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Geographies and Accompaniment: Toward an Ecclesial Re-ordering of the Art of Dying

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Geographies and Accompaniment: Toward an Ecclesial Re-ordering of the Art of Dying

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Abstract
This article identifies three geographical shifts that have altered the relative social, spatial and temporal locations of dying, church and health care, and axiology causally contributing to our culture’s deformed dying processes. It proposes an alternative script for a new art of dying drawing upon the early church’s practice of the order of widows.

Keywords
Aging, care for the dying, diminishment, Order of Widows

Since the 1960s, western culture has lamented the increasing ‘deformity’ of the dying process.1 Despite alerts raised almost forty years ago, the problem has only worsened.2 Responses have moved in two directions creating, in the insightful phrase of Michael Banner, two scripts for approaching the end of life.3 One response has been a sustained

2. See, for example, Atul Gawande, ‘Letting Go’, The New Yorker, 2 August 2010.

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effort toward legalizing euthanasia and/or physician-assisted suicide, both in Europe and in the US. The other has been a counter-push toward advancing hospice and palliative care.

Yet the palliative care movement is not without its critics. Consequently, a growing consensus of scholars and practitioners has begun to champion the development of a new *Ars moriendi*, a new art of dying for the twenty-first century. For many, this is a call for *ressourcement*, a return to the resources of the Christian tradition, particularly Christian practices, as antidotes to our current malaise. The symposium, from which the article in this journal emerged, joins this larger project.

In my short remarks that follow, I hope to advance this discussion in three ways. First, drawing on the history of medicine and the historic *Ars moriendi* tradition, I identify three important shifts that have occurred in the care for the dying, particularly in the twentieth century, that have causally contributed to the ways in which dying is experienced in our contemporary context. I name these shifts in *geographies* as they are changes that have altered the relative social, spatial and temporal locations of dying, church and health care, and axiology. Second, I sketch an alternative script that responds specifically to these three shifts and that challenges us to reframe the locus for efforts to crafting a new art of dying. This script, thirdly, joins the *ressourcement* efforts by drawing upon a mostly lost but intriguing practice of the early church—the Order of Widows. How might this ancient practice, reconfigured for the twenty-first century, provide a new way forward in imagining a more robust and integrated approach to dying as well as to the Church’s approaches to the companions of Sister Death, aging and diminishment?

### Three Geographical Shifts

Behind the current configuration of the hyper-medicalized denial-driven dying processes common to contemporary first world hospitals lie three ‘geographical’ shifts. Allen Verhey,
in his recent book *The Christian Art of Dying*, highlights the first, a shift in the geography of dying from home and community to medical institution that occurred in the early part of the twentieth century. In 1908, for example, only 14 percent of deaths in the US occurred in an institutional setting; by the end of the twentieth century, that figure had risen to 80 percent. Thus, within 100 years—a short timeframe on a human scale—the location of dying has moved to a new social space, a space that is importantly institutional.

The second shift concerns the relative geography of church and hospital. Those familiar with monastic architecture will recall the Benedictine configuration where the infirmary and the space to care for the poor and sick were integrated into the layout of the monastery. The *Ars moriendi* emerged around the same time point in the Middle Ages when medical care began moving out of monasteries and into the new institution of *hospitalia* being established in the newly ascendant urban centers. In this context, the interconnections between spiritual care and medical care continued to be embodied architecturally. Santa Maria della Scala in Siena, for example, was founded in 1193 as one of Europe’s first hospitals and served as an active hospital until the early 1990s. The hospital’s name derives in part from its location—directly across from the steps of the Siena cathedral, a building with which it is architecturally contiguous. Here church and hospital face each other. The hospital’s identity—in its very name—is tied to the church. An alternate configuration is seen in the Ospedale Santa Maria Nuova, the oldest active hospital in Florence, Italy, founded in 1288. Here we see the church integrated into the overall layout of the hospital. In both configurations, the two institutions—or two spaces for care—are connected in one architectural form. Other examples of these two models can be found across Europe. This architectural geography began to decouple as early as the late sixteenth century, facilitated by the Renaissance, epidemics, the Reformation, and ultimately the Enlightenment. As the continuing presence of religiously-sponsored health-care institutions attests, this dissolution has not been total; nonetheless today, the institutions where at roughly 70 percent of Americans die are avowedly secular.

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8. Moll, *The Art of Dying*, pp. 15–16. Moll further notes that between 1908 and 1914—just six years—the number of people dying in institutions had risen to 25 percent. It is likely not accidental that this rise correlates in time with the issuing of the Flexner Report in 1910.
10. See Katharine Park and John Henderson, “‘The First Hospital Among Christians’: The Ospedale di Santa Maria Nuova in Early Sixteenth-Century Florence”, *Medical History* 35 (1991), pp. 164-88, specifically the sketch plan on p. 166. Interestingly, here we see the original monastic form inverted—no longer is care for the sick and dying provided within the church; now the church is within the health-care institution.
12. Religiously affiliated hospitals continue to have a significant presence, at least in the US context. Catholic hospitals alone represent the largest group of nonprofit health-care providers in the US, comprising more than 640 hospitals, 1,400 long-term care and other health facilities, and 15% of all hospital admissions and outpatient visits in the US annually. See Catholic Health
The third shift relevant to the art of dying is what we might call a shift in the geography of axiology. The imaginations of those seeking a new art of dying often remain constrained by two parameters of our contemporary axiology—location and framework. Many proposals for ‘dying well’ address primarily how we can make the experience of the deathbed or a patient’s last days less deformed, less dehumanizing, more personal and communal. Shaped by contemporary bioethics the presumption is that the locus of ethics is the deathbed, the narrow window of the dying process (this presumption is shared by the scripts of hospice and physician-assisted suicide/euthanasia). Equally, the formalist, instrumentalist framework of bioethics, centered on autonomy, is presumed as normative. Thus, the ethics of dying well is largely focused on enhancing patient decision-making, primarily about which technological interventions to choose or decline.

For the *Ars moriendi* tradition, however, the axiological locus was neither the deathbed nor autonomous decision-making. The deathbed was the endpoint of a long process. The real, hard, preparatory work of moral/spiritual formation occurred in a time and place long preceding the hour of death. Decisions made on the deathbed, which were more soteriological than ethical, were largely determined by a set of virtues cultivated elsewhere. The primary task of each person was to cultivate the virtues necessary to live well—faith, hope, love, patience, humility, dispossession, and the ability to forgive—so that they became part of a person’s nature and therefore easier to exercise on one’s deathbed. Thus, the axiologically critical time and place was not the dramatic, eschatologically-fraught deathbed of the woodcuts but rather a lifelong preparation.

If these three geographical shifts have contributed to the current configuration of contemporary dying, a constructive response would seek to re-orient the geography of end-of-life preparation and care—back to the home, toward the Church, to a place upstream of the deathbed. Below I envisage a possible new script that might reshape our imaginations and, therefore, the practical possibilities for creating a new art of dying—one that takes as its starting point the early church’s practice of the Order of Widows.
The Order of Accompaniment

Allied to questions surrounding end-of-life care are equally challenging issues surrounding aging and diminishment, what Michael Banner refers to as ‘the long dying’.17 Twenty-first-century demographics differ from the era of the Ars moriendi when those who survived childhood could expect, on average, to live to their early fifties.18 In 2013, elderly persons in the US (those over 65) numbered almost 45 million. Of these, 12 percent resided in institutionalized settings and approximately 30 percent—or 12.5 million persons—lived alone, a percentage that rises with age. A significant percentage of these persons are women (80%) and more likely to be poor.19 While many elderly persons value independence, these realities often lead to social isolation and self-neglect.

While the demographic scale differed, elderly women in ancient Palestine often faced similar issues. In response, the early church instituted the Order of Widows. The Order of Widows was just that—an order, an ecclesial role—listed in 1 Timothy alongside the orders of bishop, elder (presbyter) and deacon, designed to minister to the local community. By incorporating eligible widows—those bereft of husbands, children and grandchildren and therefore in peril socially and economically—into the ministerial structure of the community, the Church provided significant material assistance for the most vulnerable members of the community. It also recognized and lifted up their practice of discipleship and continued to utilize their talents and abilities in service of the Church’s mission. The responsibilities of enrolled widows were multiple: ceaseless prayer on behalf of the community; visiting the sick, especially sick women; giving practical instruction to younger women within their communities; prophecy; liturgical presence; and facilitation of reconciliation. Widows assumed a place of honor in the liturgy, sitting in the front of the assembly along with the bishops, priests and deacons. Younger widows helped care for older widows.

What wisdom might we draw from this ancient practice for beginning to imagine—and thereby start to craft—a new social alternative to the given scripts of assisted suicide, hospice, and that ‘death before death’, the retirement home?20 Such an order—perhaps
called the Order of Accompaniment—would ideally entail some form of congregational living, an intentional community attached in some way to a local congregation—if not physically attached to a local church building then at least located in close proximity and attached in terms of relationship and identity. These communities could take many forms—informal arrangements in apartments, shared homes, former convents. These small communities of older persons of varying ages and levels of ability would live together and would include those who are active as well as those who are dwindling and even perhaps quite debilitated. Local individuals or older couples not interested in communal living but who likewise find themselves called to an intentional form of ministry and wish to serve the Church in a more formalized way might be formally affiliated with a particular ‘house’.

As opposed to the banal, consumeristic diversions of retirement communities, members of such an Order would provide an array of intergenerational ministries within their local congregation. All would be committed to an intensive practice of contemplative prayer, particularly for the needs of the community; for many members as they age, this may become their primary form of ministry. They might perform a wide range of charitable activities, particularly visiting the sick, the homebound, and perhaps those with Alzheimer’s. They certainly would be called to ministries of witness and catechesis—assisting, for example, in Christian formation programs, witnessing to a culture of life, drawing particularly on their own experiences of trial, illness and suffering, or to social action for faith and justice. Reprising the Order of Widows, they would also have particular liturgical responsibilities—a leadership of presence in addition to serving as lectors, acolytes, Eucharistic ministers.

A constant companion to such an Order would be the realities of aging, diminishment, dying and death. Yet the intentional structure of the Order would enhance the ability of congregations to reciprocally minister to the needs of its older members. Practically, the communal structure and ministerial identity of the Order would ameliorate issues of impoverishment, invisibility and marginalization, loneliness, loss of purpose, and limits on self-care. It would also distribute responsibilities for caring for sick and diminishing members broadly among members of the Order and, perhaps, younger persons in the congregation. And the ecclesial/liturgical dimension of the Order would provide members with a space for ongoing spiritual formation as they move more deeply into old age and toward death.

21. Naming is always difficult. An ‘order’ should embody a necessary service within the Body of Christ and name a particular vocation in and to the Church. ‘Accompaniment’ identifies the ministerial need being addressed by the congregation (the isolation of the elderly) as well as the vocation of the elderly to the congregation, as even in ‘retirement’ they continue to minister. The Order of Hospitality, or the Order of Ruth and Methuselah, might be other options. Further discernment around naming would certainly be warranted.

22. See, for example, the Nuns on the Bus movement launched by Network and a large group of religious sisters in the US in 2012: http://www.networklobby.org/bus2014.

23. An additional reason for creating something like an Order is that a contemporary art of dying needs a space for sustained process of formation—one that both deconstructs our deep social
More specifically, this ecclesiologically-based practice of discipleship for the elderly provides a response to the three geographical shifts at the heart of our deformed dying. It forges a new practical, physical, architectural connection between the Church and the Church’s ministries to and with the aging sick and dying. In doing so, it locates the end-of-life journey, which may take two or three decades, more intentionally within an ecclesial context, reframing it as a spiritual story rather than a medical story. Doing so would help counter the invisibility of the sick and dying and marginalization of death that characterize modernity. No longer isolated in their homes or farmed out to siloed retirement homes, through architecture, ministry and liturgy, the aging and dying would be more visibly incorporated into local congregations.

Such an Order would also provide a concrete way to return care for the diminishing and dying back to home and community—relocating it from medical contexts that inhibit the practice of authentic and sustained spirituality. Communities of the Order might structurally include a hospice room for care of dying members. Here, members of the Order, the person’s family and the congregation might share the task of companionship, providing respite for each other.\(^{24}\)

Finally, such an Order relocates axiology upstream, away from an emergency focus on the dying process and deathbed, to a space of stability where members of the community can begin, over time, to cultivate the virtues needed for dying well. Under any circumstances, congregated living spaces are fertile ground for learning to practice virtues such as patience, humility, dispossession and the ability to forgive. But one of the charisms of this Order would be the cultivation of these virtues specifically as preparation for the dying process and as a witness to others to what it looks like to die well and faithfully. Participation in the Order would provide members with a space and structure for constant formation, for them recursively to place their own diminishment and aging more visibly within a Eucharistic, Christological context. Under spiritual direction, members would be encouraged to enact the forgiveness and reconciliation needed for spiritual peace—potentially a long-term process. And it would provide the time and space, long prior to a crisis, for careful, intentional discussions of end-of-life wishes, for preparation of documents, and for conversations with family members and health-care providers.

**Conclusion**

In sum, a contemporary art of dying will require a new set of geographies, a new institutional space, where practices crucial for dying well can be cultivated over decades, practiced equally by caregivers and cared-for, enabling the aging, the dying, and the community that surrounds them to meet the dying process better formed. The Church formations (*homo economicus*) and reconstructs us theologically (*homo christoform*). For example, our social formation around time tells us that ‘time is money’ and that there is no time to care, to be present, to sit with, to deal with the inefficiencies of the elderly, sick, dwindling and dying. A Christian sense of time—which is more eschatological and kenotic—enables patience and accompaniment.

24. Trained health-care providers might need to be part of this process—either volunteers from the congregation or perhaps a staff member such as a parish nurse.
uniquely possesses the history and the infrastructure to begin to build such a space. In such spaces, the rich array of practices of the Christian tradition (baptism, martyrdom, Eucharist, reconciliation, anointing) can be integrated into the specific journeys of aging and dying of particular people.

The foregoing has merely been a sketch, a first step in seeking to envisage what such a space or script might look like. Many more dimensions could be elaborated. Logistical questions abound. But I find hope in the communion of saints who have come before us—Jean Vanier who founded one L’Arche community; Dorothy Day who started one Catholic Worker house; Dame Cicely Saunders who established St. Christopher’s Hospice. Their initial steps in creating new communal spaces where Christian commitment met real human pain and need launched growing movements that have made a real difference in the lives of many. Might grace be waiting for one congregation to take the initiative to recall our history and invite the widows and widowers in their midst to a new vocation that will witness a new way to live the art of dying to Christians and secular colleagues alike?

25. As but one example, this only addresses the art of dying for older persons. It might, however, provide a witness for people who encounter dying at a younger age or an infrastructure into which such persons could be incorporated.