

If full human healing is to occur, theological reflection is imperative. As a means to engage in such reflection, one may consider the special medical case of a burn victim and examine it in light of the church's tradition. The ethical issue this case raises is that of "life" versus "quality of life."

A Case for Theology in the Ministry of Healing

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The Ambiguous Quest for Healing

HEALING IS BIG-TIME BUSINESS in America, consuming upwards of twelve percent of our gross national product and employing one of our nation's largest work forces. Such a sizable commitment of resources indicates that the quests to be well and to get well are either signs of our national health, indications of a national obsession, or perhaps both. Clearly, Americans value health and will spend lavishly to get it. Yet, all is not well with the American pursuit of health and healing. Newspapers regularly report on maladies and epidemics that afflict public and individual health. AIDS, breast cancer, and Alzheimer's disease are just a few of the many killer diseases that plague our society with demonic and seemingly intractable ruthlessness. The evening news on television regularly confronts us with other public enemies, many of them the results of lifestyle choices. Airplane crashes, substance abuse, time bombs ticking within the food we eat, the water we drink, and the air we breathe—all leave us wary at best, paranoid at worst. The exercise industry booms, as do those offering stress reduction, or modification of bad habits like smoking or overeating. Crime, systemic unemployment, racism, sexism, and other large-scale social maladies undermine personal and social strategies to achieve wholeness. What is more,

our pluralism and individualism make it virtually impossible to come to agreement about the nature of our problems and the best solutions to them. Scholars like James Davison Hunter claim that divisive health-related issues like federal abortion policy push us to the brink of "culture wars" in which, increasingly, real bullets are fired.¹

Even our highly touted medical breakthroughs pose problems. Life-sustaining treatments and life-support mechanisms like artificial respirators have made it possible to keep people alive long enough for their bodies to mobilize their own healing capacities so that good health can return. On other occasions, however, these same medical marvels can and do extend suffering so greatly that medicine begins to look like an enemy. Now our legislatures and courts debate the "right to die" and the ethics of euthanasia, while individual citizens ponder Dr. Kevorkian's suicide machines. During the past three decades, gifted physicians have discovered how to transplant organs from living and dead donors to critically ill recipients, and Americans almost immediately found themselves faced with justice issues. Who receives the heart from the victim of an automobile accident? Which is a better allocation of resources, the expensive surgical and pharmaceutical efforts to extend the last months of failing life or programs of sex education for young people and prenatal care? In an era when the percentage of children born below the poverty line ominously increases, how do we value costly fertility therapies and technologies for affluent childless couples and individuals? So perplexing are the new quandaries and dilemmas posed by our medical abilities that a new field of studies, bioethics, has come into being.

The Christian church lives out its calling in the midst of this enormous, ambiguous, and complex quest for health and healing. To be sure, it has often been at the forefront of the quest, fashioning distinctive institutions like hospitals, hospices, and social-service agencies to provide care and cure for the ill and suffering. Few institutions, if any, can rival the churches of our land in their attempts to mobilize people for ministries of healing and practices of healthy living. Yet, the churches, notwithstanding these impressive and often underappreciated contributions, have also found themselves pushed to the health-care sidelines, marginalized by cultural forces and dynamics like secularism, specialization, professionalization, commodification, and the explosion of new medical science with its accompanying technologies. So powerful are these complex social processes and so sizable their consequences that religious communities routinely find themselves struggling to find a niche in the very institutions they created to carry out their healing ministries.

In hospitals and countless other health-care institutions across the land, a division of labor routinely hands physical healing over to medicine and its functionally secular allies, leaving religion with ancillary tasks, such as care for the soul and tending those like the poor and elderly for whom the medical cupboard is bare. Signs of the deep estrangement between religion and modern

forms of healing are everywhere: Pastors feel like aliens trespassing on someone else's planet when they call on parishioners in the hospital; bioethics consultations remain silent about the religious perspectives and values swirling around the "hard facts" of individual cases; and as the sales of church-sponsored hospitals to secular corporations proliferate, church members search privately, often desperately, for the presence of God in their modern experiences of illness and dying.

Indeed, the Christian tradition, along with its other religious siblings, appears to many in the second half of this century to be suffering from a serious disease. Its tradition of linking love of God and neighbor, of relating health and salvation, of combining practices of healing and caring has fragmented and eroded. Debates about the role of faith in healing, efforts to recover liturgical practices of healing, and the invention of new mediating institutions to bridge the gap between church and health care are, at the same time as they propose prescriptions for cure, protests against what Paul Tillich once called "unhealthy religion" and "unhealthy health."² Radical questioners like Stanley Hauerwas call for the church to break its pact with the culture spawned by the Enlightenment and to become once again a contrast model to the culture.³ Others, like Protestant Martin E. Marty and Catholic Richard McCormick, attempt to develop strategies whereby the churches and the health-care institutions they sponsor can fashion new identities that welcome modernity's good gifts but bring them into a healthier relationship with the core beliefs and commitments of their faith traditions.⁴

Getting Down to Cases

The Hebrew and the Christian scriptures abound with particular narratives or important case studies that disclose the essence of what it means to be part of the people of God or the body of Christ. Thus, we read about the barrenness of Sarah or the impotence of Abraham or about Jesus' opening the deaf-mute's ears and mouth. Modern medicine, too, teaches and learns through cases as it tests different therapies and medications in the real-life laboratory of the sickroom. In both realms, one learns about the human predicament and its amelioration by paying close attention to the particularity of human experience.

For the purposes of this essay, I have selected one particular medical case for special attention because of its peculiar disclosive capacities. This case, one in America's growing twentieth-century canon of celebrity cases, is important both for what it reveals about modern efforts to heal and about the contributions that theology can make to the modern pursuit of health.⁵

Donald "Dax" Cowert moved from the world of normal life into the realm of celebrity patient on July 23, 1973. Prior to that day he had been "Donny Boy," athletic stand-out at his high school in Henderson, Texas, rodeo rider, skydiver,

and risk taker. After graduating from the University of Texas at Austin, Cowert abandoned plans to join his father in ranching and real estate ventures, opting instead to join the Air Force. Cowert became a pilot and emerged unscathed from his Vietnam tour of duty. The only personal casualty during those precelebrity years was the breakup of his marriage to a high school sweetheart.

In July of 1973, Cowert was home from war, discharged from duty, dating again, and weighing options for the rest of his life. Would he become a commercial pilot, a real estate broker, or attend law school? The answer came on July 23, and it was a shattering "none of the above." He had driven with his father to look at a nearby ranch that was for sale. After traipsing across the ranch, the two men returned to their car to drive home. The car would not start. They raised the hood to prime the carburetor. Then they turned the ignition and their worlds came to an end. Donald's father died shortly after the fireball ignited around their automobile. Donald was, as he claimed then and still insists today, not so lucky. A leaking propane gas transmission line that had surrounded their car with an invisible, odorless deathtrap turned Donald into the "Texas burn victim" when the primed carburetor sparked.

As he lay on the ground waiting for the ambulance, Cowert made his first plea to be allowed to die. He asked the first person on the scene for a gun to take his own life. The farmer refused. In a later film about his ordeal, *Dax's Case*, Cowert describes his excruciating pain graphically, recalling the experience of seeing out through eyes that were searing into blindness and crying out for pain medication. As he endured the 140-mile ambulance ride to Dallas's esteemed Parkland Hospital, Cowert entered the world of the burn victim, one of the most painful worlds in modern medicine. A 232-day hospitalization began in which Cowert experienced medicine's gifts to him as torture. With severe burns over sixty-five percent of his body, tubes and catheters intruding and extruding everywhere, and the full antibacterial and narcotic armamentarium released into his body, Cowert began to endure the painful regimen of daily tankings to cleanse his wounded skin and debridements (cutting away dead or diseased tissue). Stubs of his burned fingers were amputated, and one of his blind eyes was surgically removed. The first several weeks of care were a battle with death. Those weeks were followed by months, and then years, of skin grafting, reconstructive surgery, and physical therapy.

Throughout his hospitalization, Cowert kept repeating the plea made to the farmer. He asked his mother, his family, the head of Parkland's burn unit, Dr. Charles Baxter, his attorney, Rex Houston, a special nurse named Leslie Kerr, and others to stop his treatment. They heard his request, but chose not to honor it, setting in motion a troubling power struggle in which the odds were decidedly one-sided. To Dr. Baxter and his medical colleagues, Cowert was a patient in need of medicine's best and his cries were the predictable "typical response" of a burn victim. There was so much that medicine could do for this patient, as was

clearly evidenced by Cowert's eventual recovery. Not to act, not to do the good that medicine knew how to do was medically unconscionable. For his part, Attorney Houston saw the enormous settlement value in this accident and knew that a live patient was necessary to protect the family's interests as they pursued their case against the pipeline owners. Cowert's mother, now a widow, felt constrained by religious beliefs that could not condone mercy killing or suicide and worried about her son's eternal welfare since he had not made "peace with God." Possessing power of attorney and backed by the experts around her, she refused to let her son die.

On several occasions during Cowert's rehabilitation, he made attempts to end his own life. On one occasion during hospitalization at the Texas Institute for Research and Rehabilitation at Houston, Cowert refused treatment for his open wounds and stopped taking food and water. On another occasion, after he had returned home to Henderson, Texas, he was discovered at the edge of the road in front of his house, planning how to throw himself in front of a truck. Years later in 1977, after he had learned how to navigate in a dark world and to eat, use the phone, and perform a myriad of daily living skills, he tried to take his life by overdosing on pain and sleep medications. Three years later he slashed his wrists with a razor blade. Each time the limits of his physical capacity and the patterns of care around him kept him from succeeding.

Cowert's ordeal, both as patient and as champion of the "right to die," brought him national attention. Films were made about his experience, articles and books were written, and the organization Concern for Dying made him the symbol of its cause. Near the end of the film *Dax's Case*, the camera closes in on the scarred face of the man who came to be called Dax Cowert. No longer Donny, he sits in his recliner chair, listening to music and sipping a beer in his Texas home. A law degree, a new marriage (which eventually failed), and a role as a public advocate are all signs of his remarkable recovery. Yet, Cowert nonetheless insists that even if he had known that this outcome was possible, if placed back in his original situation as burn victim, he would choose to die and his right to do so should be honored.

The Difference Metaphors Can Make

One of the most important analyses of Dax's experience comes from William F. May, a Protestant ethicist with long experience in the bioethics field. For May, the collision between Dax and those who kept him alive was due in large part to a fundamental misreading of the situation. Both Donny, who wanted to end his biological life, and his caregivers, who wanted to extend it, turned the crisis into an ethical quandary that weighed the value of an individual's life against a calculus about quality of life. Dax saw a future of pain, limitation, and disfigurement and found the quality of life waiting for him of

insufficient value as to merit extending his own life. In contrast, his doctors and other caregivers looked at what medicine could do and were reasonably confident that a sufficiently good quality of life was achievable as to warrant heroic efforts to save a life against the will of the patient. Thus, they entered into a tug of war about one of the classic bioethical quandaries, "life" versus "quality of life." Underneath this construal lay an image of life as a biological continuum, a line that could be extended or shortened by human decision and action.

For May, this reading of Dax's life as a biological continuum was wholly inadequate to the situation. In crises of the sort that Cowert had experienced, "one deals not with a continuous line that thickens and thins, depending upon circumstances, but with the experience of a definitive, substantive break." An approach to healing that focused on a skin graft here, an amputation there—a mechanical or functionalist understanding of healing—seemed beside the point to someone who had experienced "a total, comprehensive, all-penetrating, sun-blackening, oxygen-removing, flesh-charring, chilling, stilling, benumbing, and isolating death."⁶ Neither Cowert nor his healers recognized that Dax had experienced a death. Their biological reductionism led them into a frustrating arithmetic. One side added up how much biological life was left after the catastrophe and concluded that this was an insufficient amount and that death should occur. The other side did its own calculations and decided that death should be driven back, defeated.

May's point is that other ways of reading the situation, other root metaphors and descriptive languages, are not only possible but necessary if someone as deeply wounded as Cowert is to be healed. Dax needed more from his healers than "merely patchwork." His case required "radical reconstruction from the ground up."⁷ This kind of reconstruction, however, necessitates moving beyond a merely biological reading of life. May's alternative proposal involved repositioning Cowert's tragedy within the context of older, traditional views of healing. Following anthropologists Arnold van Gennep and Gerhard van der Leeuw, May suggests that Cowert's life could be fully healed only if it were placed into larger psychological, social, cultural, and historical contexts in a way analogous to the rites of passage in traditional cultures. "Periodically, men and women in traditional societies experienced the coming to an end of life as it was. They had to doff, as it were, the identity which was theirs, suffer a perilous period of transition, unclothed, until they entered a new estate, defined by a new identity, and new pattern of life, and accession to new power."⁸ This way of viewing life entailed much more than a biological continuum. Metaphors of "undressing" and "dressing" a suddenly exposed and vulnerable soul seemed more adequate than "repairing" or "patching." Speaking the language of death and resurrection, or viewing life as a flow of life, death, and rebirth experiences, made room for approaches to dimensions of Cowert's tragedy that the language of surgical reconstruction and physical rehabilitation had obscured.

May's analysis provides a powerful demonstration of the significance of larger theological understandings of health and healing. Paul Tillich, for example, viewed human life as a "multidimensional unity" among mechanical, chemical, biological, psychological, spiritual, and historical dimensions. Human illness could be caused by maladies afflicting any of those dimensions. Moreover, events affecting one dimension could have consequences in one or more of the others. To make matters still more complex, Tillich pointed out how interventions in one dimension—including actual acts of healing—could result in pathological, even lethal, consequences in others. For him, "complete healing includes healing under all dimensions."⁹ Dax's case provides vivid evidence of the importance of larger theological readings of human experiences of illness and healing. The languages of the religious traditions make possible alternative readings, understandings, and strategies of care. Following May's lead, we can bring other resources from the religious traditions, especially the tradition of Christianity, to cases like this one and see if these resources have disclosive and healing contributions to make.

Mystery and Gift

Centuries ago, perhaps as far back as the time of King David, a psalmist helped a congregation sing: "When I look at your heavens, the work of your fingers, the moon and the stars that you have established; what are human beings that you are mindful of them, mortals that you care for them? Yet you have made them a little lower than God, and crowned them with glory and honor" (Ps. 8:3-5). The mystery of the human person that inspired the psalmist so long ago still confronts us today, but in new, even troubling, forms like the victims of catastrophe. Faced with a body like Dax's—once so beautiful, then so disfigured, then so amazingly restored—the beholder is confronted with the wonders of creation in miniature. Ironically, the same medical science that opens the marvel of such bodies to our understanding, has demystified them, wrapping bodies like Dax's in layers of scientific explanation that render the human being an opaque barrier to the Creator's glory instead of the clear icon it was meant to be.

If our eyes are open, the discoveries of medical science take us deeper into the mystery of the Creator's work. In a body like Dax's we can expect to find more than seventy-five trillion cells. Not only can we count them, but we can now classify these cells into more than two hundred categories. As efforts to map the Human Genome proceed, we come closer to unlocking the mysteries of DNA and the chemical processes that ignite such an unfathomable process of growth—dare we call it creation?—out of the raw material contained in one spermatozoa and one egg. Within the blastocyte that forms from the union of these two packages of instruction and energy lies an encryption, a still-to-be-deciphered code which will guide life through stages of growth that recapitulate

much of the process of creation itself: single cell, several cells, embryo, fetus, infant, baby, toddler, child, preadolescent, adolescent, young adult, middle-aged individual, elder, corpse, and mitochondria that move on. This code functions as the new science's Holy Grail, luring with promises that once we find the key to the treasure chest, all sorts of health riches will appear. The genes that predispose for breast cancer, or determine eye color, or make one taller or shorter are seemingly within the reach of science. But without our understanding its intricacies, this code, different in each one of us, shapes cells into four basic types of human tissue: epithelial, muscle, nerve, and connective. Again and again over millennia, these tissues formed into organs, and then organ systems. Each of us, without a moment's thought on our own part, becomes a complex of integumentary (skin), respiratory, circulatory, digestive, excretory, nervous, endocrine, and reproductive systems. That we exist at all, that we are who we are, both as a species and then as individuals, should take our breath away. Yet, instead of feeling awe, gratitude, or wonder, all too often we become technicians of machines, counting our grams of fat, taking our pulse, and engineering our course of life.¹⁰ The scientific language of modern medicine, with its ever more precise technical terms, suffocates awe. Theology can make room for wonder by using different languages and different metaphors that reintroduce a sense of mystery.

Dax's case provides us further reasons to marvel. First, even if occasional medical failures make us pause in our affirmation of modern medicine—we have become so sophisticated that we now have a technical term for physician-caused suffering, "iatrogenic illness"—nevertheless, if we consider what medicine can do, we have further evidence of how humans have been crowned with "glory and honor." Medicine's discoveries, capacities, and accomplishments—as evidenced in the technical achievements in Dax's story—are traces of the *imago Dei*, the image of God. As physicians cut, suture, repair, prescribe, and rehabilitate, they bear witness, often unwittingly, to the mystery that encouraged the psalmist to sing: "You have given them dominion over the works of your hands; you have put all things under their feet . . ." (Ps. 8:6).

The mystery grows. An assault on a body like the one Dax experienced is so total that one has no reason to expect healing. To be sure, Dax required enormous assistance to recover. But within his own body, even against his conscious will, there surged an amazing life force that would not be denied. The body's recuperative powers, its immune system, and all of its other defense mechanisms, make it possible for humans to survive countless assaults. A full consideration of all that is happening each time one takes a breath, gulps down a Big Mac, embraces a lover, drives a car, or reads a book should leave us dazzled by the mystery of creation, both the original creation that set primordial life into motion and the ongoing creation that holds the body together when one sneezes or overwhelms the antigens of infection that would destroy life.

This larger reading of life, health, and healing is nowhere in evidence in the

descriptions of Dax's experience. Dax's body is viewed as a machine to be repaired, a biological system to be returned to equilibrium, a personal possession to be disposed of. In fact, the conflict between the physicians and the patient seems at times to be a contest between Dax's assertion that his body and life are his private property and his physicians' claim that Dax's body is a unit of biological life that imposes its own obligations to be healed and restored. Missing entirely are understandings of life as a gift from God, of healing as another dimension of the Creator's presence in life, and of gratitude for all that the body is, can do (as healer and healed), and will become. Instead, the events surrounding this tragedy take place in a grim context of power struggle, fear, and hopelessness. There can be no question that a crisis of this magnitude will occasion such responses. These are desperate moments, times of life-and-death struggle, and instances of sheer terror. But the Jewish and Christian traditions offer a larger horizon within which such moments can be placed. This horizon is one that includes recognition of the gratuity of life, of the creative presence of God, of a special relationship between God and human beings, and of genuine hope that God's creative work is not finished.

Finitude and Fallenness

Dax's case captures our interest because it takes us to the threshold of life, the borderline between being and nonbeing. Dax and his caregivers find themselves caught in what David Tracy has called a "limit situation." This special existential crisis is a time when "a human being ineluctably finds manifest a certain ultimate limit or horizon to his or her existence."¹¹ Such an encounter with finitude makes the psalmist's phrase, "a little lower than God," seem like a colossal euphemism. Dax encountered limits of every sort in his tragedy. Everything that he aspired to, every vision he had of his future, and every self-image he possessed were smashed on the rocks of historical contingency. Dax's radically altered destiny bore tragic witness to the cliché that warns about "being in the wrong place at the wrong time." His requests to end his life can be interpreted as bitter double entendre. On the one hand, the requests are screams of protest arising out of recognition that life is not his to control. On the other hand, demands to be allowed to die are last-ditch efforts to retake control of a life that has careened into chaos.

Finitude, limits (both penultimate and ultimate), also confront every other participant in Dax's struggle. Physicians discover that years of professional training and the latest technical expertise cannot create a willing, compliant patient; while they may regain some "function" for their patient, they cannot make this patient whole. They learn the painful lesson that the healing they have to offer is one-dimensional, partial, and finite. They meet their own frustrations and the criticism of others who question their limited judgment. Dax's attorney recognizes that his pursuit of justice in this tragic case must take place within the

limits of certain legal realities and that he needs to limit his patient in order to act in what he believes is that patient's and family's best interests. Dax's mother encounters her limits as well. She cannot convince her son that his is a life worth living, nor can she commend him confidently to eternal life. So she joins the conspiracy to limit her son's freedom as a way of controlling what she can.

As James Gustafson reminds us, "From a theological perspective the human condition is not only one of finitude, but also one of sin."¹² Nowhere in the accounts of this experience do we hear anyone singing, in the joyful way the psalmist does, about how good it is to be "a little lower than God." Instead, each individual reaches beyond his or her creaturely borders, seeking to bend nature and history to personal purposes. Dax's attempts to enlist others in his desire to control his own destiny and the efforts of doctors, family, and others to save his life contain within them dimensions of the sin called pride. An ambivalent word, pride simultaneously bears overtones of healthy self-respect and dangerous self-exaltation, which more than one theologian has called idolatry.

Gustafson warns that "among the forms that sin takes, pride is perhaps the most harmful in the area of medical care and research."¹³ This case provides ample illustration of his claim. Cowert's pride, his high view of himself and his potential, is obliterated. The one way that his pride can be reasserted is in the paradoxical claim to take his own life. The health-care professionals all take pride in their work; they make their living by doing what they are good at. Their need to survive depends upon their ongoing exercise of pride, which sometimes produces harm in the lives of others.

In this case, as in so many health-care situations, we confront the mystery that tormented Calvin, Luther, Augustine, and countless others across the span of the Christian tradition. We meet the dark side of the human mystery, a darkness that was given classic expression in the apostle Paul's autobiographical revelation of his fundamental agony: "I do not understand my own actions. . . . For I do not do the good I want, but the evil I do not want is what I do. Now if I do what I do not want, it is no longer I that do it, but sin that dwells within me" (Rom. 7:15–20). Paul draws deeply from the Jewish tradition that juxtaposes the mystery of creation and the mystery of the Fall in the opening chapters of Genesis. This tradition casts, as the initial problem in its long history of reflection, the double-edged riddle of human nature.

Although those informed by texts like Genesis and Paul's letter to the Romans can quickly spot signs of finitude and fallenness in many places, in Dax's case it is important to notice that no explicit recognition of either of these entangled realities seems to have occurred in interactions with him. The result is that the actors are caught in a grim power struggle to see who is right. The options made available when there is recognition that all are entangled in a web of finitude and sin, that all are wrong even when they are right, do not exist for them. Missing also is the recognition that the actors are cut off from the re-

sources of grace that the Christian tradition has to offer to those who feel the weight of the Law, the burden of finitude infected by fallenness.

Healing and Salvation

The "lifeworlds" that gave us the Hebrew and Christian scriptures stand in marked contrast to the modern lifeworlds that produce cases like Dax's. Most obvious is the contrast in knowledge and technical capacity between then and now. But another marked contrast exists in understandings of health and healing. In modern times, these understandings have fragmented and thinned out. Earlier in this article, the contrast between Paul Tillich's multidimensional and interactive understanding and the more one-dimensional understandings at work in Dax's case anticipated the need to probe more deeply into the differences.

In the Hebrew scriptures, health is portrayed as one of God's great gifts, and responsibility is placed on people to lead lives that cherish and protect this treasure. King David stands as the epitome of health, a man "who is skillful in playing [the lyre], a man of valor, a warrior, [one] prudent in speech, and a man of good presence; and the Lord is with him" (I Sam. 16:18). Although these attributes do not correspond directly with any of the dimensions in Tillich's constellation, it is clear that the biblical writer was reaching for a holistic understanding of well-being that anticipated Tillich's multidimensional model. Illness was frequently portrayed as a result of divine intervention in response to disobedience or sin, another sign of a broader and deeper understanding of health and healing. For the Hebrews, God was the physician, and healing was usually associated with divine forgiveness. One searches the Hebrew scriptures in vain for elaborate pharmacological or technical strategies of healing. Instead, the emphasis is on prophylaxis and intercession for God's gifts. The elaborate Mosaic code that regulated sabbath rhythms, edible foods, sexual relations, circumcision, personal cleanliness, and communal sanitation provides further evidence of a fundamental holism in Hebrew attitudes towards health. One could not be healthy if one did not care simultaneously for the body, human relationships, nature, and relationships with God. To be healthy, one had to be a responsible steward of God's many gifts.

In Jesus' ministry we find similar evidence of a multidimensional approach to healing. Healing is at the heart of his ministry and it takes many forms. From the first moment of his public ministry (when he taught in the synagogue "as one having authority" and healed the man with the unclean spirit, Mark 1:21-28), to the night of his arrest in the garden (when he healed the ear of the high priest's slave, Luke 22:50-1), and to the crucifixion (when he healed the grieving hearts of his mother and beloved disciple by creating a new relationship between them, John 19:26-7), Jesus is portrayed as a compassionate, aggressive,

and effective healer. Moreover, the Gospels make it clear that with Jesus, healing is now sprung free from the prophylactic and punitive understandings of earlier Jewish tradition. Jesus does not wait to be asked for help. He steps across barriers separating clean from unclean and does not demand purity as a precondition for giving health.

Physical healings, while of clear importance in Jesus' ministry, are part of a larger healing ministry. When the paralyzed man is carried to him, Jesus begins his ministry of healing by forgiving his sins; only then does he follow with a healing command to "Stand up, take your bed and go to your home" (Matt. 9:2-8). The physical healing is made subordinate to the larger healing of this man's relationship to God and neighbor. Indeed, Jesus' acts of healing—whether they restore bodies, relationships, souls, minds, or traditions—are signs of, anticipations of, and confirmations of the larger healing of the creation that is his total ministry. In these specific moments of restoration, aspects of this larger healing disclose themselves. Finally, it is God's distinctive presence and action in this whole life (Jesus' entire public ministry, crucifixion, and resurrection) that heals all of creation's fragmentations. Relationships among humans, relationships with nature, relationships between minds and bodies, relationships between the finite and the infinite, and relationships between God and fallen humanity are all healed in the one cosmic therapy called salvation.

As we have seen, this larger understanding of healing is missing from Dax's case. It is also missing from most human interactions. Such an understanding has the capacity to call people to larger and more adequate practices of healing at the same time as it grounds the faith to answer that call. More dimensions of the human need for healing and more aspects of God's gracious healing presence come into view.

Suffering and Community

When Dax was carried across the threshold from thriving life in the world to the severely limited world of the burn victim, he was wrenched out of a familiar community and hurled into the company of strangers. Suddenly, a few representatives of his old world (primarily his mother) and many unknown individuals had to create a community of sorts around a catastrophically wounded human being. As hands that he had never seen before touched him intimately, painfully, and mercifully, as caregivers began to become familiar presences and voices, rudimentary fibers of human community began to emerge. Yet, it is clear that the level of community achieved was minimal, that deep commonality and unity among people did not, and perhaps could not, develop.

In her analysis of human suffering, theologian Dorothee Soelle describes a process that permits a suffering individual to move from the powerlessness and isolation of agony to the possibility of human transformation and human solidar-

ity. At the center of this process is the phenomenon of human communication, of language. In the early phase of suffering, the individual lies either mute or moaning, inarticulate in the face of tragedy. As this individual begins to utter laments, a language that leads out of uncomprehending pain is found. Soelle notes that "liturgy at one time served to give voice to people in their fears and pain. . . ." The movement from "mute suffering" to "lamenting suffering" requires language and implies that someone is listening. It is a phase in which the situation is named, analyzed, and partially accepted, even as the cries of protest are uttered. A third step, from lamenting suffering to "changing suffering," occurs when the sufferer begins to experience trustworthy relationships with others and, together with them, finds a way to reorganize life and to engage in conquest of some of the limiting structures that had previously dominated the situation. Language shifts from the heard lament to a more rational communal discourse that can plan and consider.¹⁴

As William May's analysis revealed, Dax and his caregivers foundered in their ability to find an adequate common language. Soelle helps us see that Dax may have been free to move from mute suffering to lamenting suffering, but that a sufficiently trustworthy language to move to the third phase, one in which solidarity occurs between sufferer and the community around him, failed to develop. Dax's laments may have been heard, but instead of doing the hard work of building a community in which a language of solidarity could be spoken, Dax learned to speak the language of personal rights and his caregivers spoke their own language of power and benevolence.

To move beyond their impasse, Dax and his caregivers required a different kind of community, one that could speak a different kind of language. Here Soelle's clue about liturgy is important. Liturgy, when authentic, is a language of solidarity spoken in a real community. It is a language of laments and promises; it creates room for humans to fashion different kinds of relationships from those available elsewhere.

Significantly, Jesus' ministry of healing, and the prophylactic practices of the Hebrews, were strategies of solidarity. Types of languages were combined with kinds of behavior to take people into deeper and richer forms of community. In both the Jewish and Christian traditions, distinctive communities came to life—Israel and the church—where these distinctive languages and practices could flourish. The Christian and Jewish traditions have a sizable repertoire of resources that can help create a kind of community where suffering can be transformed and healing more fully experienced.

Moving Up To Ministry

The challenge facing those who wish to heal in our age is how to help people move from isolated experiences of suffering with strangers into commu-

nities where the multidimensional healing of the gospel can occur. This task is a complex one since it involves welcoming the Creator's good gifts through modern medicine at the same time that it involves resisting powerful temptations to reduce healing to physical cure. It implies a complex stance in which the church welcomes and, at the same time, criticizes medicine's gifts. A special kind of hospitality needs to be developed in our parishes and congregations, one that makes room for sufferers and curers within a much larger and deeper understanding of healing.¹⁵

A large part of the challenge facing the church is the need to heal our own traditions. Although our various denominations and congregations have been extraordinary innovators in the arts of healing, we have also participated far too willingly in the fragmentation of healing. Whereas we have handed bodies to physicians and minds to therapists, we have withheld only souls for a kind of spiritual care. Cases like Dax's, when placed alongside cases from the scriptures, provide an opportunity for the church to recover its larger healing vocation. This recovery cannot be simple repristination of an idealized apostolic era, or the world of health care will pass us by. Rather, a new kind of critical engagement with the worlds of suffering and curing, with the systemic and personal causes of illness and premature death, must take place. As the church learns how to read, in relation to one another, texts from its scriptures and texts from the modern search for healing like the case of Dax, it has the opportunity to mount a fresh argument with the world about what real healing is.¹⁶ At the same time, it has the greater opportunity to set human experience in a larger theological context in which God's gifts of health and salvation can be encountered in fresh, life-giving ways.

NOTES

1. James Davison Hunter, *Culture Wars: The Struggle to Define America* (New York: Basic Books, 1991).

2. Paul Tillich, "The Meaning of Health," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey (Grand Rapids: Wm. B. Eerdmans Publishing Co., 1987), pp. 163-64.

3. Stanley Hauerwas, *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church* (Notre Dame: University of Notre Dame Press, 1986), and *A Community of Character: Toward a Constructive Christian Social Ethic* (Notre Dame: University of Notre Dame Press, 1981).

4. Martin E. Marty's *Health and Medicine in the Lutheran Tradition: Being Well* (New York: The Crossroad Publishing Co., 1986) and Richard A. McCormick's *Health and Medicine in the Catholic Tradition* (New York: The Crossroad Publishing Co., 1984) are two of the early efforts by The Park Ridge Center for the Study of Health, Faith, and Ethics to assist religious communities in processes of recovery and fresh formulation of their traditions' distinctive understandings and perspectives.

5. The description of the case that follows depends upon Keith Burton's "A Chronicle: Dax's Case As It Happened," in *Dax's Case: Essays in Medical Ethics and Human Meaning*, ed. Lonnie D. Kliever (Dallas: Southern University Press, 1989), pp. 1-12. Other essays in the volume provide a number of vantage points on the case.
6. William F. May, "Dealing With Catastrophe," in Kliever, *Dax's Case*, p. 142.
7. *Ibid.*, p. 143.
8. *Ibid.*
9. Tillich, "The Meaning of Health," pp. 162-64.
10. I have written further about the problem of the body in "What Do We Do With The Body?" in *Dialog* 27 (Summer 1988), 192-95.
11. David Tracy, *Blessed Rage for Order: The New Pluralism in Theology* (New York: The Seabury Press, 1975), p. 105.
12. James M. Gustafson, *The Contribution of Theology to Medical Ethics* (Milwaukee: Marquette University Press, 1975), p. 70.
13. *Ibid.*, p. 71.
14. Dorothee Soelle, *Suffering*, trans. Everett R. Kalin (Philadelphia: Fortress Press, 1975), pp. 68-74.
15. For an example of one congregation's attempt to create this space, see James P. Wind, "One Congregation's Experience: An Introduction." This article is part of a series of articles called "The Congregation as a Place of Healing," which appeared in *Second Opinion* 13 (March 1990), 74-137.
16. I have described the American argument about health in "Religion and the Great American Argument about Health," in *New Dimensions in American Religious History*, ed. Jay P. Dolan and James P. Wind (Grand Rapids: Wm. B. Eerdmans Publishing Co., 1993), pp. 103-30. For an attempt to contribute to our current search for a more adequate theological definition of health, see James P. Wind, "Health," in *A New Handbook of Christian Theology*, ed. Donald W. Musser and Joseph L. Price (Nashville: Abingdon Press, 1992), pp. 213-16.