and respectfully heard” (*ibid.*, 32). The authors then connect compassion with the ability to “work constructively with feelings in sometimes tragic situations” (*ibid.*). What welcoming, respecting, and working constructively looks like in the clinic is left up to the reader. In *Clinical Ethics*, the authors mention empathy and its concordant virtues (patience, tolerance, and compassion) only on rare occasions, and do little in the way of relating these virtues to the performance of clinical ethics. So then, what does empathetic imagining look like for the ethicist as she responds to miracle-language? This chapter can be read as an answer to this question.

A note on the philosophical history of the term “empathy” can serve, to some degree, to illuminate the processes involved in empathetic imagining. The German term *Einfühlung* began to hold philosophical and theological weight in Germany in the late nineteenth century (Stueber 2013). Theodor Lipps (1851–1914) was the first western thinker to seriously explore the psychological and philosophical aspects of *Einfühlung*. Lipps’ central concern is what has come to be known as the “problem of other minds.” Descartes inaugurated this problem by insisting that we could never have true knowledge—in the form of “clear and distinct” perception—of the existence of other minds without a guarantee from a benevolent creator (III: 1996). Lipps accepted that this is a serious philosophical problem, and went about trying to argue for the existence of other minds based in the processes of *Einfühlung* (Stueber 2013, 2-10). Later phenomenologists like Edmund Husserl (1859-1938) and Max Scheler (1874-1928) considered empathy of fundamental importance in establishing the subject’s relationship to other minds. More recently, philosophers, psychologists, and neuroscientists have become interested in the possibility that empathy plays a significant role in understanding (*Verstehen*) not only the bare existence of other minds, but the ways other minds function in the construction and maintenance of our own sense of self (see: Gadamer 2004, 305-06 and Damasio 2012, 112-138). How might an individual come to understand the content of another’s mind? What ideas furnish the mind of that person who is not me? These questions provide the impetus that might help the ethicist gain an understanding of what exists (ontology) and what is important (moral ontology) for others.

Although contemporary clinical ethics consults may not feel an intellectual kinship with nineteenth century German philosophers, empathetic imagining is not so far from *Einfühlung* as one might think. As we saw in the previous chapter, the ethicist is trying to discover and understand the beliefs that makeup another person’s view of the world—she is trying to answer

the question, “What concepts furnish the mental world of this patient/loved one?” The ethicist obviously cannot simply say, “Could you tell me about the concepts that comprise your mental world?” Even if the ethicist would venture to ask such an awkward question, and even if the invocator understood and responded with an honest answer, the ethicist’s tasks require more than an inventory of a patient’s beliefs. True, the ethicist *is* trying to excavate and understand the beliefs of the invocator, but more than this, the ethicist hopes to understand how an individual’s beliefs inform his values and clinical preferences.

Let us return to JM’s account of “mindful listening” to continue clarifying the process of empathetic imagining (Schenck and Churchill 2012, 73-81). While “JM” mentions “mindful listening” in relation to the role of the physician, the ethicist who engages in empathetic imagining acts in a similar fashion. The ethicist “hears out” the invocator by setting aside and bracketing one’s own opinions regarding the truth or falsity of a claim. These claims can take the form of clinical-related beliefs. Consider this example: the ethicist participated in a meeting where a certain course of care was set forth and explained, but the invocator claims the team has yet to tell her about other treatment options. When engaging in empathetic imagination, the ethicist will not correct the invocator. Or, the beliefs may be directly related to theological concerns. For example, the ethicist who is not an evangelical Christian will disagree with any number of a doxological invocator’s beliefs. But the ethicist engaging in empathetic imagining will set aside her own judgments about the truth or falsity of a proposition in order to establish (or begin establishing) a relationship with the invocator. The ethicist who begins by ensuring a non-judgmental tone of conversation will have a better chance at discerning the invocator’s values—which is a primary task of the ethicist asked to respond to miracle-invocations. To be

judgmental at this initial stage will damper—if not inhibit—any budding relationship between the ethicist and the invocator.

In the context of disability studies, Catriona MacKennzie and Jackie Leach Scully connect the role of the individual's moral imagination with an expansion of "the scope of our sympathies" (2007). They argue that quality of life assessments are indebted to the process of "putting oneself in the other's place" (the process I have been calling "self-transposal") and they argue that the process of self-transposal assumes a conception of embodiment that privileges non-disabled bodies. In their analysis, they make a number of observations that can help us flesh out the process of empathetic imagining in the context of clinical realities.

They divide empathetic imagining into three distinct processes, each one a more difficult imaginative feat than the last. First, we have the individual who imagines herself existing and experiencing life in the story of another person (*ibid.*, 340-41). If I were to perform this kind of imagining in relation to Mr. Greenfield, I would try to imagine how I would respond to the circumstances if I were experiencing the same hardships as he. With this kind of imagining, I am not trying to get a sense of *the invocator's* rationale for action or belief; instead, I am imagining how *I would respond* if I were in Mr. Greenfield's situation. The second process involves imagining oneself not merely as a character in the other person's life—a replacement of sorts—but inhabiting the worldview of another person. The success of this imaginative endeavor depends on two factors: 1) the alignment between one's own experiences, and 2) knowledge of the psychological world of the other person (*ibid.*, 341). I am an educated white male who feels healthy and happy. My ability to imagine myself as an uneducated, elderly African American woman afflicted with a debilitating illness is greatly limited by my race, age, financial situation, health, and past experience—what MacKennzie and Leach Scully call "embodiment." Regarding

the second factor, if asked to put myself in this woman's place after she becomes a patient, I would be limited by the fact that I only met her recently. Perhaps the gulf between me and her could be bridged if I had the time to become part of her life and get acquainted with her world. The third kind of imaginative projection is a complete casting off of one's own identity. During this process, the individual completely inhabits the psychic space/worldview of the other person. A significant feat that very few imaginations can achieve—save great novelists and biographers, and, although they do not mention it, I imagine family members and great friends could achieve this feat as well. Here, sympathy occurs.²⁸

Neither the first nor the third kind of imagining is appropriate for the ethicist. To ask the consultant to engage in the third kind of imagining is too high a standard, and the first imaginative project merely answers the hypothetical question, “How would *I* react to this scenario?” This leaves us the middle-ground between the two inexpedient approaches—what I call “empathetic imagining.” The goal of understanding the emotional and intellectual impetus behind miracle-invocations is not sophomoric interest in the life of another person, but to alleviate clinical distress or facilitate self-reflection.

The way I have been describing this process of empathetic imagining might make the ethicist uncomfortable. Empathetic imagining is an intimate psychological and philosophical process. But if we are being honest with ourselves, the intimacy of ethics consultation can be an invasive intervention. In the process of coming to an adequate understanding about the values an individual holds, the ethicist touches upon foundational beliefs. In the same way a cardiologist

²⁸ The reader might notice that the use of “sympathy” here does not run flush with the use of the term in the history of philosophy. For example, Adam Smith (1723-90) and David Hume (1711-1776) both conceived of sympathy as a foundational “sentiment” that preceded any kind of conscience attempt at inhabiting another's worldview (Smith 1759, I:1, I:1:1; Hume 1991, III:iii, 1-5).

has to justify even a minimally invasive cardiac catheterization, the ethicist has to justify his intervention in the patient's course of care.

Now, of course there are impediments to empathetic imagining. The ethicist can misunderstand and, in turn, misrepresent the patient's values and preferences. Misrepresentation is a cardinal danger during this process; for if the ethicist misrepresents the patient's values, then the ethicist's analysis will be misguided and unhelpful—making the process unjustified. Determining when an adequate understanding of the invocator's values has been met will depend on the case. A good rule of thumb: if the ethicist can 1) translate value statements into preferences regarding end-of-life care, 2) have the patient verify the accuracy of this translation, and 3) honestly reflect upon the differences between one's *own* values and the patient's values, then she has achieved an adequate understanding of the invocator's worldview.

The Second Foundational Response: “Epistemic Inquiry”

The ethicist should not assume that miracle-invocations *must* involve a misunderstanding of the medical situation. Nonetheless, when conversing with *any* miracle invocator, it is important for the ethicist to perform some version of epistemic inquiry. The ethicist will want to see that the invocator understands the medical situation wherein he believes a miracle may (or *will*) take place. We should think of this assessment (no matter how informal) as a requirement for the ethicist. As Brett and Jersild have pointed out, patients—or their surrogates—should have a firm grasp on diagnostic and prognostic information in the event that the invocator's hope in the possibility of a miracle-event might be related to a failure to comprehend clinical prognoses (2007, 1648). DeLisser points out that an invocator who hopes for a miracle might “lack understanding about the patient's diagnosis and prognosis” (2009, 1644).

Here, even if the invocator does not agree that the clinical imagination's portrait of the world is comprehensive, we call upon the patient to exhibit an understanding and appreciation of her situation and future. Simple, routine questions like, "Could you tell me a little about why you're here?" and "What do your doctors see ahead for you?" help illuminate the invocator's understanding of his present and possible clinical situation. Let us imagine a conversation with Mr. Greenfield, the existential invocator we encountered in chapter four. We begin with the former question, and he responds with an accurate description of his diagnosis. He tells the ethicist that he has chronic liver disease from hepatitis. Mr. Greenfield responds to the latter question by saying, "Well...they want me to have a liver transplant because I am getting sicker and sicker. They are worried that my liver will fail, my kidneys will stop, my heart too. Maybe I get an infection, and I'll die. Or, if I get a transplant and follow the doctors' instructions I'll probably get better." With this projection of these two paths, Mr. Greenfield displays an adequate understanding of his prognostic picture. Since epistemic inquiry can quickly mutate into inquisition, once the invocator meets this standard, I find no reason to engaging in further epistemic inquiry.

We should also apply this practical guideline when appraising the clinical understanding of surrogates. April, for example, seems to understand her mother is unconscious and nearing death because of a series of strokes. She also understands that burst suppression therapy—a therapy once thought a viable medical option—will only hasten her mother's death. An understanding of the patient's diagnosis and prognosis is a necessary (but not sufficient) condition when acting as a patient's surrogate. A surrogate who claims to know the patient's preferences, but fails to understand the patient's clinical, biophysical situation will be unable to make an informed decision. Indeed, we should think of knowledge of the patient's clinical

situation as a prerequisite to any expression of preferences. So a prospective decision maker, like Maria—who appears unable to grasp the relationship between BST and a premature death—should be excluded from decision making because she cannot grasp the patient’s biophysical condition.

Given our project, we ought to make a distinction between potential surrogates who: 1) misunderstand the clinical situation, 2) disagree with the clinical imagination’s portrait of the patient’s situation, and 3) appear to understand the clinical imagination’s portrait of the patient, but also interpret the clinical encounter with a religious conceptual scheme. In the first scenario, the potential surrogate simply cannot grasp the patient’s illness—or is unable to communicate their understanding to the care team, making him unable to make an informed decision about the patient’s care. The second kind of potential surrogate asserts (or argues) that the clinicians involved in the patient’s care have failed to give an accurate diagnosis or prognosis. It is unlikely that this kind of potential surrogate would meet the standards required of a surrogate. We see here that exhibiting an understanding of the patient’s condition implies tacit consent with the clinical imagination’s picture of the *clinical* situation. This tacit agreement is made manifest when the surrogate makes an informed decision.

The third kind of potential surrogate is of special interest to us, given our goals. It is in this category that the ethicist will often find miracle-invocators (both existential and unshaken). For example, both of Mrs. O’Shay’s daughters employ miracle-language while simultaneously *accepting* that a naturalistic epistemology can be informative. We should not assume that miracle-invocators necessarily reject the importance of a materialistic ontology; instead, they place restrictions on its power to explain the world. April and Maria apparently understand their mother’s status epilepticus and dire prognosis, while also hoping that a miracle will occur. The

religious imagination has the ability transpose an additional conceptual scheme onto the clinical imagination's materialistic ontology without rejecting the accuracy of the clinical picture.

Should the transposition of an additional ontology disqualify the miracle-invocator from acting as a surrogate? Not necessarily—as long as the clinical imagination's portrait of the patient is has priority. Without this priority, the invocator may be unable to sufficiently understand the clinical imagination's analysis of the present (diagnosis) or projection of the future (prognosis), making the loved-one an untenable candidate for surrogacy. However, if the candidate can prioritize the materialistic ontology over their non-materialistic ontology, then the hope for a miracle should not necessarily exclude the invocator from acting as a surrogate. As we answer the question, "What does 'miracle' mean for this person?" empathetic imagining and epistemic inquiry must play a foundational role in the construction of our practical response. Also, we will continue making a distinction between the patient-invocator, the surrogate-invocator, and the loved-one who uses miracle-language.

Responding to Unshaken Invocators: Doxological

As we have seen, there are two kinds of unshaken invocators: political and doxological invocators. Both of these invocators use miracle terms while refusing to openly discuss their conceptions of the divine, the world, and themselves. Unshaken miracle-invocators might be willing to talk about their religious views. They might be willing to tell the ethicist about their views on salvation and the power of Christ, but these conversations would likely have an evangelical hue—especially if the invocator intends to have an effect on clinical care. We should not, however, equate *talking about* what one thinks about the divine with openly discussing such topics. Open discussion in our context features a willingness to engage in self-reflection.

Recall, both the political and the doxological invocator have solid conceptions of the God and the world, making any extended attempt at discussing the coherence of theological tenets fruitless. Attempting to force invocators like Maria, April, or Mrs. Montmartre into a prolonged conversation about accepting a new conception of Divine Action will sew tension between the invocator and the consultant. Since no significant benefit could come to the invocator, “theological negotiation” should be excluded as a practical response to unshaken miracle-invocators, be they patients, surrogates, or loved-ones. We will return to the prospect of theological negotiation later, when responding to existential invocators.

What the consultant must remember, however, is that the doxological invocator’s conception of the world includes entities and forces beyond the materialistic ontology promoted by the clinical imagination. The doxological invocator’s universe contains extra-material entities: a God, angels, and individual souls. Metaphysical commitments include Divine causality—wherein God can cause (or activate) a miracle-event. For the innocuous miracle-invocator, this interpretation of the world does not have a discernable effect on the medical care the patient receives. The invocator finds compatibility between the clinical imagination’s interpretation of the world and her own. For example, April’s view of the world makes room for the possibility of a miracle-event, without imposing this worldview on her mother’s care—she tells the team, “I believe a miracle can happen, but I also believe God works through humans. We are His instruments. God will do what is best for my mother.” Here, the invocator accepts the validity of clinical imagination, even though she finds it an incomplete tool for analyzing God’s creation. If the ethicist finds himself in a scenario wherein only innocuous doxological language occurs, the language will have little influence on the ethicist’s tasks and goals. Thinking back to Mrs. O’Shay’s case, had April been the only family member available to make medical decisions

about her mother's care, little conflict between the Neuro-ICU team's prognosis and Mrs. O'Shay's preferences would have arisen. Indeed, had Maria been absent, it is unlikely the Neuro-ICU team would have had reason to call ethics, as Bruce and April agree with their mother's care plan. It is only with the addition of an efficacious doxological invocator (Maria) who claims to be the best choice for surrogate that conflict ensues—and the Neuro-ICU team calls in the ethicist.

I should note that the clinical ethicist rarely encounters miracle-invocator such as April because this kind of invocator does not prohibit or complicate the decision making processes involved in end of life care. The ethicist has two primary inroads for *entrée* into the clinic: conflict and confusion—when neither is present (as would be the case with Mrs. O'Shay had Maria been absent), the ethicist will remain ignorant of clinical goings-on. Of course, many consultants attempt to get involved *before* conflict arises, hoping to prevent confusion by facilitating clear communication and setting expectations. It may be in this context of preventative ethics that the consultant hears innocuous miracle-language. For example, an ethicist joining rounds in a Neonatal ICU will hear parents and clinicians using doxological miracle-language in an innocuous fashion. In these scenarios, we find no evidence that this kind of miracle-language will lead to morally fraught situations where conflict and misunderstanding will linger because the invocator hopes to place his worldview above that of the clinical imagination.

However, unlike the innocuous doxological invocator, the *efficacious* doxological invocator insists that his conceptual scheme be placed above the clinical imagination's worldview; he insists that the non-materialist ontology he accepts be used to explain the sickness and possible healing of the patient. While the clinical imagination envisions medical decisions as

events that take place within a materialistic ontology, the efficacious doxological imagination attempts to transfer the decision making authority to their own, non-materialistic ontology. The doxological imagination wishes to superimpose its worldview over the clinical imagination's conceptual scheme. It is in this attempted prioritization of the invocator's worldview (and how one should act as a participant in this world) over the clinical imagination's worldview where conflict and moral distress arises.

Without the option of in-depth theological negotiation, the ethicist will find herself in the role of a mediator when addressing efficacious doxological invocators—at least initially. The ethicist will try to mediate by first finding the core of the disagreement. Augustine has helped us see that this disagreement is founded in divergent moral ontologies: conflict arises between the efficacious doxological invocator and the clinical imagination because of a disagreement regarding *moral* ontology. The doxological invocator places fidelity to God above any other commitment. Rejecting the clinical consensus and fighting for a certain version of medical care can follow from this commitment.

When addressing a doxological invocator who hopes to have an effect on clinical care, the question for the ethicist becomes, “When *should* a religious conception of the world be used when making medical decisions?” This question will never occur for the innocuous invocator because the possibility that the religious imagination replace the clinical imagination does not occur. The clinical imagination—as we saw in chapters one and two—has developed practices wherein religious commitments can override clinical recommendations. For example, hospitals policies allow competent Jehovah's Witnesses to decline certain blood products, even when the clinical imagination has deemed such a therapy essential for routine care. We can envision a Witness who reaches end-stage renal failure and refuses dialysis. He speaks with the Elders of

the Church; they tell him that it is his decision to make. He deliberates, and he decides that he will not undergo dialysis. Instead he wishes to receive home health care, and he accepts that he will eventually die due to complications from renal failure. While his nephrologist disagrees, the institution accepts that this competent Witness can reject the clinical consensus in order to preserve *spiritual* well-being over *physical* function. Here, the institution allows the individual to go against medical advice by refusing and dissenting from the clinical standard. We can think of it this way: policies that allow dissent from routine procedures based on religious considerations make an exception for the religious imagination.

The position of an efficacious doxological miracle-invocator is markedly different than that of the Witness in that the efficacious invocator is asking that the clinical team provide additional—not fewer—services. Mrs. Montmartre is requesting extraordinary services for her anencephalic infant. Mrs. Montmartre is a decision maker who, like the Witness, rejects the medical consensus; however, she is seeking additional, not fewer, services for her child. The moral weight of the decision shifts with this change from *refusing* therapies to *requesting* them. For the Jehovah's Witness (or the Christian Scientist), the clinical imagination accepts that autonomous dissent from an otherwise routine therapy can preserve an individual's spiritual well-being. With the efficacious miracle-invocator, however, questions of justice, beneficence, and non-maleficence come are raised. We need not rehash our discussion of the controversy that arises when a miracle-invocator requests therapies, but we should note that the distinction between refusing and requesting a therapy shifts the moral onus from the issue of patient autonomy to questions of justice and professional integrity. While a patient has the negative right to reject a therapy, she does not have the positive right to receive any desired therapy (recall **A:**

Consci. Clause). This shifting of the ethical burden makes the acceptance of a miracle-invocator's religious imagination an arduous task for the clinical imagination.

Another notable difference: a typical doxological miracle-invocator does not have the quality of institutional support when compared to the Witness. The Witness has a policy that makes room for the possibility that she can reject certain forms of therapy for solely religious reasons. The interests of the *individual* Witness has been codified (in policy form) by pressure from the spiritual *community* in American hospitals. While the institution also delivers support through chaplains or spiritual care professionals, the doxological invocator has no policy that protects her spiritual interests. Of course, the doxological invocator's community can still affect the invocator's spiritual care. Support from the community takes different forms: prayer at the bedside, spiritual counseling, mediation. Nonetheless, for the clinical imagination, the spiritual goods of an individual cannot trump either the professional integrity of an individual caregiver or the social cost without sufficient justification.

Given these differences, might there be scenarios wherein the spiritual well-being of a doxological miracle-invocator *ought to* outweigh other goods, such as the good of a physician's professional integrity or the duty to allocate resources properly? When the efficacious invocator is the patient's loved-one, we can answer with a firm, "No, the spiritual well-being of the invocator ought not overwhelm other interests." A non-surrogate loved-one can contribute to a discussion of patient preferences, but the ethicist need not employ her skills on such an invocator: the ethicist's goal is to help care for the patient, and expanding the ethicist's scope to include caring for an ardent loved-one does not serve the goal of patient care. With a surrogate who uses doxological miracle language, however, the ethicist's answer is not so clear-cut. The medical establishment calls upon the surrogate to make a *substituted* judgment. The clinical

imagination calls upon the surrogate to espouse the values of the patient rather than her own set of preferences and values.

This introduces an important task: the ethicist must attempt to separate the voice of the patient from the voice of the surrogate invocator. This is no easy task. Studies have found that about one third (34%) of surrogates fail to give an accurate report of the patient's end-of-life preferences *even after* the patient and the surrogate have had discussed end-of-life options (Shalowitz et al. 2006, 497). Perhaps the surrogates confuse the patient's beliefs and preferences with their own; or, they rely on a "best interest" standard rather than a *substituted* judgment. Whatever the case may be, the inaccuracy of surrogates should trouble the ethicist because she cannot treat the surrogate's word as completely accurate testimony. Since one of the ethicist's tasks in patient care involves excavating the values, principles, and stories that inform patient preferences, and surrogates are not completely reliable links to the patient's preferences, how might the ethicist respond to a surrogate's efficacious doxological invocation?

Distinguishing the invocator's voice from the patient's voice will be paramount—without making this distinction, our response will be misdirected. To do this, the ethicist might begin with an informal assessment of the patient's spiritual beliefs. The ethicist could ask, "Can you tell me about [the patient's] religious life?" This question will give the doxological surrogate a chance to describe the religious imagination of another person. If the surrogate answers this question without referring to his own religious beliefs and activities, the ethicist can then say, "I understand that Christianity plays an important role in your life too...Could you tell me about your religious beliefs?" This assessment will give the surrogate-invocator an opportunity to recognize the distinction between making a decision based in the values of the patient and making a decision based in surrogate's own values. If the surrogate appears to be conflating his

view with the view of the patient, then the surrogate should be told that he is to make a *substituted* judgment by appealing to the patient's preferences, not his own. If the invocator fails to make this distinction, then he should be excluded from the medical decision making process. However, if the surrogate appears to be acting in accord with the patient's preferences, and conflict between the clinical team and the surrogate continues, then the ethicist might find it expedient to bring the invocator's authority figures into the clinic. The work of Brierley et al. has shown us that hardline positions can be softened when trusted clergy are brought into the conversation (2012). When given the chance to openly discuss their hope for a miracle with a comforting presence, the doxological invocator might find that he was mistaken about the theological accuracy of his hope. Perhaps he will find that God does not wish the human body to be kept alive under all circumstances.

The ethicist should let the clinical care team know that religious language does not necessarily translate into a right to receive any treatment deemed necessary by the invocator. Here, we accept that **Argument: Do No Harm** and **Argument: Conscientious Objection** take precedence over the doxological invocator's argument that she has the positive right to a therapy the clinical imagination deems harmful. Back to Mrs. O'Shay's example: even if Maria were acting in accordance with her mother's wishes (and she has been part of her mother's religious community for some time), it doesn't necessarily mean that the patient is entitled to treatment. If the physician believes her professional or personal integrity is being violated by continuing to perform aggressive measures on Mrs. O'Shay, then the institution's mechanisms meant to protect the Neuro-ICU attending from acting against her conscience should be initiated.

The ethicist will likely play a key role in the process as it moves forward. He may be charged with discussing the physician's view with the surrogate. She might say, "We understand

your hope for a miracle, and we understand that it is what [the patient] would have wanted. But we at [institution] cannot continue to provide the kind of aggressive care you want.” From this point, the ethicist should continue to work toward an amicable solution. Not merely because this is the right thing to do from a risk-management perspective, but more importantly because empathetic imagining reveals the unfortunate fact that the invocator firmly believes that his worldview insists upon a certain stance toward life and death. The doxological invocator attempts to live in accord with her conception of God’s law—this invocator is attempting to love God as she sees best and act in accord with this assessment.

Responding to Unshaken Invocators: Political

The religious imagination of the political invocator lacks complexity, nuance, and systemization. The components of this invocator’s imagination may have religious cache. That said, no exploration of the world or self occurs for the political invocator, therefore, I believe the ethicist need not view political invocations as serious reflections of religious beliefs. Here again we must make the distinction between the patient, the surrogate, and the loved-one. Like the loved-one who uses miracle-language in a doxological fashion, the loved-one who uses “miracle” in a political sense should not be allowed to effect clinical decision making. First, the ethicist should reestablish her conclusion that the invocator continues to use “miracle” in a political sense. The tell-tale signs include: facile, unspecific appeals to the possibility that God will work a miracle, little connection with any Christian community, hostility toward clinicians and chaplains, and the threat of litigation. Secondly, if the invocator continues to show these characteristics, then the ethicist can treat the miracle-invocation as unassociated with any

attempt at expressing a religious belief. Treating the invocator's miracle-invocation as an expression of a more secular concern will involve interpretation and translation for the ethicist.

The surrogate who uses miracle language in its political mode will fail to act as a *surrogate* decision maker unless the scheme he appropriates can be identified with the worldview of the patient. For example, if the stress of her mother's sickness causes Maria to appropriate her mother's conception of the miraculous, then it is possible that a political surrogate be acting as a true surrogate. However, given that the political invocator's *m.o.* (using Christian language to gain power over family members or clinicians) it is unlikely that she will appropriate the patient's values. The more likely scenario: since miracle-language offers a quick and impressive way to make some clinicians feel uncomfortable and pensive, the political invocator's newly formed religious imagination will not overlap with the patient's conceptual scheme. When this occurs, the ethicist must question the propriety of the invocator's role as surrogate. The ethicist will remind the surrogate that her role involves making a substituted judgment; specifically, the political invocator must: set aside her own conception of the world, inhabit the world of the patient, and make decisions from within this perspective. As we saw with the doxological invocator, if the political invocator is unable or unwilling to do so, then the ethicist should work to find a new surrogate decision maker. The new surrogate, if a member of the patient's family, should appropriate the perspective of the patient; or, if the surrogate is a member of the clinical staff or the clergy, he should use the standard of best interest in order to orient his decision.

Unlike the doxological invocator—who entered the clinic with a solid sense of self and God—the political invocator appears to be using religious language as a coping mechanism. The stress of clinical experiences has resulted in a change in his psychic disposition. It is up to the

ethicist to realize that political miracle-invocations can be reactions to a feeling of powerlessness. The ethicist might ask, “Do you feel like the team isn’t listening to you?” or “How do you think you have been treated in your time at this hospital?” We should note, however, that the political invocator may latch onto religious language for a number of reasons—some of them quite justifiable. For example, if the invocator—be he the patient, surrogate, or loved-one—is a racial minority who feels beaten down or ignored by the institution, he may use miracle-language in a justifiable attempt to be heard by the medical community. The political invocator might refuse to place trust in the clinical team because he has been injured or mistreated by an individual medical professional or an institution. Perhaps a physician misdiagnosed a family friend, or perhaps the invocator views hospitals as callous and greedy institutions that put profit margins before patient well-being. In these scenarios, the ethicist might try to alleviate fears of mistreatment by: convening team meetings in an attempt to relay uniform messages, continuing to act as an empathetic rather than judgmental presence, and facilitating more open dialogue between key members of the team and the invocator.

Responding to Existential Invocators

The existential miracle-invocator deserves the bulk of the ethicist’s attention. The existential invocator is open to the skills the ethicist has to offer her clinical care. Recall, we divided existential invocations into two categories: pedagogical and tragic—both of which contain miracle-invocators who are open to self-reflection. Both kinds of existential invocators use “miracle” while trying to find a coherent, sensible self. The pedagogical invocator finds solidity, a foundation from which to imagine, interpret, and act; the tragic invocator, however, leaves the clinic shaken and rarefied. When attending to a patient who uses “miracle” in an

existential sense, the ethicist's goals should involve helping the patient come to a new understanding of himself and his world—or, minimally—helping the invocator avoid tragedy. How does the ethicist go about helping the patient find a more solid, cohesive concept of self? How does the ethicist help the patient look inward into herself, outward into the world, and say, “despite my clinical experiences, the world makes sense.” Although the ethicist should not take a linear approach to this kind of conversation, after assessing the invocator's understanding of her medical portrait, the ethicist might model her response on the kind of “care for the soul” we saw in the previous chapter. The existential invocator is, like Augustine and Socrates, searching for a fundamental foundation from which she can live and love rightly. The goal of these conversations would not be mediation or the translation of values into clinical preferences, although these goals inform the conversation. Instead, here the ethicist engages the invocator in a more intense and important task: helping the invocator understand herself and her world.

Let us return to the models of Socrates and Augustine for guidance while engaging the existential invocator in self-reflection. Both thinkers are searching for coherence of thought and fidelity between belief and action. Socrates spends his life rejecting the safety of mythical understandings of the world. Socrates “does not say what is good, he only invites people to *think*, that they think like him, that they search, that everyone *responsibly* examine their every thought. This means that they should not accept mere opinion as if it were insight, as if it were a looking-in—to live from true insight into what is here, what is present” (2002, 85, italics Patočka's). He does this by searching for solidity in coherence of thought (*ibid.*, 92). The heart of the Socratic inquiry is to relentlessly question what one assumes, asserts, and performs. Care involves the realization that thoughts must be “bound together” via reflection, not mere myth (*ibid.*, 93). It might be the case that the search for knowledge *itself* can provide a fundamental orientation for

the living of one's life. Unlike Socrates, it is very likely that the invocator believes she has found some version of truth; therefore, Augustine's search for rest (*quiesco*) can be an informative example as well. Recall, that Augustine's search for knowledge of himself and his world leads to a continuous searching for answers *even after* he has settled on certain dogmatic propositions, e.g., the omnipotence and benevolence of God.

Context is so utterly important that applying this insight to our practical response to existential invocation requires a deft touch. That said, the ethicist should help the invocator find solidity by asking questions such as: "You say that you hope for a miracle...Could you talk with me about way this hope is so important for you?" "What do you think happens after we die?" "What do you think about God, and does God play a role in your life?" These are heady questions that can easily offend; however, the ethicist will get a sense of the invocator's worldview only through dialogue about what is important—dialogue about *why* miracle-language plays a role in the invocator's conceptual scheme.

When the invocator responds to these questions, the ethicist will listen carefully. What makes this response distinct from empathetic imagining comes next: the ethicist will then situate these answers. "Situate" here means to make connections, contextualize, and set-limits, for the sake of a search for coherence. Additionally, the ethicist must be cognizant of his own biases and prejudices (Gadamer 2004, 299-306). Speaking personally, if I were to have a conversation with an existential invocator, I would have to be aware of the fact that I do not share the invocator's conception of what is. My conception of the Divine is distinct from a Christian God who has the ability to work miracles. We are not committed to the conclusion that the ethicist must facilitate the finding of Truth *in esse*; instead, the ethicist has the simpler task of facilitating an analysis of *the invocator's* conception of truth. If Mr. Greenfield were to say that he believes God is all good

but also punishes him for his sins, the ethicist can push the invocator to examine this commitment. Perhaps asking, “Mr. Greenfield, can you tell me how God can both love you and punish you for your sins?” or “Why do you think God is punishing you?” or “In what way has God show love to you in the past?” The ethicist’s skill and ability to analyze arguments and uncover assumptions will be of primary importance. What does the invocator assume about the relationship between God and humanity; or, sin and redemption; or, Christ and the miraculous? To answer these questions, the ethicist will search for reasons and stories behind the invocator’s conclusions. With sustained effort, the ethicist might help the miracle-invocator find a sense of self despite the circumstances that shook him in the first place. Perhaps Mr. Greenfield will find that evangelical Christianity can explain his suffering and provide a coherent picture of the world and his place in it. Or, perhaps he will reject the possibility that there is a God who interacts with humans. Wherever reflection leads, the ethicist devoted to promoting the overall well-being of the allocated will engage in this kind of dialogue.

Notice, that the ethicist promotes self-reflection from *within* the invocator’s conceptual scheme. To do otherwise—to add concepts to the mental furniture of the invocator’s mind—is a very dangerous prospect. Providing external critique commits the ethicist to a search for Truth. While some have argued that the role of the ethicist involves such a search (see: Meyers 2007), we will confine ourselves to the more modest position that the ethicist promotes the invocator’s search for solidity, not necessary the search for Truth in itself.

If the ethicist ignores the existential invocator’s search for solidity, then tragedy occurs when the invocator fails to come to a self-understanding. Although this unfortunate scenario might occur independent of the ethicist’s efforts, the ethicist should attempt to help the invocator find an anchor from which to live and act. We must draw the conclusion that the ethicist owes

the existential invocator her time and patience because of the severity of the tragic outcome. Here the “clinical ethics consultant” acts as an ethicist in a more robust sense: as a person concerned with the well-being of those who are shaken by circumstance. Indeed, if the ethicist fails to devote the necessary time and mental energy required of her from the existential invocator, then she fails to be an ethicist; rather, she is reduced to the role of a professional consultant devoted to efficiency before moral distress.

Neither the doxological nor the political invocator will want to negotiate theological tenets. No amount of formal critique of belief will persuade him to accept a different conception of the miraculous. However the practical response we know as “theological negotiation” can be of service when conversing with existential invocators. Although Connors, Jr. and Smith left much to be desired in their conception of theological negotiation, it can still be an expedient response because this response can solicit patient values. A notable danger accompanies theological negotiation, however. The ethicist may very well believe in the miraculous. If this is so, then the ethicist might be tempted to convince the invocator of his own conception of the miraculous—believing his vision of the divine a superior vision. When the ethicist pushes his own theology on the invocator, he will fail to attend to the invocator’s concerns rather than his own. We should also note that pastoral care and/or outpatient psychiatry services can be of great (perhaps indispensable) importance for this task of responding to existential invocations. Indeed, if the ethicist does not feel comfortable discussing theology with the invocator, then he should employ the services of the clergy—be they hospital staff or the leader of the invocator’s congregation.

Concluding Thoughts

As I conclude this dissertation, I should take a moment to address the most pressing critiques of this chapter. Just as I have excavated the moral, epistemic, and ontological values that buttress the practical responses by other scholars, I should do my best to make my assumptions explicit. First, some readers will find the division between unshaken invocations and existential invocations objectionable or suspicious. I am assuming that a life well-lived will be reflective and open—not reflexive closed off from conversation, therefore, I am working with a conception of the “moral life” or the “life well-lived” that not all readers will accept. We see my bias in my reading of Augustine: even a theologian who holds that some propositions are absolutely indubitable still engages in self-reflection. Therefore the unshaken invocator’s refusal to discuss her beliefs shows an intellectual hubris that even the father of dogmatic theology did not harbor.

Relatedly, the reader might wonder: why should the ethicist spend her time helping miracle-invocators shore up their own self-conceptions? Wouldn’t the hospital’s chaplain or a psychiatric service of some sort be better suited for the task? While a chaplain and the psychiatrist can be indispensable allies, the ethicist should not shirk his responsibility to address the suffering of those she encounters in clinical spaces. We see that I am attempting to proffer practical responses that do not require the ethicist share a system of belief with the invocator. Some bioethicists argue that such a task is impossible. The most well-known proponent of this view would be H. Tristram Engelhardt (see 2012, 97-105). He argues that there can be no authentic discussion of morality outside of religious systems of belief. The “secular bioethicist” who attempts to discuss issues of moral importance will fail to promote the patient’s interests *unless* she already shares the patient’s conceptual scheme. If we apply Engelhardt’s critique to this dissertation, we would find that since the ethicist does not share the invocator’s belief in God

and the miraculous, he will be unable to promote the patient's overall well-being. If one believes Engelhardt to be correct, then this dissertation will be of little use due to the fact that the ethicist (probably) does not share a conceptual scheme with the invocator. I disagree with Engelhardt about the nature of moral discourse and the nature of clinical ethics consultation; therefore, I accept that if the reader holds a view akin to Engelhardt's, this dissertation will be less than convincing.

The reader could also critique this dissertation by arguing that I overemphasize the importance of coherent self-reflection in the construction of selfhood and the world. I believe this is a fair criticism; I do indeed emphasize the importance of coherence between propositional beliefs. But I remind the critic that I am not wedded to the notion that propositional coherence is the sole form of gaining solidity or doing self-reflection. As Carol Gilligan has shown us, our moral worlds are formed by more than the cold logical of assent to the truths reason illuminates (1982, 172-76 especially). Nonetheless, for the clinical consultant, whose profession relies on conversation and discussion before all else, I believe it is fair to emphasize the importance of the coherence of ideas. And I do not believe this puts me at odds with thinkers who emphasize narrative as the proving ground of belief. Coherence can come in the form of a robust narrative—even when the narrative cannot be translated into propositional assertions about, for example, the nature of Christ's divinity. The ethicist should be open to the possibility that stories, images, and rituals—not solely doctrines—furnish the invocator's moral imagination.

In this chapter, I have put forward a series of practical responses to miracle-invocations. We began this dissertation with a series of questions, with the orienting question being, "How should the clinical ethics consultant respond to miracle-language in clinical end-of-life settings?" (3). I have argued for an approach that emphasizes the complexity of the religious imagination

and the importance of facilitating self-reflection. It is my sincere hope that clinical ethicists will find this dissertation a helpful guide when responding to miracle-invocations.

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