A Confession of Miraculous Mythological Epistemology for Health Communication

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This dissertation titled
A Confession of Miraculous Mythological Epistemology for Health Communication

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ABSTRACT

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A Confession of Miraculous Mythological Epistemology for Health Communication

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This dissertation examines health communication surrounding patient and family hopes for miraculous divine intervention in response to physician predictions of medical futility. The study presents an auto-ethnographic account of the author’s personal experience of this clinical context as a hospital chaplain. The context is then reframed from a particular chaplain’s experience to an examination of similar contexts surfacing in the prognosis-related communication between physicians, patients, and families, as revealed in the literature. The combination of first-person experience and third-person analysis of the same problem takes seriously the rationality of both immediately given reality and the work of thinking. At stake in any serious consideration of what all may be at play in this context are significant issues outside of the health communication domain, such as religion, myth, and epistemology. As such, the methodology is an interdisciplinary theoretical analysis of a practical problem in health communication. The theories used for such an analysis are theology, myth theory, and health communication theory. Eastern Orthodox theology forms the underlying theoretical substratum through which the immediate chaplaincy experience is filtered. Myth theory forms the next theoretical layer, examining such issues as the relationship between myth, symbol, and miracle, and the impact of these domains on the evolution of both art and
science for a historical contextualization and philosophical conceptualization of the paradigms colliding in the health communication context. Health communication theory forms the final theoretical layer. Drawing upon and building from preceding layers of theoretical analysis, problematic integration theory, hope theory, and narrative medicine theory combine to illumine the problem of interest and suggest a way forward. Teasing out the interdisciplinary aspects of the problem by interweaving multiple levels of theoretical analysis not only sheds light on this particular context, but may also suggest new possibilities for a wider range of health communication encounters at all stages of disease trajectory.
DEDICATION

To my darling Anastasia
ACKNOWLEDGEMENTS

Thank you to all of my classroom and clinical teachers at Duke, VCU, UNC, Harvard, Stanford, Berkeley, and St. Vladimir’s who have contributed to my educational journey. Special thanks to Drs. Austin Babrow, Karen Deardorff, Claudia Hale, and Vladimir Marchenkov. Words cannot express how fortunate I feel to be your student.

And thank you to Ohio University for recruiting professors of such depth and humanity, for creating unique degree programs that accommodate the exigencies of twenty-first-century education, and for truly being, in my experience, “the best student-centered learning experience in America.”
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CHAPTER ONE: SURPRISED BY A DISARMING MIRACLE

As a chaplain resident at Duke University Medical Center, I was asked to pray for the miraculous healing of many patients. Fielding this request was a struggle for me in the early days of my clinical chaplaincy before I set out on the journey I will describe in Chapter Nine. As a preview to that narrative, one of my superiors with decades of experience as a hospital chaplain shared with our residency class that she was once asked by a patient, “Chaplain, do you believe in miracles?” “Yes,” she replied, “I do believe in miracles, but the reason they call them miracles is because they don’t happen very often.”

Understood in the context where the miraculous is taken to be a violation of natural law through divine intervention, miracles do not happen in most cases, although I have heard a number of prayers by spiritual leaders in a variety of contexts which combine emotional fervor with confident proclamations that God will, in fact, work a miracle for this particular sick person at this particular time. But those kinds of prayers have never sat well with me because they seem to create unfair expectations around the likelihood of success. On the other hand, alternatives to overly expectant and irreverently assuming prayers for miracles seem to err on the opposite side of the problem. For example, chaplain colleagues have confessed to me that they do not believe in or hope for miracles, but they think they have found a way to feign connectivity to miracle-hopes through vaguely worded prayers that can mean different things to different people. This presents an ethical dilemma which may be a violation of the Hippocratic Oath and the patient-family centered paradigm of twenty-first-century health care. Offering sugar pills shaped like Advil in response to the request for an anti-inflammatory is an example of
clinical harm. How is praying a disingenuous prayer any different? It is simply another form of placebo. In one sense, it seems that an ethical approach to care would either transparently confess an inability to honor the request or find someone who can truly provide the requested service by entering into the hope of another and sincerely praying for a miracle. But is it not also an ethical dilemma, at least in some cases, to fabricate or fan the flames of false hope through a prayer that arguably places a smokescreen of hope in front of an otherwise clear reality of impending death?

How then, can I, in good conscience, respond to these perplexingly problematic requests? If, as I was reminded by my veteran chaplain colleague, miracles as they are popularly understood are, by definition and empirical experience, the least likely event to occur, and therefore this patient for whom I am about to pray will very likely not be healed, what does this mean for my prayer? Can I in good conscience create, accelerate, or even support expectations that are unlikely to be met?

While my critique of both extremes of the above approaches did not change over the course of my chaplaincy, I found myself wondering if it was perhaps possible to suspend my mental calculations on the probability of miracles for the purpose of truly empathizing with a fellow human being facing death. Could I approach a prayer for her miraculous healing with at least a measure of the kind of naked hope—hope for the seemingly impossible, not clothed in reasonable expectation—that may constitute my own desperate crying out to God if I found my angelic little daughter in a similar situation? As I began to think in this direction, I wondered if the best way to deal with
my fear of creating or contributing to a false expectation of healing would be to name my uncertainty in my prayer.

This movement from crying out to God with naked hope to naming honestly the uncertainty of the situation reminded me of the book discussion I led for our clinical pastoral education (CPE) reading assignment the previous week. Doehring (2006) advocated an approach to pastoral care through a “trifocal lens” where the three fields of focus are premodern, modern, and postmodern. Is it possible I wondered, to see my mental calculations on the probability of miraculous healing as a modern lens that I could set aside while engaging a premodern lens to enter into the naked hope of a person facing death and voice her cry to God for healing? Could I, within the same prayer, employ a modern lens to face and name my struggle to enter into the unknowing inherent in this request? What would it look like to end the prayer through a postmodern lens? How will this process be informed by my commitment to Eastern Orthodox theology? Chapter Nine will chronicle my journey of thinking and praying my way into a prayer that transformed my experience of these previously perplexing contexts from agony into joy. Here, I want to fast-forward six months and share an event in my life that illuminated this journey of discovery for me.

**Six Months Later: An Unsolicited Request**

It was cold and cloudy Christmas Day, 2009. My hands were beginning to thaw out from the early morning motorcycle ride from my home in Chapel Hill to work at Duke University Medical Center. Since it was a holiday, all of the other chaplains were out on vacation, and I was serving in-house on-call duty for the entire hospital. It would
be a busy day and a long night. There were plenty of rounds to make, but the pager had not yet sounded, so I paced myself to begin work on my “residency project.” Chaplain residents were required to produce an auto-ethnographic scholarly report on a personal area of learning of their choosing for presentation to colleagues. While I waited for the pager sound, I began to sketch out my journey from the dreadful conflict I experienced when responding to patients and families requesting prayer for miraculous healing to finding peace and meaning in these encounters. Little did I know that I was about to experience an explosion in my realization of how far I had come in this process.

When the pager finally sounded, I raced up to the intensive care unit (ICU) where I was pulled aside by a nurse who explained that she would be introducing me to a young woman, Mrs. Jones, who came in via emergency helicopter with her husband, Mr. Jones, who had suffered lethal carbon-monoxide poisoning (pseudonyms used). While the attending physician declared Mr. Jones irrevocably brain dead on arrival, other members of the medical team, moved by emotion at the sight of this young family losing their husband and father, had pushed hard for what otherwise might have been dismissed as ridiculously futile measures, given that there was not even the slightest sign of brain activity. Nothing worked. Finally, the family and the medical team agreed to remove the ventilator that was breathing for him and let him go. His wife wanted a chaplain to be present and prayer to be offered as life-support was being removed.

At last, I was introduced to Mrs. Jones, a woman not much older than me, with her two little girls, the younger of whom reminded me of my daughter. Standing beside the bed of her motionless husband, Mrs. Jones looked drained and resigned with her tear-
stained cheeks. She was also accompanied by another woman, a caring friend or neighbor, present less out of emotional attachment to the man in the bed than to give moral support for Mrs. Jones in this moment of grief. As is often the case when responding to emergency pages as a chaplain, this was a lot for me to absorb. To intensify matters, there would be no opportunity to get to know this family, to learn a little bit about the man lying motionless in the bed, to connect these people in front of me with their larger story, to develop some semblance of a pastoral relationship. Mrs. Jones requested my presence for one purpose: to stand vigil and offer a short prayer while the doctor removed the ventilator in surrender. As I approached Mrs. Jones, the doctor stood ready next to the ventilator. Mrs. Jones said only these words: “We’ve already prayed for ‘all of that.’ We just want you to pray that he will be at peace.”

In the split second as I swallowed hard while the doctor began to remove the ventilator, I felt overwhelmed with sadness. I felt so sad for this poor young man lying on his deathbed, and I felt sad for this grieving young wife, about to lose her husband. I felt sadness for these numb-looking little girls standing faithfully beside their mother, maybe not even able to understand what it meant that they were about to watch their father die. I felt so sad for this tragically shrinking young family. And when I opened my mouth to pray, the prayer that came out was some permutation of the prayer I had come to pray when people asked me to pray for miraculous healing. Only, in this case, I had almost explicitly been asked not to pray for a miracle, but only to pray for peace. What a relief that request would have been for me a few short months ago; yet, what an impossibility it had become for me in this moment. I was careful to include in my
petition Mrs. Jones’s prayer for her husband to be at peace when he died, but my prayer for peace was qualified with the expression of desire and a request, however weakly and unexpectantly offered, for a miraculous reversal of this tragic moment in time.

As my prayer came to a close, Mr. Jones, now breathing unaided by the ventilator, no longer lay motionless. He began to tremble and cry. Mrs. Jones seemed as shocked as I was, but her friend quickly brought us both back down to earth with the words, “that can happen,” accompanied by a tight hug whereby she gently turned Mrs. Jones away from the sight of her weeping husband and expressed additional encouragement not to be distracted by false hope but to engage the grief and let him go. Mrs. Jones and I both readily accepted her friend’s interpretation of what happened, and as the two embraced, Mrs. Jones leaned over and thanked me in a way that let me know that I had fulfilled her request and it was time to go. Given what I had done, in combining her desire for a peaceful death with a desperate plea for a miraculous reversal of the seemingly inevitable, it was of course debatable whether or not I had fulfilled or violated her wishes. But the way in which she thanked me left me with a sense of peace that she had not been offended by my prayer and that, far from being upset, she was sincerely grateful for my heartfelt care. Just a sense—nothing certain. But it was enough for me to leave at peace. Other friends and family were arriving as I was leaving, but the pager sounded again, and I rushed away to respond to the next call.

After a full day and busy night on-call, the memory of Mr. Jones crying at the end of the prayer and the flicker of hopeful shock that Mrs. Jones and I felt before her friend brought us back to “reality” was little more than a foggy dream. It had been a long 28
hour shift. It was time to go home and rest. A couple days later, I received an email from a chaplain manager reading something like this:

Dear John and Bob:

In my audit of the system notes over the last couple days, I noticed a discrepancy: John’s note says he offered prayer on Monday for the Jones family as Mr. Jones’s ventilator was removed and his family awaited his death. Bob’s note says that he met with the family on Tuesday as Mr. Jones was being discharged. Can you guys help me clear this up?

I do not recall anything ever coming of that email. Maybe Bob missed it as we all do given the deluge that email can be. There was nothing for me to clarify. My note in the system correctly documented my visit. Next message. Next response to the sounding pager. The chaplaincy residency year, with its combination of 40 hour weeks and additional all-night shifts, turns into a steady fog by the second half of the year. At that point, I was also working evenings and weekends on three different college campuses as a chaplain for Eastern Orthodox students, so I had neither the time nor the emotional capital to contemplate the connection between Mr. Jones’s unexpected tears and my manager’s unexpected email. The connection registered on some level, but the hamster wheel kept spinning.

In hindsight, what registered was not much more than wonder—wonder at the mystery of the encounter. Wonder at the joy of complementing my abstract calculations with the immediacy of feeling unjustified desire. Wonder at how far I had come from dreading the mention of miracles, to finding great peace and joy in these encounters, to
offering an unsolicited request for a miracle. Wonder at the possibility that my transgression of Mrs. Jones’s request had mysteriously coincided with my first glimpse of a miracle. Wonder at how wonderfully different and freeing was the trajectory of wonder than the stiflingly constrictive trajectory of calculation to which I was so accustomed. Only now as I write out this account and begin to feel embarrassed at the nakedness of my experience and my pathetically lax efforts at investigating this matter further does it occur to me that such may be the character of wonder as a form of consciousness. The opposing, more prevalent form of consciousness that makes me feel embarrassed for my lack of investigation is perhaps diametrically opposed to wonder such that the two simply do not readily mix.

Anna’s Coma

A few years later, I was home for a holiday, and my brother told me he met a girl named Anna downtown that I needed to meet. I love my brother dearly and treasure our time together, but we tend to run with different crowds. So, while I love spending time with him in his element, I don’t think he has ever made an appointment for me to meet with one of his friends or acquaintances. So, this was a little odd, but he said she had a story to tell about a near-death experience, and I was willing to listen. We met in a laid-back tea room downtown, and Anna began to tell her story. Before we knew it, she had drawn quite a crowd. Her tale was captivating. The essence of the story was that Anna suffered a horrendous car wreck a few years back and thereafter spent a long period in a coma. Although she was “non-responsive” from a medical perspective, she attested to the notion that hearing is the last sense to go, and it is entirely possible that someone who
appears quite absent lying in a hospital bed can in fact be quite present even though they appear non-responsive. Describing her existence in the coma state, Anna relayed that not only could she hear what was going on around her, but she was also in close contact with her subconscious and the divine. Snapshots from her entire life spun in front of her like pages from a life-long photo-diary blowing in a fierce wind. Everything she had ever done and said flashed before her in fast-forward at warp speed. The most fascinating part of her story was that it was eminently clear to her after some period of time that God was giving her the decision of which world she wanted to enter. Did she want to go back to life on earth, or would she continue forward to the eternal beyond? Ultimately, Anna made what she described as an overtly conscious and painstaking decision to exit her coma and return to life on earth. As odd as her story was, Anna was disarmingly endearing and strikingly believable. All of the strangers who spontaneously gathered to hear her account in our corner of the tea room lined up to meet and embrace her.

While listening to Anna’s story, my mind snapped back to Mr. Jones, the supposedly brain-dead man lying in the hospital bed, crying at the end of the prayer. I wondered if maybe Mr. Jones had in fact heard the prayer. I wondered if his carbon monoxide poisoning was the result of a suicide attempt. I wondered if he was moved by the part at the end about God suffering with us. I wondered if it made him cry. Then I wondered if he had been presented with the same fork in the road that Anna described. I wondered if he chose to give life a second chance. But maybe the email from my manager was only a dream. Maybe I was simply haunted by seeing a dying man crying involuntarily. Maybe that’s why I don’t recall responding or hearing anything more
about it. It was real enough that I do remember finally discussing it, not with the manager who sent it, but with my supervisor at the end of the residency year. That discussion, however, was not governed by investigative consciousness but by wonder.

Scott’s “Flog”

A month or two after hearing Anna’s story, my wife and I were attending a cookout hosted by a friend of a friend whom my wife had met only once through our mutual friends. Something came up for our friends at the last minute, so we showed up at the cookout knowing no one. An hour or so into the event, I found myself sitting in a circle of people talking on the screened porch. One of them was relaying a story of his work as a nurse in a medical helicopter. That story sparked other related stories, and suddenly it became clear that nearly everyone sitting around me in this circle was an ICU nurse. I was taking a course in multi-media storytelling for health communication at the time, and I asked if anyone might be interested in sharing a story on video for my project. A man named Scott, who had not said much of anything up to that point, suddenly sat up straight, leaned forward, stared a hole right through me and said intently: “I’ll talk.” I took his business card, followed up with an email, and we arranged a time to meet. When I went to the library to check out the video camera, the camera I had become accustomed to using was not available, and I was fumbling nervously through the setup process when Scott arrived. When I finally hooked the lapel microphone to Scott’s shirt and said I was ready, he asked,

“ Aren’t you going to do a sound check?”

“Nah, I’ve never done a sound check before, and the sound always turns out fine.”
“Whatever you say,” Scott said as he primed his story.

Mystically reminiscent of the email that was never answered, the sound did not come through for the video, but I didn’t care. The gift of wonder would again eclipse the verifying intuitions of investigative consciousness. Scott began by describing the grueling reality of life as an ICU nurse, how hard it can be to see so many people suffer and die, how easy it is to view hopeful doctors and families cynically. The doctors perform their clinical procedures, and the families get to see the patient after he has been cleaned up and made presentable, but the nurses are on the front lines of modern medicine’s battle against death. They do the dirty work and, for whatever they gain, many suffer from it. These nurses cope, Scott described, by supporting each other through the shared language of their shared experience. Many burn out. Others despair and grow cynical as they soldier on. Many who work in ICUs only half-jokingly swear they will have the letters “DNR” (do not resuscitate) tattooed prominently on their chest before they reach dying age so that they can avoid the torture that they are required to inflict upon others in the battle against death. The ICU vernacular used to describe the torture of futile medical heroics is “flogging.” “It’s a ‘flog’” one nurse will say to another, describing a particular patient. Depending on whose passion is driving the war against mortality, either the family or the physician pronounces the torture sentence upon the poor patient. The doctor wields the instruments of torture but often only sticks around until things start to get messy. The nurses are left to deal with the aftermath and clean up the mess. It is their job to tidy up the wounds and make the patient presentable enough to the family so that they can feel good about ordering the next round of torture.
Scott described how demoralizing it could be to see and smell the rotting flesh of a dying patient who is being kept alive by a machine that continues to breathe inside a body that is trying to die.

Illuminating ICU culture, Cassel (2005) explained “flogging” through a joke that ICU nurses and medical residents pass among each other. The joke tells the story of two missionaries in a tribal land captured by the natives and delivered to the tribal chief. The chief gives them a choice: “death or chee-chee.” The first missionary had never heard of “chee-chee,” but anything sounds better than death, so he opts for chee-chee. After watching his friend tied to the back of wild horses, dragged naked through the village, slowing giving up his body, chunk by chunk, the second missionary is given the same choice. He says, “I never thought I’d say this, but I think I’ll choose death.” The chief nods his head, says something like, “Yes, death will you get. But first…a little chee-chee!” ICU nurses often struggle to see the grueling aspects of their profession as anything other than chee-chee, or “flogging,” as they call it.

Setting this stage for his experience as an ICU nurse, Scott told me that he eventually burned out and now works in another unit of the hospital. In hindsight, he said, his cynical view was unfair to the families and doctors trying to do their best to help in any way they could with the tools they had at their disposal. Showing a great deal of humility, Scott confessed that the nurses who survive in the ICU have something he does not have: they are able to look at things differently, and he respects them. He believes their perception of the situation is more humble and mature; however, there was one time, Scott recalled, when he did view the commonly futile heroics of intensive care quite
differently. There was one time, he recounted, when the doctors and the family were ready to throw in the towel on a young family man who was flown in by helicopter with carbon monoxide poisoning. But something snapped inside of Scott, and he could not bear to see this man dismissed to the morgue.

When the emergency helicopter brings new patients in critical condition to Duke University Medical Center, there is another joke that ICU nurses often use to cope with their grief in observing so many deaths in their role as the last, best medical option. When the helicopter touches down, said Scott, a cynical welcome may emerge from an anticipatorily grieving nurse: “well, you’re not dead until you’re ‘Duke-dead.’” Apparently this man actually arrived “Duke-dead.” No flogging necessary. Instead of getting down on his knees and thanking God that this poor man could die in peace without the torture of futile heroics, Scott did the opposite: he found himself desperately begging and pleading the doctors to put the man on the machines and run the drill. Looking at the young wife and two little daughters, Scott couldn’t bear the thought of them losing their husband and father. So he made a fool out of himself with his nursing colleagues by ordering a “flog” and begging the physician generals to declare war on a death that neither they nor the family had any hope of winning. Somehow, the sheer mania of Scott’s plea created sparks that built momentum. Suddenly a man destined for the morgue was receiving the full treatment. But the more they did, the deader the man proved to be. The brain had simply shut down and, finally, everyone agreed enough was enough.
A chaplain was called to offer a prayer for a peaceful passing while life support was removed. The time it takes for breathing to cease after the removal of a ventilator varies from patient to patient. It can take seconds, minutes, hours, or even days. Scott needed a break. When one of his fellow nurses paged for the chaplain, Scott retired to the cafeteria for an early lunch. When he returned, some family and friends had arrived. One by one, they were admitted into the hectic intensive care unit to express their love and support for the wife and daughters and see their friend/relative in his final moments. Scott was making his rounds, checking the man’s status, and checking in with the wife and daughters when one of the man’s good buddies bent down over his face to hug him. As the friend leaned forward, Scott heard the dying man exclaim to his friend, “your breath stinks!” His friend responded instinctively, “Yeah, I just had a whole ton of garlic for lunch—wait a minute—what the fuck!” Scott sounded an alarm, and the code blue team burst through the doors. To everyone’s shock, the man had simply woken up. He had suffered some brain damage and did have to return to the hospital a number of times over the ensuing months for various therapies to restore connectivity to his nervous system, but, according to Scott, the brain-dead man walked out of the hospital with his family the following day.

Scott finished his story saying something like: “people talk about God and miracles…I don’t know…that sure seemed like a miracle to me.”

When Scott stopped talking, I leaned forward intently and asked: “Did this by chance happen sometime in the winter between 2009 and 2010?”

“Yes,” answered Scott. It was 2009, Christmas Day.”
Miracles as Physical Containers for Paradigm Shifts

It has become cliché to say “things happen for a reason.” But, when Scott left my house that day, and I pressed rewind to discover a mute video recording, I knew that this interview had happened for a reason. I thought back to Anna’s story about hearing everything in her coma and the choice she had made to return to this life. I thought back to Mr. Jones crying at the end of the prayer and how Anna’s story made me wonder if maybe he had heard the prayer. I thought about Scott’s belief that what he had witnessed was a miracle. Combining my long held investigative consciousness and my relatively newly found consciousness of wonder, I thought and wondered about the nature of miracle. If Mr. Jones heard the prayer, was moved by the expression of God’s presence suffering with him and God’s love for him, and ultimately made a decision to return to this life, was the event in fact a miracle? From a medical perspective, it seemed miraculous that a man whom medical science had declared irrevocably brain dead got up and walked out of the hospital. But from the perspective of Anna’s story and my growing interpretation of Mr. Jones’s tears at the end of the prayer, it seemed that this “miracle” could potentially have a rational explanation. Was the miraculous nature of what happened diminished by the rational explanation? Even if rationality could be used to explain things in hindsight, could not irrationality have been potentially pivotal in the outcome? Would I have prayed for a miracle without having given myself over to the irrational desire for the impossible? Did not Scott’s plea for a “flog” contain a heavy dose of ironic irrationality? Did Scott’s irrational plea and my irrational prayer play a role in Mr. Jones’s rational decision?
Or was the connection between Anna’s story and Mr. Jones’s crying at the end of my prayer merely coincidental? Even if that were the case, I was convinced that it could not have been a mere coincidence that I met Scott at a party hosted by a friend of a friend, and he drove to my house and sat in my living room relating this “merely coincidental” story. I was convinced that all of this had happened for a reason. But what was the meaning of it all?

I thought about how much my prayer request for Mr. Jones’s miraculous healing meant to me as a marker for how far I had come in my journey from calculation to care. Previously, I would have been greatly relieved that Mrs. Jones had already accepted her husband’s impending death and was not looking to me for a prayer to the contrary. Had this event occurred a few months prior, and had Mrs. Jones requested prayer for a miracle, I would have dreaded praying for Mr. Jones to be miraculously healed in this context of perceived impossibility. The replacement of dread with desire was a paradigm shift for me. It cracked open the door for a slowly growing possibility of conscious feeling to begin to leak down from my head into my heart. I thought about how the paradigm-shifting meaning of this event for me coincided with Scott’s radical shift from cynically bemoaning “flogs” to frantically pleading for this particular “flog” without which Mr. Jones would have been discharged to the basement morgue awaiting the arrival of the funeral home pick-up team rather than being discharged to his home the next day. Did God work a miracle through Scott’s plea? Through my prayer? In cooperation with Mr. Jones’s decision? Or is the miraculous, or some aspect of it, disconnected from human synergy? What was more miraculous: Scott’s irrational plea
for a flog, my irrational plea for God’s healing, or Mr. Jones’s potentially conscious
decision to reverse his previous decision for suicide? Could the greatest miracle be that
in and through this event, Scott, and I, and Mr. Jones all three experienced the miracle of
a life-changing paradigm shift?

What does this mean for my conceptualization of the miraculous? What might it
mean for exploration of modern medicine’s relationship to the miraculous? And are not
miracles just the myths of bygone eras, savage notions? What might it mean that modern
medicine’s definition of “brain death” proved to be “just a myth” in this incident? In a
world without Scott’s irrational plea for the “flog,” how might the potential harvesting
and transplantation of Mr. Jones’s organs before he had made the final decision whether
or not to return to this life factor in to the myth that modern medicine proved to be in this
instance?

An exploration of myth theory and its bearing on the nature of miracles will aid in
grappling with each of these questions. In Chapter Four, we will see how Marchenkov’s
(2009) identification of the modern myth of “immanentist infinitism” speaks revealingly
to this later question. In Chapter Three, we will see how my journey of transformation in
route to this miracle corresponds to the patient/family perspective on the disease, healing,
and dying process, as a journey of personal transformation. For now, we turn to Chapter
Two where the context of my personal struggle to respond to patient/family miracle-hope
is recast in terms of a brief introduction to the medical literature describing the
measurable outcomes of the miracle-hope phenomenon in response to life-limiting illness
and the communication challenge physicians face in responding to it. This brief recasting
of my problem of interest in the context of physician-patient/family communication sets
the stage for further examination of said context through the lens of myth theory as
articulated by Losev (2003).
CHAPTER TWO: MEDICINE, MIRACLES, AND MYTHICAL CONSCIOUSNESS

Absolute mythology is possession of religious wisdom, achieved in feeling and through beholding the creatively substantive symbol of the organic life of a person, and given both arithmologically-totalistically and alogically, in the person’s absolute, eternal, and infinite visage. (Losev, 2003, p. 201)

This chapter uses Russian philosopher, Aleksei Losev’s *Dialectics of Myth* (2003), to lay a foundation for informing and critiquing the physician perspective on patient/family hope for miracles in response to prognosis of medical futility. Originally published in Russian in 1930, the book was suppressed in the Soviet Union for more than half a century and its English translation was published in 2003. I begin with a brief introduction to the health communication context and spend the balance of the chapter examining Losev’s theory of myth. Losev’s theory allows a re-characterization of the context along mythological lines that will add a new and much-needed dimension to what may be one of the more emotion-laden irreconcilable conflicts between physicians, patients, and families in modern medicine.

The health communication context in question made its way into mainstream medical literature through a provocative article published in the *Journal of the American Medical Association* (JAMA). In this article, Phelps et al. (2009a) found that terminally ill cancer patients who use religion as a positive source of coping are more likely to prefer intensive life prolonging care at the end of life, a paradoxical finding for the Harvard authors who stated that one might expect religious people to be more accepting of death and therefore less likely to prefer heroic measures that are often traumatic, often
futile, and always costly. The authors attributed their unexpected findings to the religious belief in miracles and hypothesized that the belief in miracles was being intertwined with health-care decisions. Other studies suggest that patients and families who believe in divine intervention are less likely to trust the physician’s prognosis (Zier et al., 2009), and patients and families who believe in miracles are more likely to follow a more complicated and costly trajectory of intensive care at the end of life (True, Phipps, Braitman, Harralson, Harris, & Tester, 2005). Physicians bemoan the inability of health communication efforts to adequately parse out the relationship between miracles, hope, and scientifically unadvisable treatment decisions (Cadge, 2012).

Physician Bob Wachter (2012) wrote a blistering critique of these patients and families, arguing that health-care decisions should be based on science, not theology, hope, or magical thinking. Wachter called for a reasonable conversation over healthcare decisions based on scientific rationality and ended with a sarcastically pessimistic prediction that, while what he hoped for would certainly be a miracle, one can always retain hope. Wachter’s sarcastic pessimism conveys the deep frustration and even debilitating powerlessness many physicians feel in this health communication context. Cadge (2012) documented the challenge that exists for physicians in responding meaningfully to religious patients and families who counter physician predictions of medical futility with continued optimism based on their belief in divine intervention and their hope for a miracle. According to Cadge’s observations, physicians who have confidently reached a prognosis of medical futility tend to share Wachter’s frustration
with the tendency of miracle-hope to complicate communication surrounding treatment decisions.

While medical science has mastered a disciplined method of systematically breaking down problems and finding solutions at a technical level, the triumphant march of creative medical progress can come to a screeching halt when physicians face this particular health communication context with patients and families who hope against the odds for a divinely-granted miracle and infuse these hopes into their healthcare decisions for seemingly futile measures. Physicians who can casually slice open a living body and calmly navigate the most complex procedures are reduced to forms of communication that fall far short of the sophistication we have come to expect from every aspect of modern medical practice. Some physicians understandably resign themselves to the regrettable reality that they can often do no better than making quasi-adversarial pleas such as, “Well, God also instructed us in medicine.” Reflecting on the difficulty of this health communication context, one physician sums up in one telling word the judgment that may ultimately narrow the range of his perception, and with it his arsenal for communication, when he describes the function of religion for miracle-hoping patients and families as “irrational” (Cadge, 2012).

Physicians’ characterization of religiously motivated miracle-hope as “irrational” reflects a particular epistemological standpoint. Epistemology is the study of differing forms of knowledge or ways of knowing. The National Institutes of Health director, Francis Collins, and others have articulated how faith can be understood alongside science and other practices as a complementary “way of knowing” or form of knowledge
Studies show that physicians and patients/families tend to have opposing views on the extent to which faith is a form of knowledge that should impact healthcare decision making: “While most patients will ‘look to God for strength, support, and guidance,’ most physicians will instead try to ‘make sense of the situation and decide what to do without relying on God’” (Curlin, Lantos, Roach, Sellergren, & Chin, 2005). Part of this trend can be explained by the fact that physicians are more likely than patients to be atheist or agnostic (Cadge, 2012). Whether influenced directly or indirectly by atheistic paradigms, physicians’ charges of irrationality emanate from an epistemological lens that tends to privilege the rationality of scientific knowledge over the rationality of faith and other ways of knowing.

Philosopher Aleksei Losev (1930/2003) had a different view on the relationship between faith and knowledge and what it means for atheism to side with one over the other. For Losev, knowledge and faith are inseparable and indistinguishable and the “distinctive mythology underlying atheism” that makes it a “dogma, not science” is seen in the reality that “[t]o be a true atheist one must believe in [scientific] knowledge, place hope in knowledge, love knowledge, and not simply know knowledge” (Losev, 2003, p. 108). Losev’s understanding of the relationship between faith, knowledge, and atheism turns the charge of irrationality back on the physician:

Thus (1) the atheist criticizes objects of faith not on the basis of knowledge; and he was lying to us when he said that it was knowledge that made him criticize faith; (2) he establishes his own objects, again, not on the basis of knowledge (for mere knowledge would only give him logical and purely theoretical objects rather
than real ones); (3) having in fact his own original faith but allegedly deceiving others (and often himself – but no longer allegedly) by saying that he has no faith whatsoever, he gives what is in essence an unanalyzed outburst of affective pressure and blind aggression – against his own essence. (Losev, 2003, p. 107)

Irrationality, of course, is rarely limited to only one side of any intensely irreconcilable difference. According to Losev, both sides of the misguided extremes of imbalanced efforts at separating faith and knowledge and preferring one over the other are equally subject to irrationality. Losev contends that “[t]he passion of the ‘subjectivists’ and the viciousness of the ‘objectivists’ can [both] be explained only by the involvement of non-logical forces” (pp. 123-124).

Together with his diatribe against atheism, Losev’s effort to place faith and knowledge—epistemological subjectivity and objectivity—on equal planes may run counter to the logic underlying the successes of modern medicine. It could be argued that it is too much to expect a physician, rooted as he or she is in the scientific paradigm of modern medicine, to seriously consider a Losevian perspective, especially if the physician is either a committed atheist or at least unsympathetic to the faith perspective of miracle-hoping patients and families. The problem with this contention is that it runs counter to humane notions of twenty-first-century healthcare as a patient/family-centered enterprise (Berwick, 2008). An inhospitable posture toward miracle-hope conjures images of the physician as parochial patriarch forcing his way on helpless patients and families, always assuming infallibility, even though the record of unpredictable health outcomes often proves otherwise. Most importantly, physicians’ efforts to navigate
patient/family miracle-hope from an exclusively scientific paradigm are empirically unsuccessful. The often emotionally charged conflicts that characterize the health communication process in this context are invariably unproductive for all parties. The result is a non-trivial cost of time, money, and emotional well-being for physicians, patients, and families alike (Cadge, 2012).

Given the failure of the status quo, physicians attempting to dislodge patients and families from a “mythical consciousness” germane to miracles may do well to take seriously Losev’s then unlikely—but ultimately prophetic—prediction early in the twentieth century that science will never destroy myth. It might also be that physicians stand to gain new perspective from Losev’s insistence that, before one can refute mythical consciousness, one must first become a mythical subject, and part of that becoming requires coming to grips with myth as something quite other than primitive science. In the process of bringing Losev’s theory of myth into conversation with this health communication context, special attention will be given to his arguments that science itself is always mythological because, in contrast to mythology, “pure science needs neither the absolute assurance of the existence of its object nor the absolute assurance of the existence of its subject, nor conclusive veracity, [whereas] there is a specific mythological veracity” (Losev, p. v).

Perhaps the hardest and most important thing for physicians such as Dr. Wachter to come to grips with in this context is the mythological underpinnings of their presumably purely “rational” perspective. Losev instructs that “we fail to notice the myth behind a systematic argument that appears to be the epitome of science, scientific
reasoning, and logical justification” (p. 134). For Losev, the existence of a systematic scientific argument simply demonstrates that a mythological interpretation of reality has hardened into the abstractions of dogma – just as it does in any religious system of dogmatic theology. Losev will not let physicians get away with the fact that “logical justification is in the foreground” and therefore their “profession of faith or myth is usually [not] noticed,” because, as Losev demonstrates, “myths infringe with enormous power, on the sphere of dialectics and redistribute its categories in their own way” (Losev, pp. 134-135).

Losev’s theory of myth opens up the possibility of a clearer conceptualization of the health communication context at hand. But just as Losev’s challenge—that one must become a mythical subject before critiquing mythical consciousness—applies to physicians, so also, entering into Losev’s mythological reality is a rewarding, if demanding, task. To that end, and as a foundation for a critical examination of the notion of the “art” of medicine, the application of Losev’s theory of myth to the health communication context will be illustrated by taking note of how Losev’s notion of mythical consciousness is manifested in symbol, history, and painting, as contrasted with scientific materialism. Losev’s mythical approach to symbol and history is here refracted through the lens of painting, and in particular through the genre of Orthodox Christian icon-painting, exemplified by the icon known as the “Protection of the Theotokos.” I will begin by introducing this particular icon as an entry point for examining Losev’s notion of myth and later circle back to it as an illustration of the relationship between perspectival form in iconography and mythical consciousness in health communication.
Figure 1. Protection of the Theotokos. 1-a: St. Andrew and St. Epiphanius, 1-b: St. Romanos, 1-c: Theotokos feeding a scroll to St. Romanos, (Photo by Author).

The Protection of the Theotokos

The story, or as Losev would have it, the mythology of the icon according to sacred tradition, recorded in Orthodox liturgical and hagiographical works such as Markarios (2001), centers around St. Andrew (Figure 1-a), a Slavic man known in Orthodox tradition as a “holy fool” who somehow ends up as a slave belonging to a man named Theognostus in Constantinople. St. Andrew serves Theognostus so well that he is given his freedom to be a wandering monk. While the city is endangered by invaders, St.
Andrew is praying in the Church with his disciple named Epiphanius. Andrew has a vision of the Theotokos entering the Church accompanied by a host of saints and praying over the people. Theotokos, literally translated, means “Mother of God,” and is Orthodoxy’s title for Christ’s mother, known in the Western Christian traditions as the “Virgin Mary.” After the Theotokos disappears, the protection of her veil is still felt by St. Andrew and those to whom he conveys his vision, and the city is miraculously saved from the invasion (Markarios, 2001).

A distinguishing characteristic of the icon is the presence of St. Romanos (Figure 1-b), notable because St. Romanos was a 6th century saint and St. Andrew’s vision of the Protection of the Theotokos is recorded in Orthodox tradition as a 10th century occurrence. The myth of St. Romanos is that he lacked melodic skills and on the Eve of the Nativity was asked to stop singing and reading in the Church. Grief-stricken, he shrinks away from the others and falls asleep. The Theotokos appears to him in a dream and gives him a scroll to eat (Figure 1-c). He then awakens, receives a blessing to chant and mounts the ambo of the Church. Out of his mouth pours the Church’s first “kontakion,” a riveting combination of theological profundity, and beautiful poetic melody, this one specifically in celebration of Christ’s Nativity. A genre of Orthodox hymnography, “kontakion” is connected to the meaning of the base around which a scroll is wound. Subsequent to the eating of the scroll and the chanting of the first “kontakion,” St. Romanos composed more than 1,000 hymns that remain in Orthodox Church usage to this day (Markarios, 2001).
The mythology surrounding the Protection of the Theotokos icon illustrates Losev’s notion of myth. Losev takes the reader on a terrifically complex ride en route to a disarmingly simple conclusion. At the end of the philosophical journey, myth is defined as an “unfolded magical name.” Along the way Losev dubs myth, among other things, a “sacred history,” which he reveals to be a particular, holistic perspective and vital interpretation of what modern thinkers might call the bare historical facts. The idea of an unfolded magical name seems to fit every aspect of the myth of St. Andrew where three magical names unfold as symbols mediating spiritual reality. The literal translation of the Greek name Theognostus is “knowledge of God,” Epiphanius is “epiphany,” and another definition of a veil is “protection.” As a slave to the knowledge of God, embracing the identity of a fool, Andrew sees with Epiphany that the veil of the Theotokos is an agent of protection for the city and the people (Losev, 2003).

Myth and Symbol

The danger in summarizing the myth of St. Andrew’s vision of the Protection of the Theotokos in the manner done in the previous sentence is that it risks portraying the myth as a simple fable from which three “morals” can be gleaned or as some other form of allegory or metaphor. Losev carefully distinguishes myth from each of those categories, and more. For Losev, myth “can contain schematic, allegorical and complex symbolic layers,” but it is “always primarily a symbol” (p. 54). Speaking of Achilles and Narcissus, Losev counsels that, “[e]ven if there is allegory here, we must still affirm the genuine, non-metaphorical, and literal reality of the mythical image first, and then pursue our allegorical analysis” (p. 37). This is how the myth of St. Andrew’s vision of the
Protection of the Theotokos is taken in the Orthodox tradition of the icon. The tradition celebrates the feast of the Protection of the Theotokos as its own literal mythological reality, not simply as some story from which abstract points can be drawn. (Markarios, 2001).

Losev explains that in expressive forms such as schema, allegory, and metaphor images point away from themselves toward an abstract meaning existing elsewhere. By contrast, the icon and the feast of the Protection of the Theotokos posit meaning nowhere other than in the self-manifestation of the mythological elements as unfolded magical names. The connection between the meaning of a veil as a protection for one who wears it and the vision of the Protection of the Theotokos experienced in and through her veil does not point away from the image to establish an external meaning, but instead maintains the meaning within the image. This point is vital to Losev’s notion of the nature of symbol and his identification of myth as inherently symbolic. Unlike a schema where the “phenomenon” contributes nothing new to the idea; and unlike an allegory where the “idea” contributes nothing new to the phenomenon, symbol is “an independent reality” where “it is no longer possible to show where the ‘idea’ is as distinct from the ‘image’ and vice versa.” While the two are in one sense distinguishable as inhabitants of two different “planes of being,” their “encounter” at the intersection of their planes manifests them as “utterly indistinguishable” (Losev, p. 38).

The uniqueness of symbol as a vehicle of meaning might be further illustrated by another example. Schmemann (1973) rehabilitates late modernity’s notion of symbol through the lens of the Orthodox understanding of the nature of the Christian Eucharist.
Decrying the false juxtaposition that pits symbol against reality by contrasting the “real” to the “merely symbolic,” Schmemann traces modernity’s impoverished notion of symbol back to an eleventh-century debate over the nature of the Eucharist in the Christian West. According to Schmemann, the Council of Trent’s examination of whether the Eucharist was “really” the body and blood of Christ or “just” a symbol was doomed from the outset because it settled for an overly literalistic notion of reality and a misguided devaluation of the symbolic. Pitted against a devalued notion of symbol, the Eucharist had to be understood by the Catholic Church in terms of its newly coined notion of “transubstantiation.” The Reformation ultimately distanced itself from the Catholic notion of transubstantiation, together with its hypothetical vulnerability to unflattering exposure by a sacrilegious lab workup, embracing instead modernity’s impoverished notion of symbol which ultimately amounts to allegory. While subject to a wide spectrum of degrees of impoverishment, the most widespread Protestant notion of the symbolic nature of communion defines the “Lord’s supper” as a pious reminder of an event that occurred in the past.

As Schmemann explains, Orthodoxy locates the Eucharist on a different plane from the one that pits the “real” against the “merely symbolic.” Rejecting the false juxtaposition of symbol against reality, Orthodoxy embraces the term “symbol” over the term “transubstantiation” in reference to the Eucharist. But the Eucharist has not been relegated to a once-per-month reminder of an event from the past, because Orthodoxy embraces symbol as a medium for intercourse with mystical reality. To state it according to the conceptualization of symbol discussed earlier, the bread and the wine, while
distinguishable from the body and blood of Christ as inhabitants of two different “planes of being,” become “utterly indistinguishable” by virtue of their “encounter” at the intersection of their planes of being. Such is the nature of symbol so key to grasping the reality of myth: “The Protestant theory of sacraments is allegorical while the Orthodox theory is symbolic. The former is merely a pious recollection of divine energies while the latter is their actual emanation…. Thus, a myth is neither a schema nor an allegory, but a symbol” (Losev, p. 41). Just as the bread and wine in Orthodox Eucharist is not a faux symbol that points away from reality, the figures in the icon are not fictional characters that point away from themselves toward an external, abstract meaning. Rather, they are genuine living symbols, saints in whom the planar intersection of historical becoming with ideal being is miraculously manifest as it is in the Eucharist.

Myth and History

Just as the myth of St. Andrew’s vision of the Protection of the Theotokos exemplifies Losev’s notion of myth as an “unfolded magical name,” so also the myth of St. Romanos eating the scroll illustrates Losev’s idea of myth as a “sacred history” (p. 180). In order to understand Losev’s notion of “sacred history,” it is important to grapple with his understanding of history proper and its relationship to myth. According to Losev, history is composed of three tiers. The first tier is the bare facts which are not yet genuine history or even historical material but rather the “raw material that may become historical material, provided they are seen from a completely new perspective” (p. 136). For St. Romanos, the first tier of facts might be that he was a poor reader and singer who developed into an accomplished singer and composer. The practice of modern medical
“history taking” has traditionally taken pains to remain in the “objectivity” of the first tier.

The second tier of history is “the becoming of facts understood in a certain manner, i.e., facts of the understanding, it is always also one or another mode of consciousness” (Losev, p. 138). Bare facts alone do not constitute the subject of an historical account. For all of its shortcomings, postmodernism forces us to recognize that history is always a matter of interpretation (Behr, 2001, 2006). A particular perspective that embraces an understanding of facts viewed from a particular mode of consciousness is the making of a genuine history. Rather than skewing the bare facts, as one concerned with so-called “objectivity” might suspect, the particularity of perspective illuminates the facts so that the material for myth can finally become visible with the help of the second historical tier. In the second tier, St. Romanos shrinks away from the Church ambo grieving his inability to read or sing, gets away to himself, falls into a deep sleep, is fed a scroll by the Theotokos in a dream, awakens, receives a blessing from the bishop, ascends the ambo, and gives beautiful, melodic birth to a new and profound hymn of the Nativity.

The third tier of history is history as an object “of its own consciousness,” an evolving “self-consciousness” (Losev, p. 141). According to Losev, language is the conduit for history’s expression of self-consciousness, and the self-consciousness of history is expressed through the word. The rich mythology depicted in the Protection of the Theotokos icon is expressed in words that convey the meaning illustrated by the painting, for “[w]ithout words, history would be deaf and dumb like a painting which,
although painted well, does not tell anyone anything, for there is no one to perceive it. The painting must start speaking a genuine living tongue and someone must hear it” (p. 142). For St. Romanos, one aspect of the third tier of history might be the word “kontakion.” Expanding upon the depiction of the Theotokos feeding a scroll to St. Romanos, the word “kontakion,” as a symbol of the base of a scroll and the name for the form of Orthodox hymnography implanted in Church tradition by the Theotokos, through St. Romanos, becomes an “unfolded magical name” that expresses the history of St. Romanos the Melodist. At this stage of theoretical development, myth is “personalistic history given in words” (p. 142). Having articulated the vitality of “word” to myth, Losev here makes a contention that he will continue to elaborate as a vital element of his defense of myth in suggesting that “a word is by definition rational” (p. 142). How is word by definition rational, and what does this mean for the rationality of myth? How will Losevian notions of mythological rationality interact with physician characterization of miracle-hoping families as irrational?

**Myth, Painting, and Epistemology**

An important aspect of myth’s inherent rationale is illustrated by distinguishing between the various tiers of history as reflected in the nature of a painting. Losev explains that “as long as we find ourselves in the first tier, we are merely analyzing the individual paints that were used for the painting; the canvas on which it was painted…the chemical and physical qualities of all the substances that the painting consists of” (p. 138). The same could be said of words: as long as we find ourselves in the first tier, we are merely analyzing the individual letters that were used to make the word, the paper on which it
was written, the chemical and physical properties of the ink or lead with which the word was written. Applying Losev’s point to the icon in Figure 1, is this icon, as a reductionist view would have it, known and understood by the chemistry of the paint and wood, or is it something else entirely that transcends the realm of materialism and is known only to mythical consciousness? The next question becomes whether these perspectives are an either-or, zero sum game, and if not, which one is subordinate to the other; which one is simply a tool, and which one renders the “big picture?”

Sherwin Nuland answers this question as it applies to the field of medicine. For Nuland, the “big picture” cannot be seen by science. Nuland (1995) traces the success of twentieth-century U.S. medical education after a vital pendulum swing in the direction of the scientific method; however, Nuland believes that the “flash of [science’s] brilliant arc…[has] dazzle[d] the eyes of an entire profession into a kind of blindness toward the needs of the sick and dying people for whose welfare they are responsible…. [because the] pendulum has swung too far; the hegemony of science is now virtually absolute” (1995, p. 287-288). For Nuland, science is a vital tool that can only be humanely wielded by “incorporation into beneficence, empathy, and kindness, which are the primary ingredients of care.” Nuland goes so far as to call for a restoration of the “pastoral role of the physician” and prescribed “nothing less than a change in the culture of medicine” subordinating the scientific lens to what Losev calls mythical consciousness.

Applying Nuland’s argument for medicine to the icon in Figure 1, the science of paint chemistry is useful insofar as it could have been an important tool in service of a larger art. Paint chemistry falls multiple tiers short of capturing the essence and reality of
the icon. Therefore, the mythical consciousness required to illuminate the reality of the icon is inherently rational because it is the only form of logic that makes sense out of what the icon really is, and without it, the icon risks being reduced to nothing more than the parts that make up its whole. Under the irrationally narrow interpretive lens of scientific hegemony, the icon, like Nuland’s “individual patient,” is “rendered invisible” (Nuland, 1995, p. 279). Rendering the mythological reality of a subject invisible leaves one at risk of relating to it in an improper manner; for example, while knowledge of paint chemistry may be useful for the technical aspects of successfully painting over the crack running down the right side of the aged icon, this knowledge alone runs the risk of being insufficient to the task of contemplating if and how restoration should be attempted.

Only mythical consciousness ascends to the third tier of history where the small scroll obscured by the crack contains an entire universe of meaning giving birth to more than a millennium of “kontakia” for a community of sacred tradition. The same applies in medicine where increasingly technical decisions from the first tier of analysis are blind to the mythological reality seen only on the third tier of individual suffering patients (Losev, 2003).

**The Alternative to Absolute Mythology is the Partial Mythology of Materialism**

Losev argues that if history remains in the first tier and science becomes the exclusive rationale for human knowledge, all we get at the end of the day is matter which, according to Losev, is a scarecrow for living reality. Demythologizing the modern myth that matter is what we see with our eyes, Losev argues that there is nothing living that can be pointed to as a specific example of disembodied matter. Matter, then,
is no more logically legitimate than any other concept. As yet another abstract concept, matter is modern science’s emperor wearing no clothes; therefore, modernity’s “special revelation of matter” is “similar to the appearance of angels” (p. 114), and if materialists are to be granted the existence of matter, then they must also grant other believers the right to absolutize their own especially revealed abstract concepts.

I fully agree that, to materialists, this revelation of the ‘material’ absolute is quite obvious and convincing; and I acknowledge their logical right to be aware of this experience and construct its scientific system. But then materialists must acknowledge that:

1. It is not logic and knowledge that lie at the foundation of their system but immediate and, moreover, suprasensible revelation (for matter, as we have agreed, is not something sensuous).

2. This revelation gives an experience that claims absolute exclusivity, or, in other words, this experience blossoms into a religious myth.

3. This myth receives its absolute assertion in thought and hence becomes a dogma. (Losev, p. 114)

The materialistic perspective that would reduce an icon to elements of paint and wood is not a uniquely objective or uniquely rational stance on reality, but rather one among many forms of mythical consciousness. As a deity which materialists “worship” together with the “black holes [we’ve] discovered in space,” matter remains mystically elusive, unclear “whether it’s clay or manure” or a “monster” of “death” (pp. 116-117, 183).
For Losev, materialism turns out to be a belief system that replaces living mythological reality with dead, disembodied matter and then glorifies its only remaining interest: mechanistic functionality. The materialistic worldview “hypostesizes mechanism, reifies it, absolutizes it, deifies it, and replaces everything with it…. [O]nly matter really exists and rules everything…. Materialist faith, however, forces one to assert that *nothing exists, apart from matter*” (Losev, p. 116). Materialism paints a universe deprived of magic, devolving into utilitarian functionality. Tellingly, this mechanistic devolution into functional wood is precisely the path that the specific icon pictured in Figure 1 was headed when the person who brought it to the U.S. during the collapse of the Soviet Union salvaged it from being burned with the many other icons that were finding their reductionist utilitarian destination as large pieces of wood in a cold area of the world: fuel for fire.\(^1\) The medical manifestations of modernity’s beholdenness to matter and mechanism are explicated in following chapter, and an alternative application of mythical consciousness is taken up in Chapter Eight.

Zooming in from Nuland’s (1995) broader medical vision, how does the identification of a holistic perspective on the icon with mythical consciousness apply to our context of interest? Would a more holistic perspective on the dying patient and his or her family as icons make the physician less frustrated by the family’s seemingly irrational hope for a miracle? For Losev, belief in miracles is far from irrational. As the very concept that Losev identifies to characterize mythological detachment, miracle is not only rational, it forms the undergirding rationale of mythical consciousness. Mythology is by

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\(^1\) H. L. Judy, personal communication
definition concerned with the miraculous. Modern materialistic reductionism has lost sight of the perspective on reality or method of interpreting reality that gives rise to miracle because it is unable to progress past the first tier of experience. Having reduced everything to isolated and fragmented parts, it is this unable to see the forest for the trees. For the physician facing a communicative impasse with the family hoping for a miracle for their dying relative, it is understandably difficult, from the perspective of medical science, to see anything other than an irrational family that needs to step out of the stone ages and make decisions based on science as Wachter (2012) demanded.

Alternatively, a mythological perspective might see a family viewing their relative holistically as an icon through what Losev calls the “personalistic” nature of mythical reality. The doctor, however, as a product of modern materialistic reductionism, is stuck in what Losev calls the isolated and fragmented perspective of organ failure, or to put it another way, only sees the wood and paint. Without delving too deeply into the medical context at this juncture, this critique is not intended to suggest that doctors should pretend that all patients will live forever. But it might mean that their level of compassion for seemingly irrational hopes and the manner in which they engage the mythical consciousness of grieving and fearful families could be helped by an appreciation for the mythological realities of persons as icons.

**Egocentric Space and the Physician’s Gaze**

If, as Nuland (1995) claims, the future of medicine hangs on its self-(re)discovery of its previous and future identity as “The Art,” then one way of conceptualizing the doctor-patient/family relationship is to think of it in terms of how
space is used in different forms of painting. Losev uses the iconic representation of space to articulate how myth depicts the face of a person in such a way that the deeper essence of the person unfolds itself in the facial image that myth depicts.

An egocentric orientation towards the external or real world is reflected in painting as the central perspective of converging lines, space here is closed and concentric. An eccentric orientation, such as in the old Russian [Orthodox Christian] icon-painting [seen in figure 1], on the other hand, produces a space that unfolds towards the viewer. This is the eccentric system of representing space. In the egocentric system, space folds into its own depth and is subordinated, as it were, to the active penetration of the viewer’s glance into the external world. In the eccentric system, space itself unfolds from within. This is quite understandable since icon-painting was the product of a worldview based on the assertion of Substance that unfolds and reveals itself in its external being. (Losev, p. 94)

If the eccentric orientation of Orthodox iconography flows from a miraculous, mythological worldview, then egocentric orientation emanates from the era and worldview of scientific materialism. In his seminal work on perspective, art historian Panofsky (1997) explains that the egocentric perspective reduces art to what Losev calls the first tier of history by “evaporating ‘true being’ into a mere manifestation of seen things” and “anchoring the free and, as it were, spiritual idea of form to a manifestation of merely [sic] seen things” (pp. 71-72). Egocentric perspective, then, eliminates the mythical consciousness that receives art as miraculous medium and “seals off religious
art from the realm of the magical, where the work of art itself works the miracle, and from the realm of the dogmatic and symbolic, where the work bears witness to, or foretells, the miraculous” (Panofsky, 1997, p. 72). The world from the materialist perspective that has no room for mythological meaning could be said to present itself to the materialist viewer as an egocentric space that is “subordinated to the active penetration of the [objective] viewer’s glance” (Losev, p. 94), whereas the world from the mythical perspective could be said to invite the viewer into a subjective experience of the wholeness that unfolds itself toward her.

For the medical context in question, Losev’s description of the “active penetration of the viewer’s glance” recalls “the physicians gaze” a term coined by Bishop (2011), a physician philosopher of medicine. As a medical manifestation of objectification theory (Fredrickson, 1997), the physician’s gaze refers to the patient/family self-experience of feeling objectified as yet another piece of data under medical science’s microscope, where the physician personifies in his interaction with patients and families cold objectivity of self-removal, manipulation and control mandated by the scientific method. The emotionally-ravaged family, on the other hand, is yearning to be viewed not through the objective gaze invited by egocentric space, but through the subjective eyes of compassion open to seeing an eccentric space of persons unfolding themselves toward a physician-healer, rather than physician-scientist, in all of their wholeness like icons. As intimated in his book’s provocative title, The Anticipatory Corpse, the thrust of Bishop’s argument is that the practice of medicine and specifically medical care for the dying is haunted by its own epistemological roots in the human corpse as a firm foundation for
scientific knowledge and thus an ideal type. The popular idiom, the “graveyard shift” is a reference to early researchers who snuck into graveyards at night and dug up corpses to study and experiment on. To this day, doctor-patient communication is a low priority in medical education, and the first patient medical students meet and come to know is a corpse. Like egocentric space, the corpse is “subordinated,” to the “active penetration” of medical science, fully patient, and thus medicine’s ideal patient. As noted above, Losev critiques not science per say, but what he calls the materialist faith coming out of the dogma of scientific reductionism. In this faith, everything is reduced to matter, and only matter is real. But science cannot point to any particular living thing as a specific instance of matter because every living thing retains a life force, a mythological reality—a dynamism that is not fully patient to objectification through the manipulation and control of the scientific method. Because only matter is real, everything must be reduced to matter, made patient, in order to be known by science. Thus, in the faith system of materialism, “everything is ruled by a corpse and [anticipatorily, according to Bishop] reduced to it” (Losev, p. 115).

The “Miraculous” Myth of Materialism

This fascination with death as the ideal and ultimate subject of materialism’s mythical consciousness and objectifying gaze turns the conversation about the miraculous on its head. While many modern minds might be as sympathetic to the miraculous reality of St. Andrew’s and St. Romanos’s visions of the Theotokos as some physicians are to the miracle-hopes of families defying the prognosis of medical futility, Losev argues that materialism is the most fantastic myth and miraculous religion in existence since it posits
death as the source of life which is the most genuine faith and unlikely miracle-hope of all:

The only and exclusive original creation of modern materialism consists precisely in the myth of universal death Leviathan which – and this constitutes the materialist faith in miracles—is embodied in the real things of this world and dies in them to rise again and to ascend to the black heaven of a dead and dull sleep without dreams and without any sign of life. For this is the genuine miracle – for things to arise out of dead matter. (Losev, p. 117)

Matter, manure, death, corpses, paint, wood and flames, or mythology, miracle, spiritual vision, and unfolded magical names? According to Losev, reality is a matter of perspective and interpretation.

Far from a condemnation of good science, the line that Losev (2003) and Bishop (2011) draw between life-giving science and death-obsessed scientific reductionist materialism is a line that science crosses when it is applied to questions that it is not designed to answer. This is the line between science and what we now call “scientism.” Scientism is the belief that science is the answer to everything. For scientists, the tools of science are the hammer, and reality is the nail. Common scientistic convictions include the beliefs that “only scientific knowledge is valid,” that “science can explain and do everything, and that nothing else can explain or do anything,” and that “science and reason, or scientific and rational, are co-extensive terms” (Cowburn, 2013). Critics of scientism, such as Bottum (2013), point out the limitations inherent in the fact that “science studies broken and dissected objects.” The critic of scientism “does not reject
the truths that science discovers about the partial things it investigates,” but “only rejects certain philosophies of science—the ones claiming that scientific partiality discovers all that is true about those things.” Art grants to paint chemists their particular knowledge of the painting. “The whole has trouble with the part,” explains Bottum, “only when the part rebels, sets up a gimcrack throne in its tiny dukedom, and proclaims itself emperor of all.”

The provocative nature and passionate style of Losev’s argument may be a result of the fact that he witnessed such a rebellion and setting up of a “gimcrack throne.” The brief circulation of the text on which this chapter relies was an historic event in 1930. *The Dialectics of Myth* was the last independent publication of Russian philosophy in the Soviet Union. Charged with “smuggling ‘counter-revolutionary’ excerpts into an approved manuscript,” Losev was arrested and condemned to a labor camp for his heresy against the dogma of materialism (Losev, p. 13). Losev’s identification of mythical, miraculous, and dogmatic aspects of scientific reductionist materialism is more than a hypothetical theory. These arguments flow from lived experience and carefully reasoned analysis and, for Losev, there is no escaping the fact that life is lived mythically whether consciously and admittedly or not: “From my point of view, mythology and dogmatics never stopped and will never stop functioning within humanity, and so-called atheism and positivism are as full of them as any religion that openly declares itself as such” (p. 104). Everyone lives according to some kind of acknowledged or unacknowledged belief system, and each belief system evolves according to a certain pattern.
For each belief system, there are mythical realities that ultimately manifest themselves historically as absolute realities because they come to be recognized by their followers as meta-truths or organizing principles for mythical consciousness. In this process of demanding recognition as the organizing principle(s) for a particularly chosen mythical consciousness, certain myths are hardened into the form of dogma. The progression from myth to dogma is a “rational necessity” because the myth that becomes dogmatized proves itself to be a source of mythical rationality such that the/a truth of life can be seen in its light (Losev, p. 103). The next step of “rational necessity” is for dogma to be systematized into a larger framework of dogmatic theology (p. 104). Losev acknowledges that his own religion, Eastern Orthodox Christianity, developed in this same way with the resurrection of Christ progressing from mythical to dogmatic status, and he sees this progression from myth to dogma to dogmatic theology in all belief systems, whether self-consciously religious in the traditional sense or not.

Losev’s notion of scientific rationality comprising one among many belief systems exposes the inherent relativity of the physician’s characterization of the hoping family as hopelessly “irrational.” Irrational according to whose mythical consciousness, whose absolutized dogma, whose system of dogmatic theology? This question can only sound ridiculous to modern minds unconsciously entrenched in the matrix of their own unacknowledged myths. These myths are explored in the following two chapters. Here, it is enough to note that knowledge of the living will always fall short of objectivity and be subject to degrees of certainty. This is why a cursory google search of “medical miracle” will reveal that medically unexplainable “miracles,” whether attributed to God,
positive thinking, or dumb luck, while relatively infrequent, happen every day. Objective knowledge is limited, at least as applied to the living, and the miracle of life cannot be fully rationed by the mechanics of death.

Miraculous Mythological Rationality

If the rationality of medical science is not inherently superior to the rationality of more intentional forms of mythical consciousness that are self-consciously drawn to the miraculous, what is miraculous mythical rationality, and how does it work? Physicians may be surprised to hear that, at least according to Losev, a miracle cannot be fully understood as simply a rare breach of natural law by divine intervention; this understanding of miracle exposes its outsider perspective. As Losev maintains from the outset, mythical consciousness cannot be grasped merely from the outside; it must be tried on for size and experienced in order to be comprehended, characterized, and critiqued. From the perspective of mythical consciousness, miracles are not understood as the violation of the laws of nature because these so-called laws themselves are miraculous, and divine intervention is not rare; indeed the “genuine” laws of nature themselves are understood as products of miraculous divine intervention in a mythological world where “miracles are performed continuously, and all things are miraculous” (Losev, 2003, p. 145). What then is a miracle from the perspective of mythical consciousness?

Losev’s notion of miracle recalls his understanding of symbol; this should not be surprising since he identifies myth as both symbol and miracle. If symbol is an “encounter” where “two planes of being” become “totally indistinguishable,” then
miracle is a similar encounter of “two planes of personhood” where “while being entirely different, these two planes are necessarily identified with each other in some indivisible image” (Losev, p. 155). The two planes of personhood that become identified in an indivisible image are:

(1) the person by herself, apart from her change and her history, i.e. the person as an idea, principle, the meaning of her entire becoming, and the immutable rule by which her actual becoming aligns itself; and (2) the history of this person, her actual flux and alogical becoming, continuous and uninterrupted, fluid multiplicity-unity, her utter fluid homogeneity and purely temporal duration and tension. (p. 155)

More simply put, “the coincidence between the flux of a person’s empirical history, which is full of accidental occurrences, and her ideal design is a miracle” (p. 162). In miracle, the historical person who is struggling to become intersects with the extra-temporal ideal of who the person was created to be, and the “indivisible image” according to which they are identified is always an interpretation of the already invisible past from a perspective in the constantly elusive, fleeting present, lived in the hope for an altogether new and divinely granted future.

Losev’s revealing usage of the term “coincidence” in the shortened definition of miracle above highlights the reality that the line separating the “truly” miraculous from a “mere” coincidence is always a matter of interpretation. Miraculous experience “is a specific method of interpreting historical events rather than a search for some new events as such” (Losev, p. 158). Proper to this manner of interpreting is a “modification of the
meaning of the facts and events rather than the facts and events themselves” (p. 158). The manner of meaning modification that constitutes this method of interpretation, however, is anything but contrived because, as Losev points out, a “person who believes a miracle cannot be dissuaded by anything. Even the term ‘faith’ is not appropriate here. Such a person sees and knows the miracle” (p. 158). Sharot’s (2011) neurological research corroborated this point. Sharot observed through empirical evidence that the degree of certainty people have about the cogency of their memory of past events varies not according to their relative objectivity as observers or even according to the degree to which what they recount corresponds to the “first tier” bare historical facts, but rather according to their level of emotional experience of meaning. It is an empirical fact that emotional experiences that modify meaning give birth to their own reality that constitutes the interpretation of history most valued and passionately adhered to by human beings (Sharot, 2011).

The myth of St. Romanos the Melodist might serve to illustrate Losev’s point regarding the reality-transcribing experience of mythical interpretive coincidence. It is clear from the narrative that St. Romanos “sees” and “knows” the miracle through which the Theotokos transformed him into a melodist, by appearing to him in a dream and giving him a scroll to eat. Similarly, in the icon, St. Andrew is pointing to what he and Epiphanius “see” and “know” to be the miracle of the Theotokos weeping and praying over the people and gracing them with her protection. Someone else might choose to argue that St. Andrew and Epiphanius were clearly hallucinating or that St. Romanos’s dream was a “mere coincidence” that, if anything, may have motivated him to dig a little
deeper and lay claim to his latent melodic powers. In fact, this would undoubtedly be the conclusion of the “historical critical method” since the aim of modern history is to reconstruct as closely as possible precisely what would be captured by a video documentary of events if an invisible camera crew could be sent back in time.

Stuck as it is in what Losev calls the first historical tier, the modern method of doing history precludes the possibility of miraculous interpretation. Thus, it is perhaps not so surprising that medical history taking does not unearth the kind of “factual material” that Losev states is required to open up the possibility for a mythical interpretation capable of seeing more than wood and paint (p. 138). How can we speak of this vast dividing line between analyzing paint chemistry and interpreting the meaning of a painting? What exactly constitutes the tragedy of the inability to comprehend the painting by discerning the miraculous nature and true meaning of persons and events seen through mythical consciousness?

The myths of St. Romanos and the Protection of the Theotokos help us to see precisely what is at stake in the mythical interpretation required to gain entry to the miraculous reality of mythical consciousness. The miracle of the Theotokos transforming St. Romanos into a melodist by feeding him the scroll reveals the meaning, purpose, identity and reality of St. Romanos as a conduit of divine grace and vessel of divine truth and beauty. Without miraculous mythical consciousness, St. Romanos is nothing more than an uncommonly talented late bloomer. This analysis of St. Romanos would be a tragically irrational misapprehension of his true identity, as he is known by the community that loves him.
The miracle of the Protection of the Theotokos reveals the reality that the veil given to the Theotokos for the protection of her own face is in fact a protecting veil for the entire community of the “Virgin Church” that gives birth to sons and daughters of God. Without miraculous mythical consciousness, the event of the Protection of the Theotokos would simply be remembered, according to the first tier of history, so deft at culling out “what really happened,” as that time when a half-naked beggar was mistakenly allowed into the Church and disturbed the peace with indecipherable blabbering about delusional visions of the most Holy Theotokos and had to be shown his way to the door and blocked from causing future disturbances by a proper restraining order for the “protection” of the Church.

Does the problem with modernity’s inability to perceive the miraculous nature of reality boil down to an unfortunate lack of imagination or creativity? Is the forgotten third tier of history an expendable tradeoff for advances in technology? Or is there something much more vital unfolding in the sacred encounter where two planes of being and personhood coincide to produce an “indivisible image” of modified meaning known as a miracle?

Miracle and Meaning

A civilization unable to ascend from analyzing the mundane to experiencing the miraculous suffers the loss of meaning and purpose so vital to human thriving. If the only valid questions are “what?” and “how?”, then there can be no “who?” and “why?” “Why privilege science, just because it sets out to explain the world? Why not give
weight to the disciplines that interpret the world, and so help us to be at home in it?” (Scruton, 2013).

Exclusively egocentric space yields only misinterpretations of the true meaning of persons and events by failing to convey the reality revealed through the coincidence of two intersecting plains of being or personhood. But when being and personhood encounter one another in such a way that historical becoming is co-identified with eternal being in an “indivisible image,” that encounter becomes a concrete medium for, and gateway to, the bliss of mythical consciousness. What could be more rational for the genuine progress of humanity than complementing analysis with understanding by adding to the questions, “what?” and “how?” the equally rational questions, “who?” and “why?” This is the irreplaceable rationality of miraculous mythical consciousness; it facilitates human inquiry into vital dimensions of the nature of reality. By employing a perceptive rationale that allows the unfolding proper to eccentric space, mythical consciousness experiences the coincidence of two separate planes into an indivisible image as anything but “mere.” At the intersection of time and eternity, the medium of miraculous coincidence can be a container for modified meaning.

After establishing the true meaning of miracles, Losev clarifies the purpose of the often physical nature of the miraculous. Using miraculous bodily healing from disease as an example, Losev states that:

The biological and in general corporeal-organic and physical nature of a miracle is significant merely as the arena of the form or the method of manifestation for
what is called the genuine miracle. By itself, it has no independent significance, even though it is indispensable since the miracle manifested itself in it. (p. 164)

The physical nature of the miracle then is the physical or historical container for, and conduit of, the meaning conveyed just as the wood and paint are the physical containers for the meaning of the icon. The importance of this point to the medical context might be better grasped after drawing a comparison to one of history’s most celebrated miracles: the resurrectional appearance of Christ to his disciples on the Road to Emmaus, relayed by the Gospel according to Luke as illuminated by Behr (2006).

Modern history often views the miraculous nature of the resurrection of Christ exclusively in terms Losev refuted earlier, such as a question of the violation of natural law (with the idea that according to natural law, a man who has been dead for three days could not possibly be up walking about, and therefore Christ’s resurrection is a miracle and the likelihood of this supposed miracle is a matter for modern historical investigation). A close reading of the road to Emmaus narrative, however, reveals that the genuine miracle for the disciples to whom Jesus appears is their experience of a miraculous new interpretation of the nature of divinity, humanity and all of reality.

This new interpretation of reality is triggered by a new interpretation of their [Hebrew] Scriptures to convey the necessity that the Messiah must suffer. Before this encounter, the disciples were looking for a political Messiah to give them power over the Romans. From this perspective, the crucifixion was a sad defeat. As Luke 24 narrates, the Risen Christ appears to his disciples on the Road to Emmaus asking them why they look so sad. Taking him to be an uninformed gardener and scolding him for not knowing
about the recent crucifixion of Jesus, who they had hoped would “redeem Israel” from the Roman yoke, they perceive no miracle. The Risen Christ proceeds to render to them a modified meaning of the Law, the Psalms, and the Prophets. At the intersection of his cruciform personhood and their hopes for deliverance from the Romans by a powerful Messiah, Christ reveals the paradoxical power of his eternal being as a voluntary weak Messiah. This miraculous modification of meaning transforms the disciples’ conception of divinity, humanity, and reality. If the cross is the answer, then their real problem is not their lack of power over the Romans, but rather their own unsustainable search for identity outside of God’s humble love. Only after they absorb this new meaning together with Christ in the “breaking of bread” do they finally recognize him for who he is. But as soon as they experience the coincidence of recognition, he immediately disappears from their sight. As they reflect back on their experience of the miracle of his resurrection, they speak of their “hearts burning.” But they do not connect the burning of their hearts to a realization that the laws of nature have been violated by his resurrection. They connect the burning of their hearts to the “opening of the Scriptures” where they experienced a modified meaning of reality granted through a new understanding of the paradoxically miraculous nature of divine power actualized in voluntary weakness. The so-called miracle, then, of the violation of natural law, is, as Losev explains, most significant as a context, or physical container, for the genuine miracle of the modified meaning that it mediates.

Similarly for the medical context, the family’s hope for a miracle is a container of meaning begging to unfold itself to the physician who might be willing to engage the
miraculous interpretive matrix of mythical consciousness. What does this hope mean to this family? What would a miraculous healing mean to them? What would it mean for the patient? What might it mean for their relationships and their future life together? What new meaning would they seek in their relationship with their restored loved one? To be freed from the shackles of the first tier of history, and engage the painting as a whole, to be in a position to comprehend the nature of the miraculous that is hoped for, the physician must seek entrance into mythical consciousness. To refrain from being experienced as an objectivizing monster of death, physicians must exit the egocentric space of the penetrating gaze and instead become subjective students of myth. Physicians must allow themselves to become subject to, penetrated by, and patient for what unfolds toward him. The first step in this direction is a step toward what “problematic integration” (PI) theory will reveal to be a release from the shackles of impossibility through the gateway of desire.

To kindle the imagination necessary for a physician in order to risk the possibility of making a heroic journey into the magical reality of mythical consciousness, the last and most stirring word for this chapter must be given to Losev’s seductive invitation to the universe of mythological rationality:

A person wants to depend on nothing or at least to be dependent on something in a way that would not limit her internal freedom. A person does not want to fall into separate parts, dash about in contradictions, or disintegrate into darkness and non-existence. A person wants to exist like the eternally blissful gods who enjoy the infinite peace and intelligent silence of their completely independent and
luminous being. And so when the sensuous, motley, and accidental history of a person, immersed in relative, penumbral, impotent, and painful existence, suddenly arrives at an event in which her genuine and original, luminous predestination is manifested, the lost blissful condition is recalled, and thus agonizing emptiness and the confused noise and din of empirical existence is surmounted – then a miracle is being created. There is in miracle a breath of the eternal past, violated and corrupted but now suddenly rising again as a pure and luminous vision. Destroyed and disgraced, it conceals itself, unseen, in the soul, and now awakes as pristine youth and the clear dawn of being. The past has not perished. It stands as unforgettable eternity and native land. In the deep memory of the ages, the roots of the present are hidden, nourished by them. Eternal and native, this past rests somewhere in one’s breast and heart and we are powerless to recall it, as though it were some melody or painting seen in childhood, that one seems almost to remember – but not quite. This recollection suddenly arises in a miracle; the memory of the ages is revived; and the eternity of the past, inexhaustible and unending, unveils itself. Intelligent silence and the peace of eternity emanate from a miracle. It is a return from a long journey and settling in one’s native land. Everything that the soul lived by, the noise and din of being, the empty diversity of life, the wickedness and vileness of the principle of existence itself – all this is blown away like a bit of fluff and one smiles at the naivety of such being and life. And forgiveness is already given, and sin is
And a blissful languor of the flesh, as it were, is formed; and there
approaches the morning of the pristinely youthful spirit. (Losev, p. 167)

Losev’s seductive words invoke the opening line to Bottum’s (2013) critique of scientism: “I would rather live in a world with a thousand saints than a thousand scientists…. Forced to choose, I would dwell where the dragons are, where the Grail is sought, where prayer is efficacious, where the stones cry out, where miracles are so common they seem almost unmiraculous, where human life is thick and rich and sacramental.”

Before we can connect Losev’s theory of myth to Babrow’s (2007) “problematic integration” (PI) theory of communication in Chapter Five, we must first explore more deeply the implications of Losev’s arguments for our context of interest. Following Losev’s critique of materialism as a bland alternative to mythical consciousness, Chapter Three explores three particular medical myths of mechanism emanating from the foundational modern myth of matter. Chapter Four uses Marchenkov’s (2003) historical study of the Orpheus Myth to inform the manner in which modern medical myth influences physician challenges in the context of interest by rooting the communication impasse in Marchenkov’s concept of “immanentist infinitism.”
CHAPTER THREE: THE CANONICAL GENRES OF MODERN MEDICAL MYTH

Science is not in reality the purely rational enterprise it pretends to be; it is after all the work, not of computers, but of men [and women]. There is reason to believe that the paradigms of science are more than cold, sober conjectures, postulated as pure hypotheses. It appears that the top paradigms are weightier than that, which partly justifies calling them “myths.” But as I said at the start, not all myths are alike—no more than the men [and women] who embrace them. (Smith, 2001, p. 227)

I begin Chapter Three by revisiting and building upon Chapter Two’s discussion of the health communication context of interest as introduced in the medical literature. As I pointed out there, the prevailing view of physicians confronting miracle-hope in response to their prediction of medical futility is reflected in Wachter’s (2012) contention that “decisions by patients and surrogates about treatments near the end of life should be based on empirical data and science, not on hope, theology, or magical thinking…. Can we have a calm, rational discussion about all of this, built on a foundation of science? In today’s America, I’m sad to say that that would be a miracle. But a person can always hope.”

Citing research showing religious objection to the concept of medical futility (Zier et al., 2009) and the belief that a miracle could bring a patient out of a persistent vegetative state (Jacobs, Burns, & Bennett, 2008), physician Wachter (2012) laments the tendency of religious hope for miraculous healing to fuel futile end-of-life heroics that account for a substantial portion of the exponentially increasing costs of health care in the
United States. A recent ethnographic study of the role of religion in hospitals unearthed similar sentiments:

The extent to which religion and spirituality help rather than hinder in the ICU, Dr. Davis explained, “all hinges on really whether there’s a conflict about what we think as... caregivers and what the families think.” When there is a conflict based on religious beliefs, Dr. Davis says they try as physicians to be “rational,” and religion “can be in a way irrational.” (Cadge, 2012, p. 147)

The purportedly irrational engagement of religion (namely Christianity) with medical prognosis fits nicely with the Enlightenment’s religion vs. science “conflict thesis” popularized in North America in the late 19th century; however, a study of the relationship between medicine and early Christianity through the more recent “complexity thesis” lens, reveals that, while belief in miraculous healing was universal in antiquity, early Christianity held medicine in high regard and largely enjoyed a rational engagement consistent with trust in medical prognosis (Ferngren, 2009). How, then, did Christianity come to be known as a purveyor of false hope, antagonistic to rationality prized for life-and-death health care decision making? Before exploring this question, it must first be asked, why is this issue even a problem, and why is this problem so bothersome to medicine?

First, it is important to re-emphasize that reflection upon the tendency of religion to produce “irrational” health care decisions has come into focus concomitantly with the rising cost of health care in the U.S., a growing belief that the largest chunk of expendable waste is for aggressive end-of-life care increasingly deemed in equal parts
expensive, unsavory, and altogether unnecessary (Court, 2009). As noted in Chapter Two, Zier et al. (2008) observed the incompatibility of belief in divine intervention with trust in physician prognosis; Phelps et al. (2009a) found that positive religious coping predicted intensive, life-prolonging care in the last week of life, and True et al. (2005) found that late-stage extreme measures to prolong life were associated with belief in miracles. Together, these observations paint a picture of “false hope” in divine intervention as a substantial cost to the U.S. health care system. The intensity behind Wachter’s (2012) desire for a “rational conversation” flows from the context of his concern for a “health care world in which costs must be cut.”

With all of the achievements of medical science, why can it not treat religiously motivated “irrationality” in end-of-life prognosis conversations and health care decisions? What is it about “false hope” that is so impervious to modern progress? Why has medicine, in all its cleverness, not been able devise some way of communicating predictions of futility that would seem trustworthy to religious family members of dying patients? While it may be argued that engagement with religion and spirituality is outside the domain of medicine, two realities point to the contrary.

First, in a 21st century world of bio/psycho/social/spiritual, patient/family-centered medicine, health care consumers indicate that, for them, spiritual and religious care is inseparable from good medical care (Balboni et al., 2010). As Balboni and colleagues reported, the majority of patients view religion or spirituality as important to their coping with advanced illness (Koenig, Larson, & Larson, 2001), and express desire for an integrated body-soul care experience (Steinhauser, Christakis, Clipp, McNeilly,
McIntyre, & Tulsky, 2000). The importance of religion and spirituality is not merely hypothetical, but actually proves to be inseparable from the medical experience, impacting medical decisions made by patients. Unlike most physicians who anticipate that faith in God is the least important determination for patient’s anticipated inpatient experience, patients and families rank faith in God as a close second only to the possibility of the treatment to cure the disease (Silvestri, 2003).

Second, spiritual support by the medical team, though infrequent and undefined, is associated with better quality of life at the end of life (Balboni et al., 2010), and a 42% reduction in the cost of care in the last week of life (Balboni et al., 2011). Furthermore, the data indicates that while chaplaincy support is also meaningful to patients and families, the spiritual support that impacts health care decisions comes from the medical professionals with whom those decisions are being navigated (Balboni et al., 2011). If ill-advised health care decisions rooted in religiously based “false hope” are subject to the healing power of medicine, why is this communication breakdown such an intractable problem?

Wachter’s sarcasm, together with the label of “irrational,” and the tendency toward reactivity suggests that there may be something about religion-based “false hope” that gets under the skin of many physicians who repeatedly encounter it. In an ethnographic study of the role of religion in medicine, Cadge (2012) observed that patient/family religion and spirituality were generally accepted by most physicians, except when “religion got in the way of biomedicine or [was] used by families to contradict it” in which case it was “not tolerated” (p. 148).
Attending physicians and nurses tried to deal with the conflicts that resulted by engaging with families in terms of their different beliefs, often in family meetings. One physician described trying to “engage people and say, well, God also instructed us in medicine….We’re not working against God,” but this approach usually did not work. Another physician also described trying to negotiate with families. “I always think our duty is to the patient, so I think the family members are asking for something that is actually somehow harming the patient; then…I wouldn’t necessarily acquiesce to their wishes.” Most staff said these attempts at negotiation rarely worked. (Cadge, 2012, p. 148)

What is it about religion-based “false hope” that so frustrates physicians’ efforts to build communicative bridges toward common agreement with miracle-hoping families? It has become cliché to assert that what gets under one’s skin in others is what one actually hates most about oneself, but could this truism apply to medicine’s exasperation at religion’s “false hope?” Judging by Socrates’s choice words for “men of science” in the Phaedrus, Plato may have thought so:

Plato cannot follow the sophists to the end and say that human opinion will never coincide with divine truth and that the ‘illusions’ which we construct around ourselves never intersect with reality. Dismissive contempt for such ‘bad infinity’ is only thinly veiled in Socrates’s remarks about the ‘men of science’ who in explaining myths merely explain them away. Their ‘science’ is crude and their task endless because, Socrates hints, _they neglect to examine more closely their own views_ [emphasis added]. (Marchenkov, 2009, p. 35)
Could medicine subconsciously struggle with its own form of self-loathing for its complicity in religion’s “false hope”? While Wachter (2012) directs most of his ire at the religious manifestation of “false hope,” he hints at the possibility that medicine is not immune from what it criticizes. Wachter identified a “type of collusion between doctors and their patients, neither of whom really wants to confront some painful truths” and cites an ethnographic study observing not only patients but also their oncologists “rapidly pivoting from discussion of prognosis to matters of treatment options and logistics” (The, Hak, Koeter, & van der Wal, 2000). Why would medicine be complicit in the irrationality of “false hope” that it criticizes in religion? Why and how does medicine distinguish itself from what it critiques?

As an introduction to the discussion of medicine’s particular version of false hope, we should recall from the quotes above that medicine’s frustration over religion’s false hope is based on the charge of irrationality. In critiquing religion’s “false hope,” physicians’ references to rationality vs. irrationality are neither an accident nor should they be overlooked; their significance is unpacked by Lock:

The history of modern medicine has gone hand in hand with the development of a particular notion of rationality, grounded (metaphorically as much as anything) in the vivid image of the doctor scientist. Medicine has accrued symbolic capital because of its presumptions about what constitutes knowledge and how truths are discovered. It draws its prestige and claim to truth by its relation to science…. Scientific experimentation is justified through “the production of scientific
knowledge and its practices” and the “legitimization of such knowledge as truth.”
(as cited in Mattingly, 2010, p. 55)

As discussed in Chapter Two, the rationality of the physician scientist is rooted in
a distinctly modern epistemology that makes over-arching claims about what qualifies as
legitimate human knowledge. As Mattingly (2010) contends, the scientific rationality
embodied in modern medicine has its own version of false hope:

The rise of modern medicine is often seen as a potent exemplar of hope gone
wrong, especially the hope of a scientifically grounded rationality that could
change the world….Foucault] has offered a sustained and inspired meditation on
the failures and flaws of medicine’s utopian hopes…. Foucault tells a story in
which, after the French Revolution, medicine was imagined as a successor to the
church. Medicine’s dream was not only to replace the church but to help
eradicate poverty itself. When poverty was abolished, this would be the end of
sickness and of the hospitals in which the sick were housed. ‘No more indigents,
no more hospitals’ was one political battle cry. Even when this wildly optimistic
dream had to be relinquished, a specious utopianism clung to ideals about clinical
care and still reigns in myths of modern medicine, Foucault argues. This false
hope is based upon the myth of no myths, the possibility of cultivating a neutral,
clear gaze that can simply see what exists without illusion. This myth belongs to
a utopian story of the march of science and the accumulation of knowledge. (p.
56)
While the successes of modern medicine have established the preeminence of scientific notions of rationality in the Western ethos, objective knowledge, like all forms of knowledge, has its strengths, weaknesses, and inherent limitations. According to Bishop (2011), the modern medicine’s clear gaze of objectivity is a limited form of knowledge in that it inherently excludes the non-material dimensions of humanity that it lacks the power to efficiently manipulate and control:

A person seeks medical attention precisely because…he perceives his projects as disembodied once the body becomes a failing machine. The call of those who suffer emerges in the loss of function, but it is also a loss of purpose transcending the function. Medicine, however, has already excluded from its view the possibility of the particularly embodied histories and particularly embodied projects of the patient, in order to gain power over the failing mechanism. The gaze of medicine has eliminated from consideration the forma and telos of any particular body—and for that matter, all particular bodies. Medicine, in its dualism, distinguishes between embodied project and functionality, and between human purpose and the body’s physiological functionality for the sake of preserving that functionality; and all of this is done for the good of the patient. At one level, that is medicine’s calling. The dogma of medicine emerges out of this moment of failing function, of dying, when human being itself is being lost. This dogma is derived from a pale and pathetic functional remnant of the embodied purpose of the particular body. Thus, in the focus on the functionality, medicine does not, and perhaps cannot, ask itself the question: Will this mechanical
function and intervention return this body to its purposes, projects, potencies, or capacities? It does not ask itself, Can this body re-orient or change its purpose—here understood as not merely goals but goods—in light of a new bodily reality? …I have claimed that these failings are because the metaphysics of medicine thinks of body and physiology in functional terms, and so it necessarily does violence to bodies. The technologies of medicine are geared not to purpose and goods but to functionality; the assessments and discourse of medicine are geared not toward individual purpose or meaning but toward some notion of social function and/or the good death that has been captured, or created, in assessments designed for better social functioning. As such, medicine becomes forgetful of the living and embodied telos of this particular body that has called to it for help. It becomes forgetful of being embodied. As Cassell noted, medicine thereby causes suffering. (p. 298)

Bishop argues that medicine “can only classify taxonomically by breaking human being into parts” (Bishop, 2011 p. 300), and he exposes as a false hope of modernity the notion that the rationality of objective science, as embodied in the physician scientist of modern medicine, has an exclusive claim to legitimate knowledge:

In treating as inconsequential the formal or final causes of human being, [modern] medicine can never be holistic. Insofar as medicine continues to operate on the metaphysics of material and efficient causation, it will necessarily fail to adequately comprehend human living and human dying; that is to say, modern
medicine will always fail human being. And no amount of post hoc reinvestment of meaning into mechanism can save it. (Bishop, 2011, p. 300)

Modern medicine’s inability to deliver on the false hopes of scientism is a moral and political failure with far-reaching implications. As Mattingly states, “[m]any anthropological commentators have also used biomedicine as a case study for viewing Western rationality’s claims to universality and objectivity as a false hope” (2010, p. 240). Rooted in “Enlightenment ideals of truth, rationality, and progress,” false hope has “undergirded Western biomedicine and its specious claims to universal truth” (2010, p. 240). Mattingly continues,

> [a]nthropologists have carried out global ethnographic explorations of how the dream of better health and the possibilities of progress based on medical science have provided new opportunities for control of the sick, who, with their own personal hopes for care and cure, are transformed into new kinds of political subjects willing to undergo new kinds of subjugation (2010, p. 240).

Sometimes experienced as a carrot dangling at the end of medicine’s stick, “[h]ealth easily becomes, as Veena Das (1994) puts it, a ‘contested site,’ even a site ‘for the exercise of new kinds of power’ over the suffering in the name of offering medical help” (Mattingly, 2010, p. 240). But the subjugation, power, and coercion of medicine is not obvious because the “kind of coercion that medicine exerts is very often a subtle kind. New opportunities for health care—new practices—help to shape people’s hopes, and these hopes may, in turn, betray them” (2010, p. 240).
How does medical science shape people’s hopes, and why do these hopes often, in the end, betray them? After locating the false hope of biomedical truth and exposing it as just another limited lens for ordering reality, Mattingly describes the three canonical genres of modern medicine’s particular form of religious narrative: healing as science detective story, healing as battle, and healing as machine repair.

The three canonical genres of modern medicine are “very much grounded in a hope based on scientific knowledge and technologies and the individual expertise of the clinician to deploy them” (Mattingly, 2010, p. 55). If, as discussed in Chapter Two, the modern development of egocentric space that subjects a painting to the “active penetration of the viewer’s glance” corresponds to Bishop’s (2011) Foucauldian notion of “the physician’s gaze,” then it may not be surprising that all three of Mattingly’s “canonical genres” of modern medical myth share one thing in common: an egocentric use of space where the “physician-scientist is the leading protagonist of all three plots, and the patient’s diseased body is the setting in which, and upon which, the protagonist acts.” The transformation of diseased bodies into settings for plotlines ruled by medicine’s protagonist is rooted in what Losev (2003) identifies as the underlying myth of “matter.” Having painted the universe as an egocentric space where the clear gaze of medical science aimed to “realize a grand social hope” of eliminating disease, the myth of matter gives rise to myths of mechanism. Previously known as whole persons who were greater than the sum of their parts, sick people become “patient” to the objectification of the physician’s gaze, their bodies reduced to parts governed by mechanisms upon which medicine seeks to act in furtherance of its aims.
Healing as Detective Story

Sherlock Holmes, written by a physician, and modeled after a then-famous physician-teacher, embodies the literary form of this canonical healing genre of the modern medical narrative. According to the plotline, medicine is an investigative science where the protagonists are the doctor and the disease itself, understood as the “mysterious culprit of medical crimes” (Mattingly, 2010, p. 57). Like Sherlock Holmes, the “clinician as sleuth has the task of investigating crimes inside a patient’s body, leaving traces in the form of symptoms and signs that present puzzles to be deciphered” (p. 57).

Feudtner’s (2003) historical study of the development of insulin as a medicine to counteract diabetes, illustrates the “bittersweet” complexity of healing as a detective story. Feudtner recounts the historical drama of physician-scientists engaged in the quest to solve the mystery of diabetes through the wonder of insulin. Quoting a physician detective from the 1920s, who claimed that “insulin redeemed diabetics,” Feudtner discusses the burdens and dangers of an insulin-empowered life lived as a chronic diabetic and questions in what sense and to what extent it can be said that “insulin redeemed diabetics”:

People with diabetes, since 1922 have lived with the ironic dilemma of therapeutic success: how should we think or feel about a remarkable medical achievement that gives with one hand and, years later, takes away with the other? How can one be ungrateful for a miracle, one that extends life and hope? This dilemma can turn into a trap for people with disease and those who care for them. As medical science achieves greater “success” at treating diseases, transmuting
their courses onto more chronic paths, we must as individuals and as a society beware of being caught in this dilemma of success, pulled along by what seem to be therapeutic imperatives. The experience of juvenile diabetes and insulin—one of the most spectacular successes of modern medicine—suggests that the dilemma will always look less problematic and more appealing at the outset, only to grow more complex and somber as time passes. (Feudtner, 2003, p. 195)

Commenting on before-and-after photos of a young sickly boy restored to robust health through the discovery of insulin in 1922, Feudtner (2003) explores how these pictures “have become symbols of a common ‘story’ that we Americans told ourselves throughout the twentieth century, in which technological progress has solved—or is on the verge of solving—a vast array of problems that trouble our lives,” and he argues that this “broad belief in the beneficent powers of technology has especially framed the way that we have come to think about living with disease and struggling against death” (p. 202). Is this the false hope that medicine is subconsciously self-loathing as it castigates religious hopes that spring from broad beliefs in different forms of beneficent power? Calling insulin a precious but flawed miracle, Feudtner contemplates the paradox of “problem exchange” where the mysteries imperfectly solved by medical investigators create new and protracted dangers and difficulties for patients and families to grieve and struggle with.

**Healing as Battle**

The second canonical narrative Mattingly (2010) observed in the modern medical drama is healing as battle. In a war “fought against disease,” physicians and diseases are
again the main protagonists: “Pathology is a foreign invader that the physician and fellow clinicians must battle, and the patient’s body is a ‘site’ or ‘field’ of battle” (Mattingly, 2010, p. 62). Bacteria is described as “invading” or “infiltrating,” and medicine wages a just war against all offenders. Nowhere is this narrative more poignant than at the end of life:

The most dramatic instance of this genre occurs when the disease/enemy is lethal and medicine is expected to defend the body against the formidable foe of death itself. This is, in fact, the very definition of ‘heroic medicine.’ Death, conceived of as ‘defeat,’ is one of the basic tenets of the ‘technocratic model’ that undergirds modern medicine (Davis-Floyd and St. John, 1998, p. 16). Heroic warrior clinicians strategize and mount campaigns against a disease enemy, which has its own tactics and weapons in conquering the body. Cancer serves as a classic example. Treatment here is steeped in military metaphors as patients’ bodies are ‘bombarded’ in radiology or ‘chemically poisoned’ in chemotherapy. (Mattingly, 2010, p. 62-63)

Cassel (2005) observed that physician-generals too often draft patients and families into a war against death for which they may not have voluntarily enlisted. Quoting a visiting British physician who was taken aback by how strongly American physicians experience death as a personal failure, Cassel argues that, while this culture is slowly changing, “heroic” doctors often convince patients or families to persist with treatments that supporting clinicians find pointlessly inhumane. As I mentioned in Chapter One, residents and nurses use the term “flogging” to describe the apparent
cruelty of death-prolonging technology. The angst of observing, and being party to, “flogging” is sometimes processed through cathartic jokes that encapsulate the horror and allow its impact to be released through humor. In one such version of the joke, “flogging” is dubbed “cheechee” and processed as follows. This profoundly revealing joke bears repeating for its vivid depiction of the false hope of modern medicine, encoded in the modern medical myth of healing as battle. As relayed by Zussman:

Missionaries in a tribal land are captured by the natives and brought before the chief, who gives them a choice of “cheechee or death.” The first missionary chooses cheechee. He is then set upon by the group, tied to a pole, and beaten by each member of the tribe. The rope is then tied around his hands and he is dragged about a mile, losing bits and pieces of himself. Finally, he is thrown over a ravine. The second missionary, asked what he chooses, says, “I never thought I’d say this, but I would prefer death.” The chief says, “Yes, but first a little cheechee.” (as cited in Cassel, 2005, p. 156)

As a metaphor for the critical care so often preceding death in the U.S. health-care system, this joke conveys the perception that, with the imperatives of modern medical technology, death cannot come quickly, but must first be obligatorily preceded by a valiant battle against the inevitable in the form of isolating and dehumanizing treatment. Modern medicine’s battle against death is perhaps nowhere more prominent than in practice of transplant surgery. Cassel provided an example of a case where a transplant surgeon was intent on performing a third liver transplant on a patient who the attending physician believed was actively dying and beyond repair. The wife of the patient was
ready to let her husband go until she was prevailed upon by the valiant transplant surgeon who applied moral and emotional pressure to enlist the family in his holy war waged inside this dying body. After the transplant surgeon left, the patient’s condition took a turn for the worse, and other members of the medical team concluded in agreement with the family that it was time to remove the ventilator and let him die. When the transplant surgeon heard the news, he angrily pronounced, “I consider that euthanasia!” (Cassel, 2005, p. 158).

The heroic rationale of transplant surgeons is inherent in the context of their work. Placed in a role where “every single person we care for would be dead without us” (Cassel, 2005, p. 162), transplant surgeons trade in a currency requiring a heroic disposition:

Transplant surgeons are in the business of providing miracles, of giving life when there is almost no hope. To do this, they have to be more confident than most surgeons, to feel that they hold the key to life and that they will walk the patient through the valley of the shadow of death. They cannot bear anyone, including family members, questioning them and their judgment. It is this confidence that gets the patient through—when he or she gets through. (Cassel, 2005, p.163)

When transplant surgery is successful, the single-minded zeal and absolute devotion of transplant surgeons are admirable and necessary. When the transplant process comes up short, those same traits can come into question. Is blind faith or “false hope” in the power of modern medicine a prerequisite for success in transplant surgery? Observers of the culture of transplant surgery have described it in terms that almost
depict a triumphalistic war against mortality itself. Cassel (2005) drew upon Fox and Swazey, who, after a combined 64 years of research in the field, reflected on the dark side of the transplant surgeon ethos as a “relentless, hubris-ridden refusal to accept limits” (Fox & Swazey, 1998, p. 327). Fox and Swazey parted ways with the transplant culture on less than favorable terms, stating: “By our leave-taking we are intentionally separating ourselves from what we believe has become an overly zealous medical societal commitment to the endless perpetuation of life and to repairing and rebuilding people through organ replacement—and from the human suffering and the social, cultural, and spiritual harm we believe such unexamined excess can, and already has, brought in its wake” (Cassel, 2005, p. 164). Quoting Ramsey, an ethicist and theologian, Fox and Swazey warn against “the Triumphalist temptation to slash and suture our way to eternal life” (1998, p. 327).

Moore, a Harvard chief of surgery who died in the 1970s, was profiled by young Harvard surgeon, Gawande (2003), who observed the transition from Moore’s often recklessly ambitious experiments and innovations to his later questioning of the role of science in extending life. Moore is not alone in modern medicine’s self-reflective confession of false hope in the power of medical science to win the battle against human mortality. Cripe (2011) told the story of his patient, Miranda, a young woman whom he treated for 143 days in the hospital before finally sending her home to die. On the day of her discharge, Cripe heard Miranda cry out in pain as a nurse tried to slip a shoe on her swollen foot:
I saw the frustration in the face of the nurse—who knew better than anyone, other than her mother, what Miranda had endured—and I asked if I could try. I knelt before Miranda taking the shoe in my hand. She was hairless. Her skin was a mixture of a bright yellow and a dusky red with a white flakiness like an overly ripened apple in the frost. She was swollen, saturated with all the intravenous fluids she had received during her treatment. Methodically I stretched the shoe so it would fit over her taut foot without discomfort. As the shoe slipped on with only slight resistance, I looked up and said, “A glass slipper for my princess. I love you, Miranda Thomas.” (Cripe, 2011, p. 46)

For years, Cripe (2011) recounted this story ending as an argument for the modern medical research imperative. As Cripe watched Miranda’s father guide her wheelchair into the hospital elevator, Cripe felt confirmed in his decision to pursue a career in leukemia research since “the only rational response to a young woman dying of leukemia…was to develop better treatments” (Cripe, 2011, p. 46). After recounting the tremendous progress of medical science in understanding leukemia at the molecular level and his devotion to redouble efforts in search of a cure, Cripe turns about-face and makes a startlingly transparent confession:

I’ve come to realize in the past year or so, that by telling Miranda I loved her I was, in a sense asking for forgiveness. While treating her disease, I had lost sight of her. Miranda’s life had been cruelly compressed: from normal to diseased, health to illness, college campus to hospital, wide horizons to limited goals, confidence to uncertainty, and a chance to no chance. I was not unaware of or
insensitive to the collapse of her life. I did not know how to speak of it with her. I recommended that Miranda try an allogenic stem cell transplant (ASCT). More than recommending it, I encouraged her…. My stem cell transplant colleagues were not in favor of the transplant…. But I insisted. “It’s her choice. She deserves a chance.” I argued. What I was really thinking as Miranda left the hospital was why had I recommended an ASCT? What had I done? It wasn’t that I did not inform her of the risks of ASCT or the low likelihood of benefit. I informed her that either death from the complications of ASCT or the refractory ALL was the most likely outcome. What I wasn’t able to say was that I believed she would die regardless of what we did…. I carry Miranda’s photograph to remind me that care of people who die will not improve unless physicians develop the willingness to speak about death and dying in a way that allows us to modify expectations and then care. (Cripe, 2011, p. 48)

Would it be too strong to draw a conclusion from Cripe’s confession and postulate that perhaps medical science is often complicit in fabricating the very false hope that it then turns to criticize in others? What if Miranda’s father had refused to take her home that day and insisted that she be taken to the ICU citing his belief in miracles and requesting prayer for healing? Would the ICU staff judgmentally wash their hands of his “irrational” religiosity with no knowledge of the fact that the “false hope” they were judging was fabricated by a well-meaning doctor who didn’t know how to lose his battle with leukemia like a good sport? One ICU physician admits that unrealistic family expectations in the ICU are often the result of the way they have been cared for and
communicated with up to that point: “I think the most difficult part is the end-of-life issues….They’re frequently difficult because things have not been handled well before a patient gets transferred to us, and families arrive with unrealistic expectations” (Cadge, 2011, p. 157).

Healing as Machine Repair

The third canonical genre of the modern medical narrative is healing as machine repair. According to this narrative, the body is what Davis-Floyd and St. John call a machine “made of interchangeable parts that [can] be repaired or replaced from the outside” (as cited in Mattingly, 2011, p. 67). In this genre, illness is a breakdown, and the physician is a super-mechanic. The notion of doctors “fixing” broken body parts and functions is so common that no story is needed to illustrate this basic plotline. Mattingly, however, tells the story of a surgeon, Dr. Sanderson, who first utilized and then revealingly contradicted this trope. After describing to the parents of a critically ill infant the mechanics of her “conditions from head to toe,” Dr. Sanderson radically departed from his description of her body as a broken machine to a personal invocation of Arlene as a child, confessing to her parents that “what I ask myself every time I enter her room is, ‘am I doing the best thing for this child?’” (p. 72). After a long, exhausting description of Arlene as a machine beyond repair, Dr. Sanderson turned his focus to the non-mechanical reality that, unlike a machine, Arlene is feeling pain and suffering the cruelty of the constant “bagging and pounding” necessary to repeatedly bring her back from the death that the machines are ruthlessly prolonging. In this most recent encounter, Dr. Sanderson took off the clinical gloves and appealed directly to Arlene’s humanity
after a long and tumultuous battle between the clinicians who insisted that the child should be taken off of life support and the parents who thought differently.

For Andrew, Arlene’s father, neither Arlene, the machine beyond repair, nor Arlene, the suffering child, is sufficient cause for the transition that the doctor has in mind. In response to Dr. Sanderson’s question, “Am I doing the best thing for this child?” Andrew retorted, “Yes. Yes. We don’t want to take her off the machines. When she goes, she’s going to go on her own. That’s how I believe. That’s how she’ll fight it out” (p. 72). Dr. Sanderson then qualified the notion that Arlene is still fighting: “As long as you know that it’s not her but the machines that are keeping her alive” (Mattingly, 2011, p. 72). Andrew conceded the point but remained firm.

Just as the transplant surgeon above appealed to humanity to pressure the weary wife to concede to a third liver transplant, so also Dr. Sanderson appealed to humanity to persuade Arlene’s father that it is time to remove life support. Just as the transplant surgeon angrily charged “euthanasia” when the man was removed from life support, so too, Dr. Sanderson and his team were as dumbfounded as they are horrified by what felt to them like an unconscionable sentence of “flogging” or “cheechee” by a father to his infant daughter. The incomprehensibility of family decisions to medical professionals recalls Bishop’s words: “Insofar as medicine continues to operate on the metaphysics of material and efficient causation, it will necessarily fail to adequately comprehend human living and human dying; that is to say, modern medicine will always fail human being. And no amount of post hoc reinvestment of meaning into mechanism can save it” (Bishop, 2011, p. 300).
Why was the combination of Dr. Sanderson’s post hoc reinvestment of meaning into mechanism (every part of Arlene the machine is broken beyond repair, and, also, Arlene the child is suffering cruelly) not enough to sway a loving father like Andrew, and why is this both reprehensible and incomprehensible to modern medicine? For Mattingly, the answer lies within the drama of a fourth healing genre that stands outside of the canon of modern medical orthodoxy.

Healing as Transformative Journey

For families of critically ill patients, healing is not simply or even primarily a science detective story, a biochemical battle, or a machine repair, but instead, a transformative journey:

The practice of hope families are engaged in is often deeply connected to notions of personal transformation and to the idea of life as a kind of journey that demands self-transformation. Hope, in this genre, can in no way be reduced to “success” or “cure” in any simple sense. Science, biotechnology, and clinical experts are no longer primary protagonists, though they still have their parts to play. If it were not for the pervasiveness, indeed the centrality, of this genre among the families in this study, I might have chosen simply to write about “clinical hope” or “biomedical hope.” But, as I argued at the outset, the sort of hope that biomedicine and biotechnology can provide (or serve to promise at some future time) is only a small part of the picture of hope from the perspective of these families. Hope cannot be reduced to this canonical portrait. Instead, this is the genre of “blues hope.” It is remarkable how often the patients or their
families portray hope as a journey that requires not merely a transformation of the body but the transformation of a person’s, a family’s or even a community’s whole life. (Mattingly, 2011, pp. 73-74)

Having introduced the genre of healing as a journey of personal transformation, Mattingly can now return to the question of Dr. Sanderson and Arlene’s parents:

Parents often call upon the religious connotations of this genre…. Why do [Arlene’s] parents agree with the physician that their child would die without these external machines, that every system is faltering or failing, and that she has been on the brink of death many times, yet disagree with this conclusion? Why do they speak of their child as “having a fighting spirit,” as they do in this exchange and as they very often insisted in interviews? (They also told many of their own stories about these harrowing back-from-death moments in the eighteen months their daughter lived.) They are intensely religious people. For them, this genre of transformative journey spans much more than a human life. It speaks to a much grander history. The practice of medicine and its machinery are just a short story in a cosmological narrative. From their perspective, the clinicians simply misunderstand their own role in human history. They seem to believe that they (or these parents) should be in charge of life and death. But this is not a human matter. It is about hoping, struggling to hope, doing everything possible to sustain life while at the same time recognizing that life and death are not fully under human control. For them, the practice of healing (and the hope of healing) invokes a plot that brings in an array of cosmological actors. Not only does this
narrative encompass the personal, the interpersonal, and the structural—it is on a
scale such that all of human history and its creations constitute one small episode
in a much vaster epic. (Mattingly, 2011, p. 75-76)

Mattingly’s discussion of the religious connotations of the fourth healing genre almost
seems to suggest that the family’s cosmological lens on healing is so vast that physicians
hailing from medicine’s narrowly mechanistic purview may be as far removed from
meaningful engagement with these families as bed bugs approaching a dinosaur, and this
truth threatens to snuff out hope for a deeper engagement between such contrasting
dramas.

Having come full circle in our exploration of the roots of medicine’s rage with
religious false hope, we have seen that, indeed, like each one of us, when medicine sees
something in another that it disdains in itself, it attacks the holder of the mirror. And as
Foucault (1973) observed, medicine is particularly defensive in its denial of complicity in
the phenomenon of false hope because the false hope of science somehow defeating
mortality, eliminating poverty, and snuffing out all human suffering lingers deep in the
roots of the modern medical utopian project. A cursory scan of marketing rhetoric of the
nation’s leading hospitals demonstrates that Foucault’s critique remains current and
cogent. MD Anderson hospital is “making cancer history,” and Boston Children’s
hospital’s tag line is: “until every child is well…this is the promise that drives every
doctor, nurse, researcher and staff member.” The marketing collateral for Boston
Children’s includes the following utopian jingle: “gonna build a world that’s free from
struggle…until every child is well” (http://www.youtube.com/watch?v=YD2OSkd3zgU).
Religious “false” hope can be nothing but a terror to modern medicine because it holds up an aggravating mirror to modernity’s “myth of no myths” and exposes the false hope inherent in the modern medical project. Bishop’s (2011) argument that even modernity’s brand of “bio-psycho-social-spiritual” medicine will “necessarily fail to adequately comprehend human living and human dying” (p. 300) is supported by Cadge’s observation that physicians are unable and unwilling to fruitfully engage with families whose religious perspectives do not agree with their medical calculations. These families and their perspectives are sometimes unwelcome in the hospital. As previously noted by Cadge, “When spirituality and religion got in the way of biomedicine or were used by families to contradict it, however, they were not tolerated” (Cadge, 2013, p. 148). This does not reflect poorly on individual physicians but on the modern medical myth into which they are indoctrinated and within which they operate.

Ultimately, contrasting myths produce contrasting – if intertwined – cultures that speak contrasting languages. According to Mattingly (2010), the disagreement between physicians and religious families is not limited to their impasse over legitimate employment of hope but further confounded by the inherent disconnect in the contrasting languages they employ to engage the matter: “The clinicians’ language of statistical probability departs sharply from the spiritual discourses common to many families” (Mattingly, 2010, p. 145). And “these disparate discourses and stances foster confrontational stances” (Mattingly, 2010, p. 146). But at least on the patient and family side, the confrontational stance does not keep them from considering the doctor’s probability data, it just means that they balance that data with other equally important
considerations. As Mattingly writes, “It is not that families in our study reject the biomedical discourse of probabilities and risks. Rather, they feel it presents only part of the picture. After all, they frequently point out, ‘The doctor is not God,’ and ultimately, the fate of their child rests in God’s hands and not in any human hands” (Mattingly, 2010, p. 145).

The two great challenges for modern medicine in adopting the myth of “healing as transformative journey” are that this myth both replaces the physician scientist with the patient/family as protagonist and posits an unscientific transformation as the highest goal of health care. Both of these challenges are illustrated in Cadge’s (2012) observation that religiously-based false hopes which contradict biomedicine are “not tolerated” in hospitals. Given Foucault’s point that the entire modern-medical project is rooted in false hope, it is not the falsity of the religious hopes that is “not tolerated” by modern medicine. What modern medical dogma will not tolerate is that these hopes spring from myths in which the physician scientist is not the protagonist and the highest goal of human healing is an unscientific transformation of humanity. For medicine to make the transition to a truly patient-centered paradigm ruled by the patient/family myth of “healing as a transformative journey,” it must first come to grips with the extent to which these two great challenges to such a paradigm shift are rooted more than anything else in modernity’s foundational myth of “immanentist infinitism” (Marchenkov, 2009).
CHAPTER FOUR: THE ADOLESCENCE OF “IMMANENTIST INFINITISM”

The disdain for allegorical “miracles” in opera is the result of the growing awareness that the integrity of the work of art is ensured by the independent activity of the artist. It also means that this integrity, i.e., a purely intrinsic aesthetic characteristic of the work, moves to the foreground and displaces the work’s extra-aesthetic significance. The task of opera is no longer to illustrate in an entertaining manner moral truths, aristocratic virtues, or metaphysical principles. It consists rather in elaborating artistic form that would best fulfill the ideal of “naturalness.” “[I]n art we can in the end rival nature only when we have learned,” remarks Goethe in his “Introduction to the Propylaen” (1798), “at least in part, her method of procedure in the creation of her works.” For, as it follows its own immanent laws, artistic form thereby most faithfully imitates nature that likewise lives by its own laws and barely needs a supernatural arche. This principle, God, becomes little more than an unnecessary hypothesis. (Marchenkov, 2009, p. 91)

The myth uniting the canonical genres of modern medical narrative so antithetical to supernatural miracles is modernity’s myth of “immanentist infinitism.” In The Orpheus Myth and the Powers of Music, Marchenkov (2009) traces the development of “immanentist infinitism” through history by showing how profoundly it impacts cultural expressions of the Orpheus myth and consequent notions of the power of music. This foray into the arts is hardly a diversion; the process of uncovering the modern pseudo-myth of immanentist infinitism through the cultural manifestations of a genuine myth
drives straight to the heart of our topic. Marchenkov’s analysis of the philosophical implications of immanentist infinitism for music, art, and reality itself bears heavily on the nature of the miraculous and the context of modern medicine. “The dialectic contained in the miraculous,” says Marchenkov, is one of the most “powerful forces driving the evolution of the Orpheus myth” (p. 26). In addition to furthering our pursuit of the nature of the miraculous, Marchenkov’s aesthetic lens is critical to deepening our understanding of the medical context.

As we have already learned from Losev (2003) and Panofsky (1997) in Chapter Two, modern art and modern history were both conceived under the same historical conditions that mark the philosophical paradigm of modern medicine. The same will be shown by Marchenkov’s (2009) appropriation of Bakhtin (1981) to be true of modern literature. To fully realize their vital potential, the “art of medicine,” medical “history taking,” and “narrative medicine” must seek to cultivate an identity in art, history and narrative forms that truly serve to complement the spectacular, if one-noted tools of the modern medical paradigm. Complementarity requires distinction; therefore, as I will discuss more fully in Chapter Seven, the “art of medicine” broadly conceived, and medical “history taking,” as well as “narrative medicine” in particular, must necessarily distance themselves from the philosophical limitations of the modern medical paradigm so as to discover and manifest medical science’s vital complement. As this inquiry will demonstrate, the rediscovery of modern medicine’s paradigmatic complement may only prove possible through the genuine reconciliation of humanity’s relationship with authentic myth. Locating the overarching pseudo-myth undergirding modern medicine
within a philosophical exploration of genuine myth, music, and art will challenge our myth of reality by helping us to come to terms with the reality of myth. By situating our discovery of the myth underlying modern medicine precisely in the arts, we will put ourselves in a position to consider the possibilities and challenges for the art of narrative medicine. A mild interrogation of narrative medicine will protect us from duplicating tired dogmas under novel banners and challenge us to imagine a truly mythological epistemology for health communication. Applying such an epistemology to clinical navigation of miracle-hope in response to the prognosis of medical futility will not only offer new possibilities for enriching such encounters but also imply new arcs for narrative medicine far earlier in the disease trajectory. What follows in this chapter is not an attempt to give a comprehensive account of either the historical developments of the Orpheus myth or the related powers of music, but rather to trace through certain stages of this history some ideas that are vital to our purposes.

As one last introductory observation, it must be noted that the Orpheus myth itself, from the perspective of the basic content of its story arc, could not be more applicable to the clinical context at hand. Throughout its varied manifestations over the millennia, the Orpheus myth is a tale about Orpheus’s musical entreaty to the powers of death requesting the deliverance of his wife, Eurydice back to the realm of the living. This connection begs a question to which we shall later return: could hope for miraculous deliverance from the realm of death somehow be conceived in musical terms a la the Orpheus myth?
The Evolution of Myth as the Lifecycle Development of Humanity

This dissertation seeks to advance the notion that human effort to understand the past and contemplate the future may be well served by broadly conceiving human history along lines roughly analogous to our more narrow conceptions of the life-cycle development of particular human beings. In particular, I seek to advance and reflect upon the notion of modernity as the adolescence of humanity. If, as we will postulate in greater detail in Chapter Nine, modernity can be conceived as the adolescence of humanity, then the various stages of antiquity and the middle ages can be envisioned to correspond to progressive stages of the childhood of humanity. While any effort at precision in such an exploration would distract from our purposes here, it does behoove us to note that the early stages of the Orpheus myth are described in such a way as to evoke an image of the various stages of childhood development. Marchenkov describes a successive unfolding, but he warns against construing the process “as a straightforward progression from initial naiveté to rational self-consciousness” (p. 1). This warning is based on Buxton (1999), where the concept of progression seems to be rooted in modern western rationality as the ultimate destination. Buxton points out that the rationality of the present is but one kind of rationality and that other forms of rationality may have their own claims on sophistication and value.

A life-cycle notion of human development would only deny Buxton’s (1999) insight if it were based on the adolescent notion of childhood as a simplistic progression from successive levels of sophistication culminating in the grand and final achievement of adolescence. While such a consciousness may be germane to the “from myth to
reason” trajectories Buxton critiques (as cited in Marchenkov, 2009, p. 1), it could not be further from the assumptions of life-cycle notions rooted anywhere other than the adolescent perspective of adolescence. Conceiving of the development of humanity as somehow akin to the lifecycle of individual humans only devolves into Buxton’s “from…to…” construct if the adolescence of modernity is considered the end or if the movement from the various stages of thought and wonder that could be imagined to constitute childhood development are conceived as progressively superior stages of consciousness culminating in the ultimate progress of adolescence. If however, adolescence is seen with the measured ambivalence any adult may assign it, then the “from…to…” characterization is not necessarily descriptive of an unqualifiedly upward ascent. Nor is the process devoid of cyclicality and non-linearity. For any adult seeking access to the beauty and wonder of childhood consciousness, notions of life-cycle development may be adequately complicated by enough non-linear nuance as to escape Buxton’s critique. Rather than tracing a supposedly triumphant march from myth to reason from the perspective that modern rationality is the final destination, this life-cycle perspective attempts to imagine the ambivalencies of humanity’s evolving relationship to mythical consciousness from the perspective that modern consciousness, as adolescence, avails humanity of great powers of “unprecedented agency” that adult humanity must struggle to properly wield.

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2 A concept repeatedly emphasized by Professor Austin Babrow in COMS 7900 seminar discussions at Ohio University, Fall, 2013.
The Childhood of Myth

Spanning from the 7th century to the mid-5th century BC, the three phases of the first stage of the Orpheus myth trace a snapshot of what could arguably be conceived as some step along the life cycle path of humanity’s mythological evolution. In the first phase, as Marchenkov describes, Orpheus displays shaman-like qualities and the powers of music can be described as syncretic. Regarding the syncretic, “Orpheus symbolized the sway of music over all strata of ancient cosmic hierarchy: natural, human, and divine” (Marchenkov, p. 10). As for the shamanistic element, Marchenkov eschews Tomlinson’s (1993) characterization of shaman ecstasy as “soul loss” in favor of the notion of soul discovery in consciousness’s evolution toward distinguishing physical instinct from the process of thought. A Losevian notion of miracle is both constituent of, and vital to, this process. In the next phase, intellectual reflection leads to a greater level of self-awareness in Orpheus’s frequent appearances in the texts of Bacchic mystery cults. “The desire to explain,” says Marchenkov, “betrays a growing rationalistic attitude. Myth, by contrast, directly states what it has to say; its aim is not to explain, but to present reality to consciousness” (p. 15). Demonstrating Hegel’s observation of the need to pull the gods out from under the rule of fate, “Orphic speculation gropes for a way in which the realm of the irrational can be comprehended and accommodated by the rational world-principle epitomized in Zeus” (p. 16). The third phase sees a shift away from the cultic representation toward artistic depiction as the myth becomes fuel for aesthetic contemplation. Depicted in the evolution of Attic vase painting from the 6th to the mid-5th centuries, the transition is conceived by Hegel as a “progression from myth as simply
consciousness to art as self-consciousness” (p. 25). When Orpheus becomes a character in Aeschylus’s play, Bassaridae, the transition to theatre creates a division between spectators and actors that constitutes a detachment between myth and reality (Marchenkov, p. 1-27).

As mythical consciousness evolves through these stages of the childhood of humanity, the powers of music evolve with it. When Orpheus’s singing breaks out of time into eternity, “[m]usic enunciates what the world ought to be and thereby….lays bare…the imperfect state of immediately given reality” (Marchenkov, p. 27). Thinking over this dichotomy creates a desire for a breakthrough into musical mysticism. Such an experience, however, reveals the “possibility of a purely aesthetic attitude toward music” whereby “music is no longer employed in earnest to ensure the initiate’s unity with the god but is openly played for the sake of ludic manipulation of external reality in mimesis and of the psyche in catharsis. Such manipulation is embodied by Odysseus’s cunning in contrast to the straightforwardly transformative beauty of Orpheus’s song (p. 21).

After exploring three phases of the first stage in the progression of the Orpheus myth and establishing spiritual ecstasy, mysticism, and most importantly, miracle as constitutive of its earliest mythical reality as well as its approach to the powers of music, Marchenkov follows the Orphic song to its manifestation in Platonic thought. Plato’s philosophical approach to myth, or perhaps more properly, his “mythosophical” approach to philosophy provides a blueprint for the trajectory of ideas mapped out by Marchenkov’s study and their implications for our context of interest: “Music is woven into the ideal structure of the universe in the vision of Er the Pamphylian” in the Republic
where “the Fates sing about the things that were, are, and will be.” Broadly patterned on
the contours of the Orpheus myth, “the idea that absolute knowledge is communicated in
song gives it a particularly palpable Orphic touch.” Noting that this vision is described
by Socrates as the completion of his theory or “logos,” Marchenkov emphasizes the
deliberateness of Plato’s choice for the moment of climax and locates a similar “move
from rational discourse to wondrous insight” in the Symposium where Diotima’s speech is
the same kind of “culminating moment” (Marchenkov, p. 33).

According to Marchenkov, the exalted status of myth and music in Plato’s
philosophy is not well received in this stage of humanity’s life-cycle development. At a
time when philosophers increasingly conflate myth with poetry and criticize such
supposed oppositions to reality, Plato finds himself at odds with the sophists: “The
underlying problem here—myth’s problem—is that consciousness cannot return to its
prior condition. As Burkert puts it, ‘the gods are no longer part of the unquestioned
necessity of being’ and, once begun, the questioning of their necessity can be neither
stopped nor forgotten” (as cited in Marchenkov, 2009, p. 34). The indeterminacy of myth
seems to invoke an imperative of philosophical investigation, but such an imperative
risks entrapping the investigator in the circular logic of self-determination (Marchenkov,
2009).

Noting the importance of Socrates’ dialogue with Parmenides, Marchenkov
highlights its demonstration of “the mutual necessity of being and nonbeing, the one and
the many” that is “already implicitly grasped in art and aesthetic consciousness” where
“life’s reality becomes an object for thinking only in contrast with art’s frank illusions”
and vice versa (p. 35). By insisting on reason alone to the exclusion of myth, the sophists eliminate the wholeness of integrated reality by removing the vertical plane of reality and the limit it imposes on the horizontal plane. Confronting this epistemological move that traps thought in infinite regress making “ultimate reality inaccessible to rational thinking,” Plato stands against the sophist dismissal of myth: “Plato cannot follow the sophists to the end and say that human opinion will never coincide with divine truth and that the ‘illusions’ which we construct around ourselves never intersect with reality,” explains Marchenkov. “Dismissive contempt for such ‘bad infinity,’ is only thinly veiled in Socrates’s remarks about the ‘men of science’ who in explaining myths merely explain them away.” Recalling physician characterization of medical science as rational and religious hope as irrational poses a question: might Socrates also assess these “men of science” with the charge employing a “bad infinity”? On what ground could the impeccable pedigree of scientific rationality be challenged? “Socrates hints,” in his dialogue with Phaedrus, that “they neglect to examine more closely their own views.” As we shall soon see, Marchenkov answers Socrates’ call for a close examination of the views underlying the “bad infinity” of the “men of science” (Marchenkov, p. 35).

Marchenkov’s ultimate conclusions are foreshadowed by Plato’s recognition “that the analytic process cannot continue indefinitely but must possess a **terminus ad quem** and yield some final result. [Plato’s] solution is to articulate this result in the manner of traditional mythopoeia. It is the last step in the ladder of the intellect’s ascent—a step that at once possesses a finality and leaves room for uncertainty” (Marchenkov, pp. 35-36). In the next chapter of this dissertation, we shall discover in the context of health
communication theory the extent to which the realization of finality in combination with
the room for uncertainty is no small achievement.

This achievement of uncertainty-imbued finality requires what Morgan (2000)
calls a “breakdown in analytic progress” since, as Marchenkov explains, “dialectic is not
‘the highest music’ in Plato’s thought.” Indeed, Plato views the “breakdown in analytic
progress” as “not merely desirable, but necessary” (Marchenkov, p. 37). The necessity
for breakdowns in analytic progress again foreshadows the next chapter of this
dissertation, where we will see that such breakdowns create space for what problematic
integration (PI) theory might call “impossibility-eclipsing desire through ‘evaluative
orientations.’” For now, it suffices to note Marchenkov’s observation that “[m]iracles are
the most vivid cases of a ‘breakdown’ in analysis.” Recalling physician characterization
of religious hope for miracles as “irrational” (Cadge, 2012, p. 147), the notion that
“Plato’s mythosophy is a witness that miracle is, in fact, deeply rational” exposes
diametrically opposing notions of rationality (Cadge, 2012, p. 38). Marchenkov explains
that “Plato’s argument with the sophists lays bare the tension between infinite regress and
the holistic view of things” and contended that “the entire conflict between abstract
rationalism and mysticism is fueled by this tension” (p. 37). For physicians viewing
miracle-hope as a deeply irrational breakdown in the analytic process of futility
prognosis, Plato’s argument with the sophists also lays bare the tension between the
opposing approaches to rationality seen in “immanentist infinitism” of modern medical
myth and the genuine mythological epistemology of what Mattingly (2010) observes is
the patient/family-defined reality of healing as “transformative journey” (p. 72). As
Marchenkov traces, the sophist preference for a rationality characterized by an infinite regress of analytic progress becomes prominent in the modern era and ultimately leads to a world in which “[r]eality becomes something merely probable” (Marchenkov, 2009, p. 156).

The Pre-adolescence of Myth

Before addressing the pseudo-myth underlying modern medicine, it is helpful to briefly look at its historical predecessor in medieval Christianity. After Plato worked to carve out a favored place for myth in relation to dialectic, the medieval era takes full advantage of Plato’s establishment of myth’s vitality to rational human consciousness through the myths of the Holy Trinity and Orpheus-Christus. Regarding the former, Marchenkov advances a fascinating argument concerning the relationship between the myth of the Holy Trinity and the musical establishment of polyphony, seeing the discantus of polyphonic music as both a representation of the Christ-figure as the second person of the Trinity and an example of the evolution of human consciousness: “The human person asserts herself in the face of God as an independent agent,” explains Marchenkov, and the “transcendent voice of heaven, cantus firmus, is now supplemented by the voice of its immanent other, discantus, and the relation between them is ruled by a rationalistic sense of harmony, punctum contra punctus” (p. 44). The relationship between the evolution of human agency and the myth of the Holy Trinity lies in the reality that “in the Trinity she sees herself.” Rather than the ancient “dissolution of the human being in impersonal [divine] nature,” which is critiqued by Hegel as “not anthropomorphic enough,” the medieval Christian “self does not lose itself in the
contemplation of the ultimate mystery but stands before it, retaining its own identity” (Marchenkov, p. 54).

In addition to its roles in the Trinitarian origins of polyphony and the evolution of human agency and human identity in relationship to the divine, the mythologem of Orpheus-Christus also produces a particularly “new song” that might be called a precursor to modern “Gospel music.” “The New Song of the Christian theologians” observes Marchenkov, “stands for cosmic harmony, the moral force of the new religion, the mystical doctrine itself, and its soteriological power” (p. 48). If myth is Plato’s “highest music,” as established above, then the myth of the Christian “gospel” may be the highest music of the medieval era of human consciousness. Invoking Orpheus’s musical instrument of choice, Christian tradition refers to its gospel of the cross as a “lyre.” Extant in the “Octoechos” of the Eastern Orthodox Church, where it is chanted liturgically, the Christian gospel is hymned as a “lyre of the apostles whose many strings were moved by the Holy Spirit” (Orloff, 1898). Described by St. Paul as the “word of the cross,” the Christian gospel, articulated by Behr (2006) as the message of the “God made known on the cross,” is universally represented by the symbol of the cross. Invoking St. Gregory of Nyssa’s description of the cross as the axis mundi, or axis around which the world rotates (Behr, 2006), another early Christian theologian, Clement of Alexandria, equates a similar image with the notion of “pure song.” Marchenkov observes that “[t]his ‘pure song’ is, according to Clement, ‘the stay of the universe and the harmony of all things, stretching [like an axis mundi] from the center to the circumference and from the extremities to the center’” (as cited in Marchenkov, 2009, p. 48). “Like Orpheus” with
his lyre, “and David,” with his harp, “Christ,” with his cross, “becomes the healer of the discord in the soul.” Foreshadowing our discussion of the relationship between the freedom of the Passion and the slavery of the “passions” in Chapter Eight, Christ, the “divine minstrel, says Clement, ‘has come to bring a speedy end to the bitter slavery of the daemons that lord it over us; and by leading us back to’ the Garden of Eden through ‘the mild and kindly yoke of piety he calls once again to Heaven those who have been cast down to earth’” (Marchenkov, pp. 48-49).

In addition to fitting the Orphic role as soul-healer, Christ also fits the Orphic role as journeyman into the realm of death in the pursuit of securing life for his erotic lover: “Orpheus’s catabasis is likewise conflated with Christ’s harrowing of hell and Eurydice is interpreted as the human soul who is now truly saved.” This conflation is understood by Christian theologians as more than just another stage in the evolution of myth but more along the lines of Plato’s theurgy or, as modern apologist Lewis describes it, “myth become fact” (Lewis, 1994, pp. 66-67; see also 2 Peter 1:16). In fulfillment of the prophetic truth of ancient tragedy, “Christ,” says Clement, “is an actor (agonistes) in the real drama unfolding ‘in the theater of the whole cosmos’” (Marchenkov, p. 49).

The identification of the Christian gospel as a song and Christ as a minstrel highlights at once the mystical nature of music and the image of the cross of Christ as a musical instrument. Regarding the former, it is, in one sense, odd that the Christian gospel was understood by early theologians as song since unlike David and Orpheus, Christ is not depicted with a harp or a lyre. This curiously non-musical music recalls the popular euphemism describing paying close attention to body language and other non-
discursive cues in conversation as a way to listen to another person so as to hear not just the words but also the music. This notion of trans-musical music or the sense of music as just as much a vehicle for meaning as it is a vehicle of anything else is certainly conveyed in the “new song” and “pure song” of the Christian gospel: “As it creates a legitimate place for Orpheus in medieval culture, the mythologem of Orpheus-Christus at the same time foregrounds the moral and, above all, mystical significance of music. The New Song is a mystical symbol *par excellence* in which actual music is almost completely obscured” (Marchenkov, p. 49). On the other hand, as referenced above, there is an extent to which the cross of Christ becomes the musical instrument *par excellence* for a period in the history of mythical consciousness. As seen in above in the imagery of the cross as “*axis mundi*” and “pure song,” the music of the cross rings so clearly in the ears of early Christian souls that its meaning becomes an Orchestra in which all other manifestations of truth unite into one harmonious chorus and a pitch fork according to which all other claims of music ring true or discordant.

As referenced above and developed in more detail later in Chapter Eight, the mystical music emanating from the cross of Christ is a melodic riff on the meaning of the Passion of Christ and the relationship between Christ’s “Passion” (or voluntary suffering) and human “passions” (or destructive attachments). In order to understand how the mythologem of Orpheus-Christus turns the cross of Christ into a musical instrument for Passionate melody, it is necessary to explore the context in which the Orpheus-Christus image is depicted within the Christian tradition. If the myth of the Christian gospel may be the highest music of the late antique and medieval eras, then the mythologem of
Orpheus-Christus may be uniquely significant to its Eastern Orthodox manifestation. Western historians, Christian or not, tend to interpret Christ’s above-described Orphic descent into Hades as the “harrowing of hell,” a significant but not overly emphasized event thought to have happened between the crucifixion and the resurrection. Eastern Orthodox Christianity understands the Orphic myth of Christ’s descent into Hades differently. As described by Behr (2006), the difference between the Eastern and Western interpretations of this myth is made clearest through an examination of the Eastern Orthodox icon inscribed with the word “Anastasis,” depicted below in Figure 2.

The Greek meaning of the word “Anastasis” is “resurrection,” and the Anastasis icon is the iconographic depiction of the resurrection of Christ in the Eastern Orthodox tradition. Western paintings of the resurrection do not depict the event described by the West as the “harrowing of hell,” focusing instead on depicting the historicizing narrative of Christ’s ascent out of his tomb, having rolled away the stone, such as the fifteenth century depiction by Mantegna in Figure 3 below.

*Figure 3. Western Resurrection. “The Resurrection,” by Andrea Mantegna, 1459, Musee des Beaux-Arts de Tours, Tours France. Public domain wikimedia photograph.*
The iconographic inscription, “Anastasis,” or resurrection, in Figure 2 is often re-titled “Harrowing of Hell” in the West, as a result of the Euhemerist assumptions of the West’s dominant epistemological approach to theology. Drawing on Bakhtin (1981), Marchenkov describes Euhemerism as a “middle phase” between the walling off of miracles in the “absolute past” of the epos and the elimination of miracles in the modern novel. In the “middle phase” of Euhemerism, mythical events are interpreted literalistically “as historically actual” in a way that fixes them in the past. Therefore, the resurrection of Christ must necessarily be depicted by the removal of the stone or the literal emergence from the tomb in historicizing fashion. As a result of this Euhemerist epistemology, Western depictions of the scene from the Orphic Anastasis icon are often labeled “Harrowing of Hell” rather than, or in addition to, “Anastasis.” The Orpheus-Christus mythologem, however, showed a “reverse development” in late Antiquity when Christianity facilitated a rebirth in the life-cycle development of humanity’s mythical consciousness whereby Christian myth is taken “precisely *qua* myth, i.e., a true story about miraculous reality” (Marchenkov, p. 55). While Euhemerist perspectives tend to place greater emphasis on the Easter story as a historicized rendering of Christ’s physical resuscitation in super-human form depicted by his miraculous rolling away of the stone, the Eastern Orthodox iconographic tradition bears witness to the mythological epistemology of the Orpheus-Christus mythologem. As noted in Chapter Two, the physical aspects of miracles serve as containers of revelatory meaning which itself becomes the focal point of reflection upon the miraculous.
The liturgical music tradition of the Eastern Orthodox Church confirms the iconographic inscription “Anastasis” as anything but an error. The revelatory meaning of the Anastasis icon defines the meaning of Christ’s resurrection for the Eastern Orthodox tradition. For example, the meaning conveyed in the Anastasis icon dominates the Eastern Orthodox celebration of the resurrection. The text of the hymn sung in celebration of Easter or “Pascha” in the Eastern Orthodox tradition is “Christ is Risen from the dead, *trampling down death* by death, and upon those in the tombs bestowing life.” Rather than the western Euhemerist image of the resurrection as Christ’s removal of the stone from the tomb and reappearance on earth in super-human form, the Eastern Orthodox theological tradition celebrates the resurrection as an Orphic “trampling down” of death, “a true story about miraculous reality.” Far from denying the miraculous nature of the resurrection, the Eastern Orthodox emphasis is vital to a truly mythological understanding of theology because it rescues theological reality from the static deposit of what Bakhtin (1981) called the “absolute past” and inscribes it directly in the dynamic, living present as a viable alternative to normal waking consciousness, precisely *qua* reality. As such, the content of the resurrection of Christ celebrated by Eastern Orthodox Christianity is focused precisely on the event depicted in the Anastasis icon and sung repeatedly in the Paschal (Easter) services, Christ’s “trampling down of death by death,” not as it might be imagined euhemeristically but specifically as it is depicted theologically and, coincidentally, Orphically, in the icon.

The significance of the Eastern Orthodox emphasis on the Anastasis icon as the location of meaning for the resurrection of Christ is that this locus of meaning sheds light
on both the Orpheus-Christus mythologem and the notion of the cross of Christ as a musical instrument. For our purposes, this manifestation of mythical consciousness offers a pre-modern alternative to the adolescent consciousness of modernity, challenging approaches to miraculous phenomena of both modern medical and modern religious paradigms. In the Anastasis icon, it is not Christ who is coming out of his tomb, but Adam and Eve who are being pulled out of their tombs by the risen Christ. The resurrection of Christ is celebrated Orphically in the Eastern Orthodox Church. As Orpheus descends to the realm of death to rescue his lover Eurydice, Christ descends into the realm of death to rescue his lover, humanity. As seen in Figure One above, between the tombs of Adam and Eve lies Hades, the realm of death, personified and defeated as seen by the ropes tying him up and constraining his previous power over humanity. Around the personified depiction of Hades are keys that previously failed to open the locked doors of the underworld, imprisoning humanity in the realm of death. While the music of Orpheus may have charmed Hades, teased the lock and foreshadowed the key, Eurydice is never fully delivered. Christ, however, succeeds where Orpheus failed. Marchenkov references Friedman’s discussion of this theme from Ephraim of Syria (Marchenkov, p. 49). The homilies of St. Romanos the Melodist and music of Bach reference the same theme (Mellers, 1987; Old, 1999). The doors of Hades are torn open and reshaped into the form of a cross on which Christ stands triumphant, pulling Adam and Eve up out of their tombs. In addition to standing on the unlocked doors of Hades, reshaped into the form of a cross, Christ is depicted in typical iconographic form with the cross-beams in his halo. The emphasis on the cross in the image of the resurrection
demonstrates Behr’s (2006) contention that the cross and the resurrection are not understood as distinct events in the Eastern Orthodox tradition. Rather, the Passion encompasses the full spectrum of the crucifixion and the resurrection which cannot be understood properly in isolation from one another. This emphasis on the importance of the cross in the Anastasis icon is pinpointed by the accompanying lyrics to the Orthodox Anastasis hymn previous mentioned, that are sung liturgically in the Paschal (Easter) season when the icon is venerated: “Christ is Risen from the dead, trampling down death by death.” It is specifically through his voluntary death on the cross that Christ tramples down death, unlocking the doors of the underworld and rendering Hades captive to the power of the cross (Behr, 2006).

If the voluntary death on the cross proves to be the key to unlocking the doors of the underworld and rescuing the Eurydice of humanity, then it becomes clear why Christ was depicted as a musician a la Orpheus and how the cross can indeed be understood as the musical instrument par excellence. It was contended above that, as will be developed further in Chapter Eight, the mystical music emanating from the cross of Christ is a melodic riff on the meaning of the Passion of Christ and the relationship between the Passion (voluntary divine suffering) and the passions (destructive human attachments). We stated that in order to understand how the mythologem of Orpheus-Christus turns the cross of Christ into a musical instrument for Passionate melody, it is necessary to explore the context in which the Orpheus-Christus image is depicted within the Christian tradition. Depicted in the Anastasis icon as an unfinished event, the resurrection is ongoing in the present where the Eurydic Church as bride of the Orphic Christ is being
pulled up out of the realm of death. By accomplishing the mystical purpose of Orphic music in unlocking the doors that held humanity captive to death, the Passionate melody of the cross simultaneously unlocks the doors of the passions entrapping supposedly living humanity in the waking death of involuntary enslavement to our own attachments. By embracing the melodic romance of Confession, Eurydic brides of the Orphic Christ voluntarily die to the self-enslaving passions and receive the Eucharistic fruit of the Tree of life as the consummation of divine intercourse rendering a mystical transformation that can only be expressed through the worshipful song of thanksgiving (Alfeyev, 2009).

Regarding the notion that Christ succeeded where Orpheus failed, might it be possible to conceive of modern medicine as the traditional Orpheus figure whose music miraculously suspends the powers of death but who nonetheless fails to ultimately rescue Eurydice? In juxtaposition to the failed Orphic project of modern medicine, the crucified Christ (while perhaps less reliable for the ultimately futile purposes and false hopes of what Marchenkov calls “immanentist infinitism” in the adolescence of myth discussed below) offers an arguably more rational offer of miraculous healing. Christ’s offer of miraculous healing speaks to the patient/family-centered healing reality/myth/consciousness as a journey of personal transformation and frames the broad contours of this infinitely varied journey as one from attachment to the involuntary slavery and death of the passions to an experience of detachment from the passions resulting from attachment to divine love through the sacramental life of the Church. In a book aptly titled for our purposes, *Truth is Symphonic: Aspects of Christian Pluralism*, von Balthasar (1987) sums up the child-like mythologem of Orpheus-Christus and sets
the stage for an examination of its adolescent other as personified by the modern medical project with the following juxtaposition between what he calls the “David” of the Church and the “Goliath” of the world:

Even when they are working together to eradicate suffering, the world is fighting for quality of life, whereas the Church is fighting for salvation. The quality of life and the happiness of the majority are in the forefront, while behind them there is still the unconquered fact of death. Salvation, however, embraces man and the world in their total destiny, which will only achieve fullness beyond time and beyond death. The unity of the world is continually falling apart in death, but the Church’s unity, which adumbrates the unity of the coming Kingdom, gathers up the world’s fragile unity—but in doing so it surrenders itself to that death that its Lord has already overcome. (von Balthasar, 1987, p. 107)

Just as Orpheus Christus offers a mythological alternative to the modern medical paradigm, it also offers a possibility for deepening modern religious notions of the miraculous. Regarding the above articulated notion that the resurrection of Christ can be appreciated as much more than a Euhemerist image of static, historicized literalization, the same may hold true for religiously motivated miracle-hope. If the greatest Christian miracle, that of the resurrection of Christ, is best imaged by the Orpheus-Christus “Anastasis” icon as an historical event that points to a transhistorical unfolding of divine economy toward creation, then the same can be said for the ultimate fruition of all Christian-motivated miracle-hope. While inseparably rooted in the historical experiences of specific human tragedies and desires for immediate physical resolution, all the
particulars of Christian hope must also remain inseparable from resignation to the mysterious, eternally manifested reality of divine love and universal salvation granted through the voluntary crosses and miraculous resurrections of heavenly-Kingdom-oriented individuals and communities. This reality can only be explored clinically through mediums of compassionate communication unveiled in health communication theory in the following chapters.

Having departed from Marchenkov’s philosophical study for a foray into related theological concerns pertinent to our purposes, we now return to Marchenkov in earnest for an exploration of the pseudo-myth underlying modern art, myth, and music that will shed light on our mythological analysis of the modern medical project.

**The Early Adolescence of Myth**

With the “growing self-consciousness of the artist” in this period of the life-cycle development of humanity, Orpheus gains popularity as a “mirror in which the Renaissance painter, poet, and musician examine their own features” (Marchenkov, 2009, p. 61). This period is characterized by the emergence of opera as a new art form, the conquest of symbol by allegory, and the beginning of what Marchenkov dubs modern “infinitism,” which he defines as “the acceptance of infinite regress as more rational than pre-modern holism” (p. 61-62). Especially pertinent to our medical context of interest, the underlying logic of this infinitism renders miracles impossible, and they become from now on signs of falsehood, error, and fiction. The only manner in which the
synthesis of the intelligible and the sensible is considered possible now is 
allegorically. What was a tale about reality is now a fable. (p. 62).

Christian as Ficino’s human subject may be, he is also the self-created center of Ficino’s newly empowered humanistic order in the early adolescence of humanity. Mirroring the scientific method, Italian composer, Guilo Caccini’s foray into a novel musical monodism

is not that of a magus in mystical ecstasy, but a series of trials that test a hypothesis. Rather than relying on mediating spirits, Caccini achieves the desired outcome ‘of speaking musically’ by his own deliberately and purposely applied effort….subjectivist and…voluntaristic. (Marchenkov, p. 67)

Embodying such voluntarism, Orpheus in Monteverdi and Striggio’s L’Orfeo is “a superhuman singer [who] soothes and subdues the forces of darkness blocking his path” (Marchenkov, p. 67). Like the early adolescent, the early modern subject understands the forces of darkness to be whatever stands in the way of the unreflective wielding of its newfound powers of death-defying invincibility. Reminiscent of Foucault’s critique of modern medicine’s utopian hopes,

Orpheus’s success stands for the cosmic advance of man, his mastery of the elements, and bold ‘disarming’ of nature. Characteristically, the Renaissance artists suppress Sophocles’ warning in the Antigone that man’s artistry can have a repulsive side (lines 365-375). Similarly elided is the mention of death as the ultimate limit of man’s progress. Monteverdi and Striggio make death rather the
greatest but surmountable obstacle in Orpheus’s triumphal march. Immortality is what Orpheus really seeks. (Marchenkov, p. 68)

Just as the medical scientist is the protagonist investigating the patient matter of the human body in search of immortality for the infinite human subject, Monteverdi and Striggio’s Orpheus is interested in saving Eurydice for self-serving purposes, as she is no more than a “mere aspect of Orpheus himself” (Marchenkov, p. 69). Like the early adolescent, the early modern subject is so taken with his growing powers that he sees himself on par with the divine. Ficino deems man “capable in a way of making the heavens.” Unlike the medieval subject whose ultimate desires focused on preserving her immortal soul at the expense of her bodily well-being, Ficino’s immanent subject rivals its transcendent counterpart. Lauding the “techne of the human artist,” Coro di Spiriti “marks the fruition of this tendency” to elevate immanent humanity to its own self-secured godhead. “What is desired now,” diagnoses Marchenkov, “is immanent immortality, a perpetual, deathless existence in this world and in this, untransfigured body. It can be achieved by means of artistry crowned with man’s impassioned, irresistible will” (p. 69).

This view of the human subject in relation to divine being corresponds with musical evolution from “medieval, mystical-symbolist” to “modern rationalistic-allegorical.” Before we explore the significance of this transition, it bears noting that, in contrast to Orpheus-Christus, and much like the modern medical project in its effort to overcome death by human effort, Monteverdi and Striggio’s “Orpheus does not succeed
by his own effort. He loses Eurydice through the despair caused by doubting the gods and through the hubris of over-relying on the power of his own love” (p. 69).

Marchenkov begins a section describing the transition from symbol to allegory by describing two pivotal developments during the Renaissance period “that erode the basic conditions of [premodern] myth’s existence” (p. 70). These two developments are the dissipation of “medieval immediate availability of reality” and the related consequence that “the way of thinking that necessitates miracles yields to a mindset that is inhospitable to their very possibility” (p. 70). The mindset of hostility to the very possibility of miracles invokes Cadge’s (2012) ethnographic observation that when religious beliefs such as miracle-hope conflict with biomedicine they are “not tolerated.” How is the loss of immediately given reality and inhospitality to miracles connected to the transition from symbol to allegory, and how is this connection reflected in the medical response to miracle-hope?

Harkening back to Losev, we may recall his co-identification of symbol and miracle as the intersection of two planes, immanent and transcendent, historical becoming and ideal prototype. If immediately given reality is not taken seriously, then events previously interpreted as miraculous become funneled through the sanitizing lens of scientific investigation that deems them mere coincidences. Losev, however, used the term “coincidence” quite differently. For Losev, the “coincidence,” or the coinciding of the historical becoming and the ideal prototype is precisely the place where the miraculous is revealed and experienced. Similarly, the coincidence of the immanent and transcendent is revealed and experienced in the symbolic medium. In a world where the
interpretation of these coincidences devolves from “miraculous” to “mere,” i.e. mundane, such a manner of interpretation can be nothing other than a rejection of the transcendent, vertical plane. The transition into adolescence could similarly be described as a transition from interpreting the coincidence between the warnings and guidance of authority figures and actual events as miraculous and the reinterpretation of such points of intersection as “mere coincidences” interpreted as misleading signs of falsehood.

Stepping outside of Marchenkov’s analysis to our exploration of the cross as a musical instrument, it seems that when the cross’s vertical plank of tradition, authority, and transcendence is rejected, the cross can no longer serve as a musical axis mundi (axis around which the world rotates); its intersecting beams are torn asunder and replaced with two parallel planks, preserving a two-fold division of reality and positing immanence to both. Returning to Marchenkov, we might imagine modernity’s adolescently re-formed parallel planks of the cross to correspond to his parallel planes of reality in a world where the transcendent plane no longer intersects with the immanent plane and symbol is exchanged for allegory. Allegory is an expressive form that projects a world split in twain: on the one hand, there is abstract content and, on the other, external form. These two sides of existence recede into infinity as two parallel planes. The perpetually deferred synthesis of content and form is the weak side of allegory; it extinguishes one’s hope for a full grasp of truth. (Marchenkov, p. 81)

Allegory’s extinguishing of hope for a full grasp of truth recalls Schmemann’s (1973) critique of the false juxtaposition of the “real” against the “merely symbolic” in the
Eucharistic transubstantiation debate and suggests the possibility that, rather than “real” and “symbolic,” the categories proper to the debate may have been “Euhemerist” and “allegorical.” Like the Eastern Orthodox approach to sacraments as truly symbolic in a Losevian sense of miraculously mystical, the nature of the “hope for a full grasp of truth” that is extinguished by allegory is both a hope and a truth that, like “Christ’s victory over the nether world” and the “redemption of immanent being” that it signifies, “remains irreducibly mystical” (Marchenkov, p. 71). In exchange for the irreducible reality governed by mystery, the totalizing adolescence of modern humanity prefers infinitely reducible reality governed by technology:

Since the universe never comes to a completion and since the ideal and the material in it never fully intersect with each other, miracles are unthinkable. The only way these planes can be brought together is through an act performed by the artist-technologist…. [S]ynthesis…depends solely on the will of the human individual. (Marchenko, p. 81).

Hope for miracles through divine intervention does not fit in a world where synthesis depends solely on the will of the human individual. According to Marchenko, the transcendent plane is replaced by a second horizontal plane. Hovering in parallel with the immanent human subject are the infinitely various laws of nature.

We may now be in a better position to address our question: “How is the loss of immediately given reality and inhospitality to miracles connected to the transition from symbol to allegory, and how is this connection reflected in the medical response to miracle-hope?” When the epistemological lens of the scientistic gestalt limits reality to
its terms of objectivity, manipulation and control, immediately given reality is lost. When immediately given reality is lost, what was previously a miraculous coincidence of immanent and transcendent devolves into a “mere” coincidence, illustrative of meaninglessness and chaos. When miraculous coincidences devolve into mere coincidences, the vertical plane of the ideal prototype and the transcendent being is rejected. When the vertical plane is rejected, reality is limited to the horizontal plane(s) of immanence. When horizontal planes of immanence govern reality, miracle-hope that conflicts with biomedical calculation is not tolerated in the medical landscape that is governed by the infinite aims of immanent man. Allegorical reality thus pays homage to the imagination and will of the human agent, invoking Marchenkov’s theory of “immanentist infinitism:”

Allegory is thus jointly produced by rationalistic immanentism and infinitism.
But in order to ensure even such tenuous synthesis as it is capable of supplying an effort is necessary on the part of the only agent who remains on the stage: man.

In the arsenal of human faculties there are left now only two that are suitable for such an operation: imagination and will. Both of them stand between the two planes: imagination is thinking that assumes the forms of external phenomena and will ensures the transition from thinking to external action. The will of the human artist replaces medieval mystery; it becomes the undecomposable principle that forms the core of the modern person and manifests itself as the *je ne sais quoi* of the artwork. (Marchenkov, p. 82)
The allegorized god in *L’Orfeo* expresses the Baroque concept of illusive reality in a world composed only of horizontal planes and governed only by human imagination and will: “Mundus est fabula, the world is a fable in which man steps forth as the sole hero, driven by the will to immanent immortality” (p. 82). The immanent drive for immortality allows for the possibility of “miracles” as long as they derive from horizontal planes of immanent human will and imagination. This is seen in the above referenced health care industry’s marketing of miracles produced by medicine and the utopian hope, critiqued by Foucault as an effort to usurp the church, for a medically secured miraculous future free from illness.

Immanentist infinitism’s hope for immortality as a miracle of its own making exposes the truth of Marchenkov’s contention that despite all its laudable successes, what drives early modern consciousness is not so much rationality or the search for truth as the “will to power and possession” (p. 76). Drawing on Horkheimer and Adorno’s analysis of Bacon’s attitude toward this kind of knowledge, Marchenkov notes that “knowledge becomes instrumental in this era, a mere means for achieving dominion over nature” through “conscious and purposeful manipulation of natural phenomena” (p. 76). This point is important because it underscores the extent to which the adolescence of early modernity not only rejected the authoritative plane of transcendence but simultaneously shirked its own responsibility to follow the divine mandate to serve as a faithful steward of creation. Without the vertical plane, the “external world becomes something ephemeral, a mere means of achieving a goal that is posited apart from it. Not only
reason and art have become instrumental, but with them nature herself. Nature has been
turned into a mechanism” (p. 82).

Consistent with the turbulence of early adolescence, early modernity has a
problem with what adults like to call responsibility. Rejecting both its responsibility to
the vertical plane (as seen in moral decline) and its responsibility for the horizontal plane
(as seen in environmental degradation), early adolescent modernity relishes in the
invincibility of its newly found powers of infinite imagination and will (as seen in the
phenomenal successes of modern medicine). As a result, the adolescent “immanentist
mindset now holds the entire world in its grip but the gain comes at a price: the world is
not whole any more” (Marchenkov, p. 71); according to Donne, it is a world “all in
pieces” governed by a Cartesian god who turns out to be nothing more than “the content
of [the human] ego” (as cited in Marchenkov, 2009, p. 77). Marchenkov senses
melancholy in Tomlinson’s description of a “dualistic subjectivity” in the early modern
voice that “does not touch the soul,” or as Marchenkov would have it, finds itself in a
“new order” where “both the body and the soul find themselves within the domain of the
immanent, in perpetual separation from the transcendent unity of the world” (p. 83). It is
within this context that opera surfaces as a new artistic medium giving voice to the
isolated, empowered adolescent human subject who has evolved from connecting with
God to manipulating matter:

Operatic voice enunciates human subjectivity as the only self-evident reality,
woven of three threads: abstract understanding, imagination, and will. What used
to be felt as reality earlier is now displaced and finds itself outside the walls
created by Orpheus’s “metaphysical song.” That old reality still retains a vague presence but it can be viewed now only through the prism of subjective consciousness. As the theurgist at the helm of the cosmic ark exchanges his robes for the frock [white coat?] of the technologist, God retires into the distant, murky regions of irrelevance. (p. 83)

The invocation of operatic voice as artistic embodiment of technology sans divinity recalls Bishop’s (2011) dissatisfaction with both the intensive and palliative manifestations of care for the dying and his suggestion that perhaps only theology can save medicine. Marchenkov describes operatic effects as “mechanical rather than miraculous. Distinguished, as was noted by Socrates, from a mystical rite by the fact that it is based on rational knowledge, technology perpetually accomplishes only partial syntheses and never the final and complete one” (p. 83).

The void Bishop (2011) calls for theology to fill in modern medicine may be merely a symptom of the theological void in an adolescent humanity all too taken with itself:

The world where Orpheus’s aria sounds is not mythical, but mechanical and there is only one arche in it that is capable of realizing man’s goals: will. Thus, instead of partaking of the Eucharist in the humble hope for salvation, the Orpheus of Baroque opera commands nature to give up her secret. Accordingly, instead of reveling in the mystical unity of [Trinitarian polyphony or the apophatic music of the cross where the transcendent and immanent planes coincided in intersecting harmony], music embodies in sound the purpose-driven, active will of the
individual who resolutely leads forward and upward the community of natural
human beings and indeed nature herself. (Marchenkov, p. 83-84)

The purpose-driven will of the individual is expressed in monody and tonal harmony
where “the most important thing communicated…is the thought of the subject’s
movement toward its goal, i.e., that this subject is really defined by its history.” The
fixation of this movement, goal, and history is immanent and infinite. “Rather than only
an immediate unity with the absolute, what is of moment for this subject-melody is the
purposeful progressive unfolding of its own infinitely varied content” (p. 84).

It is no surprise that Freud described the history leading up to this era that we are
calling the adolescence of modernity as a “libidinous evolution of the individual”
culminating in the pinnacle of human maturity with science, adaptation to “reality,” and
self-seeking paramount (Marchenkov, p. 121). From the adolescent perspective of the
libido, history can only be characterized as Freud’s “libidinous evolution” and can only
culminate in adolescent consciousness, a consciousness characterized, more than
anything, by naively unconscious manipulation and exploitation resulting from
unreflective, if productive and well-meaning, wielding of newfound powers:

Contrary to appearances, positivism’s reality consists not in observable
phenomena—be they natural, sociocultural, or psychological but in their
manipulation based on exploiting the laws and regularities that lie in their depth.
All human action, maintains Chernyshevskii, relies on the laws of nature.
‘Nature,’ he continues, ‘is […] merely a hospitable or inhospitable arena for
human activity.’ This manipulation is designed, in turn, to serve the infinite
progress of immanent humanity. The impossibility of miracles in the realistic universe is predicated precisely on the infinite nature of this process. The final synthesis seems impossible in principle because it is supposedly unthinkable that human progress may end. It may appear, then, that this progress is the essence of reality for this type of consciousness but it cannot live up to such a role. The logic inherent in the notion of progress renders its infinitist version absurd. Infinite progress is a *contradictio in adjecto*, an internally contradictory combination of concepts, for without the final goal it is impossible to measure movement in its direction and without such an assessment (point B is closer to point C than point A) it is impossible to speak of progress. Progress is possible only in those contexts where the concepts of the finite and the infinite are equally taken into account, whereas positivism conceives of infinity as the endless repetition of the finite, thereby condemning itself to a perpetual failure to reach genuine infinity. Obsession with the finite manifests itself in positivist realism’s attention to the process of manipulation itself—narrowing of vision by virtue of which reality becomes technical through and through. It is precisely this unfinalizability that, as Mikhail Bakhtin perceptively notes, becomes the fundamental aesthetic category that marks modernity’s chief literary genre: the novel. (Marchenkov, pp. 117-118)

Positivist realism’s obsession with the finite, seen in its narrow attention to the process of manipulation itself, is evidenced by research tracking patient-provider discussion of prognosis (The et al., 2000). Rather than facing the likelihood of death and
discussing a variety of options in the interim, health care decision-making processes often degenerate exclusively into discussion of treatment options as if the only reality up for consideration is the infinite repetition of finite manipulation through the technical reality of the modern medical matrix. Physicians feel stuck in the narrow mode of this matrix because they “do not want to pronounce a ‘death sentence’” for fear that they will destroy hope. They also often claim that patients do not want to hear the truth (Morris, 2004), which is sometimes the case (Vos, 2001). But on other occasions, family members perceive doctors willfully if unconsciously leading patients down the narrowing path of infinite manipulation of the finite, perhaps because they do not feel comfortable facing and discussing difficult realities themselves (Morris, 2004), and they are trapped in the modern medical reality that has become “technical through and through.” Seen not only in medicine, but also in music, the arts, and now literature, through Bakhtin’s above-referenced observations of the modern novel genre, to which we shall return in our exploration of narrative medicine, adolescent humanity’s libido rages in its new-found powers of manipulation and exploitation undergirded by its wholesale, if unconscious, adoption of the modern myth of “immanentist infinitism.”

In addition to becoming technical through infinite manipulation of the finite, reality ultimately becomes “merely probable” through infinite cognization of immanent nature:

The Hermetic Orpheus as he is reconstructed in Renaissance musical magic represents the aspiration to analyze divine mystery into a rationally comprehensible chain of causes and effects. Thus in the modern era the mystical
unity of the transcendent Creator and immanent creature yields to the perception of the world as immanence unlimited by transcendence. And yet, far from vanishing, the medieval division of the world into two contrasting dimensions is partially preserved as it is superimposed onto the immanent universe where it assumes the shape of natural phenomena and natural laws. As immanent, both are presumed to be infinitely cognizable. However, since cognition supposedly goes on ad infinitum certain knowledge of reality becomes impossible and is replaced by an infinite series of hypotheses. Reality becomes something merely probable, and the world view is thereby thoroughly aestheticized. (Marchenkov, p. 156)

In the following chapter, we trace the development of this “merely probable” reality.

Modernity’s adolescent myth of “immanentist infinitism” undergirds the myths articulated in Mattingly’s “canonical genres” of modern medical dogma and explains why miracle-hope violates the rationality of medical myth and is so frustrating for those steeped in medical dogma flowing from the wells of “immanentist infinitism.” As noted in Chapter Three, medicine’s problem with religiously motivated miracle-hope in response to the prognosis of medical futility is not a problem with the foolhardy pursuit of impossibility, as such a pursuit is indeed constitutive of the modern medical project’s relationship with mortality. Rather, medicine’s problem with religiously motivated miracle-hope in response to the prognosis of medical futility is that this kind of hope is deemed heretical by the dogmatic stance of the canonical genres of modern medicine because it posits a narrative in which the physician-scientist is not the main protagonist and in which the highest form of transformation is not scientific. This kind of hope
reflects a worldview in contradiction with the adolescent pseudo-mythical consciousness of “immanentist infinitism” that posits man as the sole agent of his own self-generated and technologically produced immortality. Therefore, the communication impasse between physicians and miracle-hoping families surrounding health care decisions made in view of predictions of medical futility is not so much an issue of rationality vs. irrationality as it a collision of contrasting myths and competing dogmas seen in the evolution of Orphic music aimed at rescuing Eurydice from the realm of death. Indeed, as we shall see in later chapters, the postmodern critique “lays bare the irrationality of modernist conceptions of personhood and teleology” inherent in “immanentist infinitism’s” preference for the medical scientist over the patient/family as protagonist in the canonical healing genres of modern medical myth (Marchenkov, p. 130).

**New Possibilities for an Unrealized Future**

According to Marchenkov, the next stage in the life-cycle development of humanity unearths a compelling vision for transcendence beyond the adolescence of immanentist infinitism, but this vision was not able to fully curb the adolescent appetites of modern man, remaining largely unrealized as articulated. If Schelling teems with a compelling if romantic desire to transcend the mechanics of immanentist infinitism with the development of new myth, Hegel transcends Schelling’s romanticism in the development of a potentially unparalleled philosophy of art to fulfill the future role of genuine myth. Because the visions of Schelling and Hegel await realization and thus exert minimal impact in the immanentist infinitism characteristic of modern medicine, this section of Marchenkov’s study will receive less attention here than it otherwise
deserves; however, Hegel’s notions of the utterly serious role of art, the “[g]enuine transformation of reality” that is possible “through artistic creativity” (Marchenkov, p. 86), and the work of thinking as a midpoint between abstract rationalism and mysticism are concepts to which more attention might be given, especially for future research related to our purposes, as they bear on possibilities for the evolving role of the “art” of medicine.

The concept of thinking as a midpoint between the potential abstractions of mysticism and rationalism is vital to Hegel’s thought and Marchenkov’s analysis. And it may be useful as a lens for previewing later chapters in this dissertation through a brief consideration of the modern notion of the uncivilized “savage” (p. 92). “In the Middle Ages,” says Marchenkov, “there existed an impassable abyss between ancient and Christian myths: the radical change brought about, as the medieval mind was convinced, by divine revelation.” Marchenkov goes on to point out that the “Enlightenment attempts to close the abyss by pushing the notion of revelation into the background and by replacing it with an immanentist vision of an homogeneous cultural-historical continuum.” Ultimately, the “fables of Antiquity are similar to the contemporary fantasies of the savage and both are subsumed under religious superstition.” The culmination of this trajectory invokes our above discussion of the physician perspective of miracle-hopers in the family meeting:

The miraculous and the magical are, according to this view, fictions created by those who lack knowledge and experience. The mind of the savage is thus qualitatively similar to the enlightened mind; like the operatic furies and specters
it merely needs to be disabused of superstition and prejudice, both of which are the effects of ignorance. (Marchenkov, p. 92)

This characterization of savagery begs a question to which we shall return: does modern medicine view miracle-hopers as ignorant savages waiting to be disabused of their archaic fantasies? And is there a place for the Hegelian work of thinking in mediating a role between the abstract mysticism of the so-called “savages” and the abstract rationality of modern “adolescents?”

In addition to Schelling and Hegel, Marchenkov traces the compelling efforts of Solov’ev, Scriabin, and Ivanov to transcend what he calls the aestheticization of reality. Here, it suffices to observe that as compelling as such visions remain, adolescent humanity has something akin to mountaintop experiences at summer camp through the efforts of these and other artists and philosophers, but, time and again, promptly reports back to the country club pool for the rest of the summer of modernity where it continues to bask in the sun of “progress” while remaining comfortably submerged in the cool waters of immanentist infinitism.

As stated, the sophist preference for a rationality characterized by an infinite regress of analytic progress becomes prominent in the modern era, and the historical playing out of immanentist infinitism ultimately leads to a world in which “[r]eality becomes something merely probable” (Marchenkov, p. 156). We now turn our attention to the realm of health communication theory to sketch the development of the modern notion of probability that comes to consume this world in which reality becomes merely

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3 through a series of readings culled by PI theorist, Austin Babrow, in the context of a graduate seminar on probability and uncertainty at Ohio University, Fall, 2013.
probable. In so doing, we zoom in to a perhaps more granular exploration of the roots of an epistemological imbalance plaguing medicine, whereby, as PI theory lays bare, the abstract rationality expressed in calculations of probability is too often unaccompanied, or at least too little accompanied, by complementary reflection on value. This raises the provocative question: does the myth of immanentist infinitism come perilously close to dichotomizing probability over and against value such that calculations of probability are deemed rational scientific knowledge while reflection on values is dismissed as irrational savagery?
CHAPTER FIVE: PI THEORY & HOPE FOR THE MIRACLE OF COMMUNICATIVE TRANSFORMATION

Most people are subjective toward themselves and objective toward all others, frightfully objective sometimes—but the task is precisely to be objective toward oneself and subjective toward all others. (Kierkegaard, 2013, p. 423)

According to Bell Laboratories’ 1948 researcher, Claude Shannon,

The fundamental problem of communication is that of reproducing at one point either exactly or approximately a message selected at another point. Frequently the messages have meaning. That is, they refer to or are correlated according to some system with certain physical or conceptual entities. These semantics of communication are irrelevant to the engineering problem. (As cited in Rogers, 1986, p. 88)

– Claude Shannon, Bell Laboratories, 1948

In an ambitious work aimed at tracking the history and theory of information, Gleick (2011) emphasizes the extent to which human communication in the information era is in some measure defined by the reality that meaning has been subordinated to more technical aspects of calculating, encoding, and transmitting information. During this period, communication evolved from a face-to-face “meeting of souls” to a technology driven digital deluge of “total noise.” For Gleick, this “sacrifice of meaning” explicit in Shannon’s “Mathematical Theory of Information” was a merciless abandonment of psychology and human subjectivity previously engaged in the pre-information era where a “meeting of souls” was at least an ideal of human communication. Drawing from
Dretske, Gleick points out that, for epistemology, information is “barren” without meaning; therefore, the information glut provided by the engineering infrastructure of digital communication creates an “opportunity and a challenge” for understanding the relationship between information and other vital elements of human communication, such as how we interpret information, how we come to believe one thing rather than another, and what constitutes authentic human knowledge (Gleick, 2011, p. 416). The opportunity and challenge of understanding and reintegrating the role of meaning in human communication may be nowhere more important and exigent than it is in the current US healthcare crisis.

The twenty-first-century transition from modern medicine to postmodern health care may require a seismic shift away from Shannon’s notion of communication as the transmission of information. From decision aides and shared decision making to narrative medicine, palliative care, and hospice, a great deal of progress along this path has already been made. The current level and status of health communication, however, as sensitized and enlightened as it may be compared to where it was a few short decades ago, falls far short of delivering on its potential to realize the art of medicine, and in so doing, to transform the U.S. health-delivery system into an entity that has some chance of sustaining itself through the twenty first century without bankrupting the country (Schieber, 2009). The reinfusion of meaning into communication is particularly vital to the navigation of uncertainty in health care decision making. Babrow’s “problematic integration (PI) theory” may be uniquely suited to conceptualizing the challenge and opportunity for health communication to transform the art of health-care decision making.
by properly reintegrating meaning into the communication process. While Babrow (1992, 2001, 2007) is quick to point out that PI theory does not pose any radically new concepts per se, it may still provide an exceptionally deep, lucid, and rigorous conceptualization of existing knowledge, perhaps providentially ordained to play a unique role in mapping out a landscape for the reintegration of meaning and information in human communication contexts of uncertainty, and, for the purposes of this dissertation, health communication in particular.

The Basics of PI Theory

At its most basic level, PI theory contends that humans develop two interrelated “orientations” to reality: a) “probabilistic” and b) “evaluative” (Babrow 1992, 2001, 2007). Probabilistic orientations refer to beliefs and expectations, answering questions such as: “What will be the outcome of this decision?” Evaluative orientations refer to evaluations, answering questions such as: “Is this a positive or negative outcome?” For PI theory, probabilistic orientations and evaluative orientations integrate with each other and also with other dimensions of human thought and experience. The integration between probabilistic and evaluative orientations is seen in the way that one impacts another. Perception of probability can impact estimation of value just as perception of value can impact estimation of probability. The symbiotic and synergistic relationship between probabilistic and evaluative orientations can become quite complex and, not uncommonly, problematic. Integration is usually not problematic when beliefs and values align, such as, when you believe something will happen and you are happy because you view this occurrence as a positive thing; however, integration can quickly
become problematic when beliefs and values are at odds with one another, such as, for example, when you believe that a negatively valued outcome will likely occur. This “divergence” of desire and expectation, and other troubling constellations of probabilistic and evaluative orientations, lead to mutual “destabilization” of beliefs and values (Babrow, 1992, 2001, 2007).

Babrow (2007) asserts the usefulness of PI theory for theoretical analysis of practical problems. In what follows, we will expand our exploration of PI theory in just such a manner. But before delving more deeply into the nuances of PI theory through the lens of communication surrounding miracle-hope as a response to predictions of medical futility, the discussion of meaning above will be briefly revisited and complemented by a discussion of probability in an effort to better understand the roots and implications of PI theory’s probabilistic and evaluative orientations as they currently manifest themselves in twenty first century health communication.

**Probability and Meaning**

Drawing upon Greenwald (1989), Babrow (2007) indicates a connection between evaluative orientations and meaning. This bodes well for PI theory’s role in taking up the above referenced challenge and opportunity of re-infusing information with meaning for a more nuanced theory and experience of communication. PI theory also observes that while probabilistic orientations are germane to the human experience, evaluative orientations are less often appreciated as such (Babrow, 2007, p. 184). Indeed, even with all of the above referenced initiatives for improvement, health communication can still too often devolve into a transmission of information with an imbalance in favor of
probabilistic orientations to the diminishment of evaluative orientations. This may be due to the development of statistical science and its role in reshaping and advancing probability as a tool for the reduction, management, and attempted/assumed control of uncertainty. As a result of the success of statistics in mapping out probabilistic orientations, an exclusively probabilistic outlook has come to form a default, if unconscious, ideology in the health-care industry, manifested in health-communication messaging.

PI theory uncovers this latent “ideology of uncertainty reduction” in the rhetorical approach to breast self-examination where uncertainty became an enemy women were morally obligated to defeat to remain compliant with the imperatives of public-health dictates (Babrow & Kline, 2000). While presumably geared toward the health of women, the ideology of uncertainty reduction was identified as a potential threat to their wellbeing. According to PI theory (Babrow, 2001, p. 569), this ideology of uncertainty reduction identified in the breast self-examination context is more widely applicable across the health-care spectrum. This highlights the prevalent tendency of probability, as understood through statistical calculation, to be unwittingly transformed from a tool among many in the toolbox of information, understanding, and communication, into a dogma transcribing health-related reality. Like everything, the evolution of this tendency for statistical probability to manifest as an unexamined ideology for controlling uncertainty has a history, and this history is instructive for our exploration of the role of probabilistic orientations in problematic integration for health communication.
In *The Emergence of Probability*, Hacking (2006) traces the evolution of statistical probability calculation. In the mechanistic universe of first causes mapped out by the “high sciences of astronomy, geometry and mechanics,” in the early seventeenth century, probability was to be found with “those lowly empirics” such as alchemy and medicine “who had to dabble with opinion” (p. 28). As a notable aside to which we shall later return, Hacking’s history reveals that the earliest emergence of probability was as much a theological, or at least pseudo-theological, enterprise as anything else. Protestant theologians led the fledgling probability movement, envisioning it as a tool for Christian apologetics, namely for establishing the likelihood of God’s existence and convincing evidence for divine miracles (Hacking, 2006).

Starting out as, among other things, a tool of odds-makers evaluating the functions of dice in games of chance, the modern notion of probability hatched from a medieval meaning of well attested opinion to the current day algorithmic software used to reduce, manage, and control uncertainty in many fields, none more prominently than health care. By attempting to calculate probability, the discipline of statistics was forced to acknowledge and engage the reality of uncertainty. Direct engagement with the reality of uncertainty forced the field of statistics to swim upstream in its infancy against a scientific establishment more interested in mapping first causes than grappling with degrees of uncertainty. One branch of statistics, frequentism, found success in subjecting various forms of population-level uncertainty to objective manipulation and calculation through analysis of existing population data. The success of frequentism established a modicum of legitimacy for statistical probability as a science fully capable of modern
knowledge through the air-tight paradigm of objectivity, manipulation, and control (Hacking, 2006).

While frequentism proved useful in projecting predictive control of future uncertainty through examination of vast data from the past, Bayesian statistics set out to navigate uncertainty in problems for which vast data from the past was not available. In *The Theory That Would Not Die*, McGrayne (2011) tracks the treacherous journey of Bayesian statistics into mainstream usage. Just as other forms of probability calculation before it, Bayesian statistics struggled to gain traction and respect in a world dominated by what were deemed to be higher sciences, but Bayesian statistics faced a steeper climb into scientific legitimacy because it operated outside of the scientific paradigm of absolute objectivity, manipulation, and control. While frequentist statistical probability had established itself as an objective science for discovering patterns and norms through the examination of vast sets of data, Bayesian statistics was dismissed, deplored, and ridiculed for attempting to reduce and navigate uncertainty by calculating probability through subjective means. To be clear, Bayesian statistics is far from an exercise in pure subjectivity, but it does benefit from the use of what it calls “subjective priors” as starting points for analysis. Even the slightest semblance of subjectivity, however, was enough to rattle the scientism police (McGrayne, 2011).

Nowhere were the enemies of Bayes rule more virulent than within the field of statistics itself, where the level of discrimination, disparagement and disavowal of Bayesians by frequentists rivals any historical narrative of closed minded dogma and outright bigotry. It did not matter to frequentists that Bayesian statistics proved
empirically invaluable for everything from wartime intelligence and nuclear power-plant safety to workers’ compensation insurance and the invention of computers and software. What mattered to frequentists was that Bayesian statistics did not fit under the frequentist dogma that only objectivity gives birth to rationalism. Ironically, frequentists reduced themselves to decades upon decades of embarrassing levels of irrational bigotry in their blind refusal to objectively evaluate the results garnered by Bayesian statistics as they willfully buried their heads in the sand, insisting on the absolute exclusivity of their objectivist brand of rationalist dogma. McGrayne asks “How could otherwise rational scientists, mathematicians, and statisticians become so obsessed about a theorem that their argument became, as one observer called it, a massive food fight?” The 150-year story of irrational resistance to Bayse’s theorem convinces McGrayne that “The answer is simple. At its heart, Bayes runs counter to the deeply held conviction that modern science requires objectivity,” and this requirement triggered a fundamental and “profound philosophical disagreement” with the scientific establishment (McGrayne, 2011, Kindle location 90-103). By attempting to reduce uncertainty through subjective means, Bayesian statistics violated the dogmatic epistemology of scientism by seeking knowledge in a non-objective manner, namely through a subjective calculation of probability, tacitly admitting that uncertainty was ultimately beyond human control and could be meaningfully engaged as such. The only salvation for Bayesian statistics was that it ultimately brought its naysayers to their knees in what McGrayne calls a twenty-first-century shift to pragmatism where, for example, a “man who had called Bayes ‘the
crack cocaine of statistics….seductive, addictive and ultimately destructive’ began recruiting Bayesians for Google” (McGrayne, 2011, Kindle location 96).

Such is the modern history of PI theory’s probabilistic orientations. The ideology of uncertainty reduction identified by Babrow and Kline (2000) reflects the very fabric of the epistemological paradigm at the root of every major branch of modern medical science from chemistry and biology to anatomy and statistical probability: objectivity, manipulation, and control for the purpose of attaining certain knowledge. There can be no doubt that the modern epistemological paradigm for scientific knowledge has been fruitful beyond anyone’s wildest imaginations. What can be questioned, however, is whether the success of science at achieving its objectives justifies the dogma of scientism as the dominant guiding principle for human action. Are the sciences to be used merely as tools in the hands of some greater cause, or has science itself become an “ism” to which human action is beholden? Is modern scientism an implicit state religion, an “ideology,” the greater cause to which humanity must seek to conform itself and faithfully serve? The answers to these questions may be as important and alarming as the questions are extreme (Beck, 2007; Hyslop-Margison & Naseem, 2007).

As extreme as these question may sound at first to some, they may not sound extreme to women serving the ideological scientistic dictates of uncertainty reduction through breast self-examination. One study participant stated the following: “In my mind, the ‘routine’ breast exam is not routine at all: It’s a grim, lonely ritual in which we probe our bodies, our womanliness, for death” (Schneider, quoted in Babrow & Kline, 2000, p. 1809). This telling plea for a health-communication paradigm ruled not
exclusively by probabilistic orientations demonstrates both the need for balance imparted by PI theory’s balanced combination of both probabilistic and evaluative orientations and also the reality that the search for objective certainty that defines the modern scientific paradigm, when applied to the health care context, can only reach its fruition in death; the human corpse is the only stable, static source of objective knowledge of the human body, and death itself is the only ultimate and final success in the reduction of human uncertainty (Bishop, 2011). Limited exclusively to what PI theory calls “probabilistic orientations,” the focal point and fruition of human being lies only in the probabilistic certainty of death.

If the twenty first century ushered in a new era of pragmatism allowing Google to recruit twentieth-century “infidel” Bayesians, then perhaps it is no accident that PI theory’s analysis of breast-cancer communication was published in the year 2000, at the dawn of what McGrayne calls a more pragmatic century. Connecting Babrow and Kline’s (2000) identification and critique of the “ideology of uncertainty reduction” to the story of Bayes’s unwelcome position in a world that understands probability in terms of an ideology of objectivity, Appendix B in McGrayne’s account relays public outrage at the 2009 recommendation by a government task force on breast cancer that most women in their 40s should not have mammograms. While the announcement may have been alarming to a culture steeped in the “ideology of uncertainty reduction,” Bayesian statistics showed that only three out of 100 women in this population who test positive for breast cancer actually have breast cancer, and therefore the health problems created by the fear generated in the other 97 women who were “false positives” far outweigh the
value of the “true positives.” Thus, the decision to discontinue mammograms for this population at this particular point in the evolution of mammogram effectiveness. Bayes proved what PI theory prophesied: an exclusively objectivist ideology of uncertainty reduction is inadequate to the human condition and should not be followed blindly as an unquestionable dogma. Rather, other forms of knowledge rooted in subjectivity, meaning and human evaluation are necessary complements to objective data and must be re-valued as lenses through which objective data can be viewed.

Although it is indeed heartening that probabilistic orientations can now be augmented by the addition of Bayesian subjectivity, McGrayne’s account of the history of Bayes theorem reveals a disdain for subjectivity at the heart of both the modern probability project and the scientistic paradigm of objectivity to which it is sometimes beholden. If subjectivity is not even welcome as a resource for improved uncertainty reduction until it produces more than a hundred years’ worth of objective evidence that it can be useful to the objectivist “ideology of uncertainty reduction,” what does that mean for the much greater level of subjectivity inherent in PI theory’s “evaluative orientations?” If the so-called postmodern era is to offer more than a niche boutique for intellectuals taken by French philosophy in a world still very much governed by modern paradigms, then more attention must be given to theories aimed at the epistemological rebalancing act necessary to guide a sustainable 21st century. Having established an equal footing for probabilistic and evaluative orientations, PI theory carries promise as just such a framework and therefore merits increased application to theoretical analyses of practical communication problems. The following is an effort to explore PI theory
through a paradigmatic practical problem in health communication that may serve as a
basis for the unique value of PI theory in conceptualizing, diagnosing, and treating the
ideological ailments of modern health communication.

**Futility Prognostication and Miracle-hope: A Health Communication Challenge**

As described in previous chapters, the health communication context we seek to
examine is a regularly occurring scenario in hospitals across the country. When a
physician meets with a patient and/or family to deliver the prognosis of medical futility
for late-stage, life-limiting illness and they discuss next steps for the health-care decision-
making process, many patients and families take the physician’s prognosis with a grain of
salt and look instead to a higher power, often hoping in God for a cure or extension of life
through a miracle of divine intervention. According to national surveys, 75% of
Americans believe God can cure when medical science gives no chance of survival
(Cadge, 2012); these beliefs impact the physician-patient/family relationship and the
health care decision-making process. Studies show that belief in divine intervention
decreases trust in physician prognosis (Zier et al., 2009), patient/family illness perception
is affected more by religious variables than physician prognosis (Ford, Zapka,
Gebregziabher, Yang, & Sterba, 2009), and positive religious coping and belief in
miracles lead to preferences for intensive life-prolonging care at the end of life correlated
with decreases in patient/family quality of life and corresponding increases in utilization
and systemic cost (Balboni et al., 2010; Balboni et al., 2011; Phelps et al., 2009a; True,
2005).
Cadge (2012) observed that patient/family religious identity and expression is welcomed by clinicians unless or until it comes into contradiction with the dictates of medical science, in which case it becomes patently unwelcome in the hospital. Cadge documented the fact that physicians, who often become quite frustrated in these encounters, characterize the religious perspectives of patients and families hoping against all odds for a miracle as “irrational.” Physicians interviewed by Cadge reported that they have not discovered a way to fruitfully engage this communicative context, stating that their attempts to negotiate for medical science-dictated health care decisions in this situation are rarely successful. Notably, physicians, while usually epitomes of rationality and objectivity, can become uncommonly irritated, recalcitrant, incredulous, and forceful in this health communication context (Cadge, 2012; Hinshaw, 2013; Mattingly, 2010; Wachter, 2012).

Palliative care communication scholarship has recognized PI theory as a “theoretical basis for understanding the process of end-of-life decision making” especially when “life prolonging treatment continues as a means to managing the uncertainty about prognosis” as a result of roadblocks in communication (Ragan, Wittenberg-Lyles, Goldsmith, & Sanchez-Reilly, 2008, p. 15). Drawing on Parrott, Silk, Weiner, Condit, Harris, and Bernhardt (2004), Ragan et al. (2008) also highlights the importance of recognizing the role of human spirituality in the interplay between emotion and the various forms of problematic integration outlined by PI theory. How might this health communication context be understood and approached through the lens of PI theory?
**Futility Prognostication, Miracle-hope, and PI Theory**

If problematic integration can occur when negatively valued outcomes become probable, then both the physician and the patient/family in this context may be facing at least some level of problematic integration given that the prognosis of medical futility at the end of life tends to be negative (except in cases where it is experienced as release/relief). Citing the prevalence of optimism bias, Babrow (2007) states that evaluative orientations can sometimes influence estimations of probability such that people can tend to overestimate their chances of realizing a desired outcome. Given Zier and colleagues’ (2009) observation regarding the relationship between belief in divine intervention and trust in physician prognosis, it would seem that patient/family evaluation of death as negative and a miracle precluding death as positive, it may not be a stretch to postulate a role for faith in mediating the relationship between evaluation and probability.4

Physicians also have their own PI challenges in this context. The medical literature is full of accounts of physicians so hopeful for positive outcomes for their patients that honest communication surrounding the prognosis of medical futility can be postponed and avoided indefinitely (Katz, 1984; Morrison, Meier, & Cassel, 1996). If and when physicians finally come around to discussing futility, they can do so in a way that, like avoidance of the conversation altogether, shields their discomfort with the uncertain nature and raw emotions of the situation. For physicians looking for solid

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4 This consideration is complicated by the notion that people of faith should, or at least might, see death positively, as a gateway to heaven, etc. This dichotomy, which might be summed up by the joking statement, “I want to go to heaven, just not today,” is addressed through an examination of different kinds of hope in the following chapter.
ground to stand on in a futility prognosis conversation, PI theory warns that self-
protective evaluation can result in pessimistic belief (Babrow, 2007). This pessimism
may be a subtle distinction between impossibility and extreme unlikelihood, out of a
desire to both themselves and the patient/family from the sorrow of unfulfilled
expectations, but such a distinction may be vital. From the patient or family’s
perspective, when the conversation finally happens, the combination of previous
avoidance and current self-protective pessimism on the part of the physician can make
their situation appear as if it has instantaneously gone from hopeful to hopelessly
impossible. The shock of such an abrupt transition can be destabilizing. PI theory
emphasizes how probabilistic and evaluative orientations can function to destabilize one
another as well as become stabilized by other things in the process of problematic
integration. Could it be that the combination of physicians wishing to protect against the
sorrow of unfulfilled expectations and patients/families viewing the prognosis of medical
futility through the lens of faith introduces three layers of orientational destabilization?

Combining the orientational destabilization that may occur in patients/families
viewing probability optimistically through the evaluative lens of faith with the
orientational destabilization that may occur in physicians viewing probability
pessimistically through the lens of defensiveness against the possibility of sorrow from
unnecessary expectations, a third layer of orientational destabilization may occur when
these two opposing forms of PI come into conversation with one another. Perhaps this is
why physician-patient/family communication rarely proves fruitful in this context
(Cadge, 2012). Babrow (2007) suggests that communication has the power to transform
otherwise intractable challenges of problematic integration. Given the physician’s position of power in this communication setting, it would seem incumbent upon him or her to take the lead in seeking and initiating a communicative process for transforming patient/family problematic integration in this context; however, it may not be possible for physicians to even attempt to lead a communicative transformation of patient/family PI without first engaging in some self-reflection on their own PI as well as some sympathetic reflection on the perspective of the other. By characterizing religious motivations for patient/family miracle-hope as hopelessly “irrational” and themselves as correctly “rational” (Cadge, 2012), physician finger pointing and labeling of the “other” may expose their complicity in the dysfunctionality of this interaction and prevent them from functioning as healing sources of communicatively transformative PI. In order for physicians to function as healing sources of communicatively transformative PI, they might begin by countering their frustration with “irrationality” of miracle-hope with a greater openness to sympathy and compassion.

Perhaps a helpful starting point for physicians steeped in scientific rationalism to sympathize with the perspective of the miracle-hoping patient/family is to do so from a scientific perspective by contemplating the neurological phenomenon of “optimism bias.” In *The Optimism Bias: A Tour of the Irrationally Positive Brain*, Sharot (2011) uses the same term to describe “optimism bias” as physicians use to characterize the perspective of miracle-hoping patients and families: “irrationality.” For Sharot, however, as curious as optimism may seem in its many manifestations, the characterization of irrationality is made with less irritation and greater sympathy. Even though Sharot uses strong language
to characterize persons with optimism bias as “taking rational reasoning hostage,” this tendency is not disturbing to her because, as a neuroscientist, Sharot understands its positive features. While physicians can become exasperated by patients and families overestimating the possibility of a miracle and underestimating the possibility of near-term organ failure and death, Sharot’s research indicates that this same kind of irrationality where people overestimate the probability of the positive, and underestimate the probability of the negative, exists in innumerable life contexts and is typical, in one way or another, of every population demographic imaginable.

Sharot explains how pilots suffering in-flight vertigo have false illusions of special orientation that can only be countered by digital navigational systems. Simply put, the pilot insists that the plane is right side up, when in fact the plane is upside down. Interestingly, the knowledge of their skewed perception is not enough to change the pilot’s perspective and erase the illusion. Many plane crashes are caused by the failure of pilots to trust the navigational systems due to their powerfully convincing vertigo-induced perspective. It is possible, of course, for a plane navigational system to become faulty, therefore, in order for a pilot to be open to steering the plane against the dictates of his personal perception, he must have complete trust in the onboard navigational system (Sharot, 2011).

Like most analogies, the subordination of pilots to on-board navigational systems under conditions of in-flight vertigo falls short of fully mapping the end-goal for this communication context. It is not usually the goal of patient/family-centered health communication to convince patients and families to subordinate their own health care
decision-making “illusions” to the dictates of the physician; however, the reality for pilots that knowledge to the contrary of perception does nothing to change orientational illusions may explain why the probabilistic orientation of physicians almost never impacts the perspective of miracle-hoping patients and families. Rather than viewing this reality with frustration, physicians prizing rationality may benefit from the neuroscience perspective that, without the irrational denial of death, the knowledge of death would have singularly halted the course of human evolution, threatening the future development of the species (Sharot, 2011). According to Sharot’s research, the fundamentally human trait of contemplating the future had to develop at the same time as the irrational tendency for optimism bias. From the rational perspective of neuroscience, then, irrationality was a necessity for the evolutionary progression of the human species. Indeed, without irrational optimism, the human state is nothing short of clinical depression. According to Sharot (2011), humans are so necessarily and fundamentally optimistic that only those diagnosed with mild depressive disorder are likely to realistically predict future events.

While this information in defense of the irrationality inherent in optimism bias does not adequately characterize or resolve the PI issues in the health communication context under study, it may be helpful for physicians as a first step toward challenging any temptations toward unsympathetic othering that could stand in the way of both self-reflective PI for the physician and also communicatively transformative PI with patients and families. Citing the fear of death as a case in point, Babrow (1992) states that communicative engagement with others experiencing PI can in turn trigger PI in the
one(s) who would engage. Facing and struggling through one’s own PI, especially related to issues as weighty as contemplation and potential fear of death, may position physicians to be better prepared to communicatively navigate miracle-hoping patient/family PI in the futility prognosis context. In order to map out a potential path for the evolution of physician self-reflective PI in this context, it may be helpful to consider Babrow’s (1992) forms for probabilistic orientation alongside Babrow’s (2001) reconsideration of and expansion upon this framework. Both PI’s original forms and its later re-characterization of ambiguity may be useful in exploring physician PI in this context.

Regarding the physician PI in our context of interest, there are certainly exceptions to every rule, and the exceptions between specific physicians and specific contexts of prognosticated medical futility and patient/family miracle-hope may vary widely. However, the position taken by physicians in Cadge’s (2012) study, as well as in other narratives describing similar scenarios (Mattingly, 2010), may be generally characterized as one of “impossibility” as it characterized by Babrow’s (1992) discussion of early PI theory forms. When physicians in the surveyed literature encounter patient and/or family miracle-hope in response to their prognosis of medical futility in late-stage, life-limiting illness, they default to the PI theory form dubbed “impossibility” in that they view the hoped-for miracle as impossible, and they navigate the communicative context from that perspective. Babrow observes that the interesting thing about the notion of impossibility is that it “denotes certainty.” However, as Babrow points out, certainty about the future is fundamentally elusive. Furthermore, Babrow states that the choice of
whether to focus on a theoretical possibility or what appears to be a pragmatic impossibility could be framed by desire. Quoting Aristotle’s *Rhetoric*, Babrow invokes a provocative notion regarding impossibility: “It may be plausibly argued: … That those things are possible of which the love or desire is natural; for no one, as a rule, loves or desires impossibilities’ (as cited in Babrow, 1992, p. 120). Is it unnatural for a patient or family to desire a miracle cure or extension of life over death? If so, then Aristotle may quibble with imposing the certainty of impossibility upon anyone hoping against hope in response to predictions of medical futility.

A simple Google search of “medical miracle” will call into question any allegedly certain prediction of medical futility or death. Human being is inherently unpredictable. Even the supposed certainties of death and taxes are cheated by innumerable people every day. If the certainty of impossibility is elusive, and the characterization of impossibility can be said to depend on desire, could it be asked of physicians facing patient/family miracle-hope in the face of likely impending death whether they desire for the patient/family to get what they’re wishing for, as unlikely as it may be? Put another way, if one of the many scientifically unexplainable medical miracles did somehow happen for this patient/family, what would be the physician’s evaluative orientation toward this outcome—would it be a good thing? It is probably safe to answer this question in the affirmative. Why then does the literature reporting physicians’ perspectives on patient/family miracle-hope consistently describe some physicians as so deeply frustrated to the point of irritation in this context? Could it be, as suggested above, that the physician’s focus on impossibility might be an example of defensively
managing PI under such extreme divergence of probability and value by trying to protect both the patient/family and (if unconsciously) themselves from the sorrow of disappointment that would likely occur if the situation was approached as anything other than an outright impossibility?

Whatever the reason for the physician perspective of impossibility, Babrow’s (1992) discussion of O’Brien’s *Going After Caciatto* demonstrates the meaning that can be gleaned from letting go of the semblance of control and certainty inherent in the perspective of impossibility and instead “follow[ing] the (im)possible path and thereby explor[ing] the relationships among expectation and desire, reality and imagination, and impossibility and possibility” (Babrow, 1992, p. 123). Provocatively challenging the role of desire in the physician perspective of impossibility, PI theory declares that “value only seems irrelevant to impossibility when an impossibility has no great value” and suggests that there can be “deep significance” in the “willingness to consider valued (im)possibilities” (Babrow, 1992, p. 124). What could that deep significance be for physicians, and how might they attain it?

Before answering this question, it is important to state that this journey we seek for PI theory to illumine is by all accounts a “narrow way.” In *Mastering Communication with Seriously Ill Patients: Balancing Honesty with Empathy and Hope* (2009), Back, Arnold, and Tulsky, the virtual Dali Lamas of physician-communication, speak revealingly to our context of interest. While Back and colleagues deserve credit for placing an emphasis on exploring the miracle-hoping patient/family perspective they may err on the side of ultimately assuming that information is the answer, counseling
physicians to respond by asking if a statistical probability breakdown would be helpful (Back, Arnold, & Tulsky, 2009). PI theory, on the other hand, disputes the notions that uncertainty necessarily stems from a dearth of information, that people respond to uncertainty exclusively by seeking information, and that the main purpose of discussing uncertainty is to reduce uncertainty. This does not mean to suggest that uncertainty reduction through statistics, as suggested by Back and colleagues, has no place. Clearly, these seasoned physicians have found it to be useful in their practice. PI theory further counsels that value reappraisal can be as important as uncertainty reduction in the process of problematic integration (Babrow, 2007, p. 190).

How then can physicians use value reappraisal, step back from the certainty of impossibility and self-reflectively recalibrate their own PI in relation to miracle-hope in the face of prognosticated futility in late-stage life-limiting illness? One of the “PI processes” is “changing forms” whereby one form of the problematic forms can change into a different one of the problematic forms such as “divergence.” In the discussion of changing forms, Babrow (2007) provides an example the evolution out of the impossibility form that can occur “by convincing ourselves that there is hope.”

How could physicians, in response to a miracle-hoping patient or family, convince themselves that there is hope for a patient for whom they have just determined and delivered the prognosis of medical futility? If, as Babrow (1992) suggests, the line between certain impossibility and less than certain divergence can be determined by desire, might it be enough for physicians to intentionally subject and expose themselves to a nearly impossible desire in order to escape the certainty of impossibility? According
to Babrow (2007), this change in form may lead to either divergence or the need to “learn to live with some form of uncertainty.” This effort on the part of the physician may require an emotional struggle to shed the semblance of control inherent in the other/self-protective stance of impossibility, unlearning the objectivity prized in medical science and embracing instead the subjectivity inherent in intentionally desiring an all but impossible outcome. What might be the challenges of such an endeavor?

If the physician considered stepping out of the self-protective othering of miracle-hoping families inherent in the charge of irrationality and instead exposed himself to the subjectivity inherent in intentionally desiring a highly unlikely outcome, one challenge may be in staying true to his own beliefs and values. For example, an atheistic physician would not be able to, in good conscience, hope in God for a miraculous cure or extension of life. Fortunately, PI theory as expanded by Babrow (2001) accounts for precisely such a challenge. By distinguishing between ontological and epistemological uncertainty, PI theory allows physicians to enter into the patient/family practice of hope at the level of language and emotion. Because PI theory distinguishes between ontological and epistemological levels of uncertainty, a physician need not be a like-minded believer to migrate from the PI probabilistic form of “impossibility” to the PI probabilistic form of “uncertainty” in order to compassionately engage patient/family hope. Even an atheistic physician could remain ontologically certain that there is no God who miraculously cures diseases or extends lives while admitting and embracing epistemological uncertainty regarding whether or not a non-theistic medical miracle may occur, whether by accident
of chance or by some humanistic psychological or energetic force such as the “power of positive thinking” operative in a patient or family’s hope in God.

Another more general challenge for doctors moving from impossibility to epistemological uncertainty may be the investment of emotional capital necessary to execute such an ideal. Is this a reasonable expectation? One might argue that it would be more appropriate for another member of the hospital staff, such as a chaplain, to offer this kind of care since it is outside the physician’s domain of expertise. While chaplains have their own indispensable role in the hospital setting, they also have limitations. Chaplains do not have the medical expertise necessary to integrate spiritual care into the health communication that informs patient/family health care decision-making. Balboni (2011) determined that spiritual support from the medical team is more effective than spiritual support from that chaplain at mitigating the quality-cost conundrum identified with religious coping at the end of life.

Garfinkel (2008) suggests “breaching experiments” involving the violation of everyday rules and status quo practices as ethno-methodology for revealing and testing the limits of social norms. For physicians seeking to embrace the communicative challenges of providing twenty first century patient/family-centered health care, what might be the fruit of self-reflective PI in the form of a self-induced Garfinkelian “breaching experiment” constituting an intentionally caring embrace of desire leading to a migration from impossibility to uncertainty in this communicative context?

Physician migration from PI form “impossibility” to PI form “epistemological uncertainty” could be the first step to unearthing a previously unimaginable social
dynamic, opening up a whole new world of communicative possibilities and unleashing the kind of communicative breakthroughs one hopes for innovative theories to uncover. Stuck in the self-imposed perspective of probabilistic impossibility, physicians who have confidently reached a prognosis of medical futility may have no access to engagement with the evaluative orientations of patients and families. This may explain why physicians in Cadge’s study reported that their communication efforts in this context invariably amount to frustrating failures. PI theory, however, provides a framework for charting a map out of this dead end. By first allowing themselves to let go of the feeling of control that comes from clinging to the so-called objectivity of other and self-protection, physicians may enter into the subjective realm of evaluative orientations and therein become human by compassionately embracing desire. Desire—that distinguishing characteristic that PI theory identifies as delineating perceptions of possibility and impossibility—allows physicians that shred of hope that constitutes the line between impossibility and epistemological uncertainty. Only from the perspective of shared desire can physicians navigate this communicative context in a way that allows patients and families to experience them as something other than objectivizing purveyors of the “physician’s gaze” in the cold confines of egocentric space.

By entering into the patient/family evaluative orientation and discovering shared desire for an unlikely outcome, physicians may become productive partners in the work of problematic integration. Indeed, PI theory holds that communication not only gives rise to PI, as it no doubt does when patients and/or families receive the prognosis of medical futility from their physician, but also has the unique power to transform PI. If, as
Babrow (2007) states, “communication creates and shapes the experiences of PI that arise out of [probabilistic and evaluative] orientations” (p. 192), then physician migration from impossibility to uncertainty could fundamentally reshape the experience of PI for a patient and/or family receiving the prognosis of medical futility from said physician. PI theory also points out the importance of the “rhetorical choices” that communicators make in expressing difficult news: “We may warn, chide, educate, coach, indoctrinate, advise, incite, inspire, encourage, reassure, commiserate, or comfort” (Babrow, 1992, p. 105). Embracing desire and moving from impossibility to epistemological uncertainty might allow physicians to naturally move from indoctrinating, inciting and chiding, to commiserating, comforting, counseling, and coaching. If physician self-reflective PI allows a move from impossibility to the epistemological uncertainty conducive to transformative communication, what might the PI process led by PI-prepared physicians look like for patients and families?

PI theory speaks of a “chaining” of forms and foci where thoughts shift to and fro in exploration of tangential dimensions of consideration in the process of problematic integration (Babrow, 2001, p. 556). If belief in divine intervention can increase doubt in physician prognosis (Zier et al., 2009), perhaps this evidence suggests that miracle-hoping patients and families might chain back and forth from PI form “divergence” to PI form “ambivalence” as their focus shifts from the context proper to their engagement of the physician’s perspective and their consideration of whether and how they might want to factor the prognosis in to their problematic integration. When the physician shields himself from desire and hides behind the assumed certainty of impossibility, the
patient/family effort to integrate the physician’s perspective becomes problematic because it poses an ambivalence constituted by PI theory’s “mutually exclusive alternatives” (Babrow, 1992).

One might imagine the patient/family experience of ambivalence to occur roughly along these lines: “If we accept the doctor’s prognosis of futility and entrenched position of impossibility, then we must embrace impending death and let go of our hope for a miracle. If we want to hold on to our hope for a miracle, we must reject the doctor’s prognosis. Therefore, (as observed by Zier 2009), we must doubt the doctor’s prognosis, chain back to divergence alone, excluding the physician from our decision-making process, and demand all aggressive measures (as observed by True, 2005 and Phelps, 2009), because entrenched in impossibility as he is, the doctor does not see and cannot comprehend our hope.” In the face of seemingly intractable ambivalence such as this, PI theory holds that communication can be “especially challenging” but “potentially consequential” because “through communicative activity the ambivalence of mutually exclusive alternatives may be changed into other forms of PI” (Babrow, 1992, p. 118).

When the physician intentionally chains from impossibility to epistemological uncertainty by embracing and expressing desire for the unlikely miraculous outcome hoped for by the patient/family, this enlightened breaching of the otherwise intractable dysfunctionality of the exchange might allow the family to experience the physician as something other than a problematic cause of ambivalence, and this time, chain over to epistemological uncertainty together with the physician, and, from there, become open to
relational engagement of problematic integration through communication together as a
team.

Now, finally, the physician may be in a position to engage in communicatively
transformative problematic integration together with the patient/family. This is no small
accomplishment since, according to PI theory, “a person confronted by diverging
probability and evaluation may find relief only in communicative reconstructions of the
problem” (Babrow, 1992, p. 105). Among reconstructions considered by PI theory are
the reframing and the employment of holistic perspectives. We know from Balboni et al.
(2011) that the perception of spiritual support from the medical team decreases the
associations between religious coping and preferences for intensive life-prolonging care
in the last week of life, and solves the lose-lose quality-cost conundrum. How might a
spiritual intervention by the physician employ holistic perspectives and reframing to
allow for a communicatively transformative reconstruction of the problem in this
context? A satisfactory exploration of this question requires a thorough investigation into
the nature of hope and how it functions in communicative contexts surrounding late-
stage, life-limiting illness. This will be undertaken in the next chapter. For now, it is
clear that PI theory has lived up to its promise to blaze a trail beyond its theoretical
predecessors which, tended to “take integration of probability and value to be
nonproblematic and coldly machine-like” (Babrow, 1992, p. 96).

This progression past the assumption of nonproblematic and coldly machine-like
integration of probability and value is an evolution beyond communication in a world
heavily influenced by Shannon’s above-referenced notion that meaning is “irrelevant to
the engineering problem.” Vital to this progression is the suggestion that the importance of a postmodern, twenty-first-century revaluation and embrace of subjectivity is not limited to Bayesian statistics. The promise of re-integrating meaning into communication by engaging PI’s evaluative orientations ultimately unlocks the importance of subjectivity to facilitate a true reintegration of engineering and meaning, belief and value. PI theory’s disarmingly simple question for evaluative inquiry—“would it be good or bad?”—pulls the finger out of the dam of epistemological imbalance. The answer, “it would be good; if the miracle happened, it would be a good thing,” allows for the next simple question: “Then why don’t I allow myself to (shed the mask of objectivity and subjectively) desire it? Perhaps I should let go of uncritical attachment to the ideology of uncertainty reduction that traps me behind the mask of impossibility and allow myself to desire this unlikely outcome that, improbable as it may be, cannot be dismissed with 100 percent certainty and, if it were to occur, would be a good thing.”

PI theory’s intentional re-integration of meaning into the communication process demonstrates to Shannon and the information era how meaning not only isn’t irrelevant to the engineering problem but, in fact, can transformatively re-engineer problems of health communication such as the communicative context surrounding patient/family miracle-hope in response to the physician prognosis of medical futility. Just as Bayes’s embrace of subjectivity eventually prevailed in augmenting statistical approaches to probability, so also PI theory can take yet another step beyond Bayes in the direction of true subjectivity, not just for the purpose of uncertainty reduction germane to the field of statistics, but for the purpose of genuine human connection that leads to the creation of
shared intersubjective space constitutive of less reactive and more heartfelt communication and, thus, the possibility of more reflection and intentionality in the health care decision-making process.
CHAPTER SIX: COMMUNICATIVE HORTICULTURE FOR THE FLOWERING OF HOPE

“The [exclusive] focus of our current healing tradition on the material value of the human person is not only wrong but harmful” (Balboni, 2010b).

Do physicians really have any business broaching the spiritual realm with patients and/or families? Balboni (2010b) identifies lack of spiritual support as a problem affecting the delivery of end-of-life medical care in the U.S. While identifying a broader problem of division between the body and soul in all of medical care, Balboni focuses on end-of-life care as the clearest demonstration of the broader phenomenon. Both current and comprehensive, Balboni’s unparalleled outline of the problem will be followed closely as a brief introduction to the issues at hand.

Beginning with an historical overview of the previously integrated relationship between body and soul in medicine, Balboni shows that the current medical body-soul divide so evident in end-of-life care is a novel product of modern, Western scientific culture. Citing the existence of shamans, Chinese medicine, the recent ascendancy of acupuncture and medical uses of yoga in the west, Balboni reminds us that modern, scientific medicine is not the only paradigm. The original Hippocratic Oath, while including a material focus, also gave integrative credence to the Asclepian healing tradition, which included, for example, the ancient practice from the cult of Asclepius where the sick slept in a temple to receive healing instructions from Asclepius in a dream.

Tracing the rise of hospitals to Byzantine [Orthodox] monastic communities, Balboni (2010) notes that the Hippocratic tradition was appropriated within the Christian
understanding of healing as a spiritual calling. Byzantine physician/theologian Saint Basil of Caesarea’s description of an integrated body-soul relationship sees the soul as primary and the body secondary, where medicine is viewed like a sacrament, reflecting larger spiritual realities. This approach to medicine was short-circuited with the fall of the Byzantine Empire. As Protestantism began to flourish after the fall of Byzantium and the westward migration of the Christian empire, medical care was moved out of the monastery context. With the Enlightenment, human reason, materialism, and reductionism replaced religion as sources of truth, and secularism separated the public domain of objective science from the private domain of subjective religion.

Acknowledging Western medicine’s legitimate role as a healing science, Balboni (2010b) argues that patients suffer, especially at the end of life, in the modern medical culture where physical healing is not understood in a spiritual context as it was in the past. Citing the classic example of an injurious technological imperative in modern medicine, “When too much is too little” (Morrison, 1996), Balboni juxtaposes the clinical “code-blue” experience to a poignant account of death in a monastic healing community where the dying person receives confession and dies humanely with members of the community circled around his bed singing and praying. The modern medical paradigm that values the body enough to shock everyone who codes, although most do not survive cardiac arrest, but will leave anyone alone to die, although everyone dies, is rejected as “not only wrong but harmful” (Balboni, 2010b).

After sketching a brief history of the problem, five research questions are answered to illustrate how the body-soul “schism” impacts patients at the end of life.
First, citing Koenig’s (2001) many studies and her own “Coping with Cancer” study (Alcorn et al., 2010), Balboni (2010b) showed that the majority of patients view religion or spirituality as important to their coping with advanced illness. Second, the importance of religion and spirituality are not merely hypothetical but actually prove to be inseparable from the medical experience, impacting medical decisions made by patients. Unlike physicians who anticipated that faith in God would be the least important determination for patients’ anticipated inpatient experience, patients and families ranked faith in God as a close second only to the ability of the treatment to cure the disease (Sylvestri, 2003). Third, the top two issues patients identify for quality of life at the end of their lives are pain and peace with God (Brady, 2000). Fourth, serious illness raises spiritual issues for most patients (Moadel et al., 2000). Fifth, research shows that the majority of patients with advanced illness express desire for an integrated body-soul care experience (Steinhauser, 2000).

The importance of clinical soul-care at life’s end is not only a theological, philosophical, ethical, and customer-satisfaction issue, but also a quality and cost issue for health services delivery. According to a series of NIH-funded Dana-Farber studies of terminally ill cancer patients, religious coping predicts lower patient reported quality of life at the end of life (Balboni, 2009), and increased utilization of late-stage, futile life-prolonging measures (Phelps et al., 2009). All religious copers eventually die, and Medicare pays over $50 billion for health care in the last two months of patients’ lives, with 20 to 30% of this expense going to care deemed not impactful (Court, 2009). Therefore, shortcomings in end of life soul-care may come at the expense of substantial
quality and cost to the US health-services delivery system. Balboni’s (2010; 2011) own research gives evidence to this claim, demonstrating that spiritual support by the medical team increases the quality and decreases the cost of care for advanced cancer patients in the last week of life.

**Hope at Life’s End: Miracle Cure or Peace with God?**

In response to a *JAMA* follow-up letter to a study (van Laarhoven, 2009), Phelps and colleagues (2009b) pointed out that not only religious coping, but “religiousness per se” and belief in miracle healing are related constructs that have also been associated with a preference for extending life at all costs, and she highlights the need for research to “assess how other domains of religion and spirituality (e.g., religious beliefs and values, attainment of spiritual peace) might influence end-of-life decision making and health care outcomes” (Phelps, 2009b). As part of the Dana-Farber research team with Phelps and colleagues, Balboni hypothesizes that the kind of religious coping that is leading to a preference for life-prolonging measures is connected with belief in miracles. Balboni therefore suggests that an integrated approach to care of the body and soul at life’s end should be able to communicate a “religious understanding of meaning and hope” that “should translate into a willingness to forgo aggressive medical care” when the situation is futile. Phelps and colleagues’ and Balboni’s hypotheses beg the question: What is the relationship between a) the kind of “*hope*” that fuels religious belief in miracle healing, translating into a preference for prolonging life at all costs, and b) Balboni’s “religious understanding” of “*hope*” that she suggests “should translate into a willingness to forgo aggressive medical care”? 
Could the health-services delivery and cost of integrated, end of life body-soul care turn on vastly differing religious appropriations of hope? Hope theory, as applied in clinical contexts, may provide valuable constructs for a critical examination of end-of-life health-services delivery.

There is evidence to suggest a disparity in the appropriation of hope within the terminal-cancer patient population. Elliott and Olver’s (2007) qualitative study concluded that patients dying of cancer use the term “hope” differently as a noun than a verb. Use of “hope” as a noun was limited to medical/biological absolutes, whereas use of hope as a verb encompassed non-medical/psychological, moral, and interpersonal terms (Elliott & Olver 2007). Another qualitative analysis aimed at illuminating cancer patients’ lived experience of hope delivered similar findings. While not connecting varying experiences of hope with grammatical usage of the word “hope” as a noun or verb, Benzein, Norberg, and Saveman (2001) discovered a tension between “hoping for something, that is a hope of getting cured, and living in hope, that is a reconciliation and comfort with life and death.” Hope in being cured generated confidence in treatments, however, declination of treatment, when perceived as meaningful, seemed to deepen patients’ experience of hope. Philosopher Gabriel Marcel’s idea of “recollection” provided a lens for approaching the tension between hoping for a cure and living in hope, inspired partly by “confirmative relationships.” Hope, for patients suffering from incurable cancer was determined to be a “dynamic experience” (Benzein, et al., 2001).

Studies suggest that the dynamic experience of hope can evolve from an exclusive emphasis on the kind of hope focused on being cured to a broadened hope characterized
as “living in hope.” Among caregivers for terminally ill patients for whom hope is “continually unfolding and changing,” a chronology of hope was identified where the caregiver’s “definition and description of hope moved from very specific hopes” to a “more general sense of hope” (Herth, 1993, p. 544). One caregiver in the study compared the unfolding of hope to the blooming of a rose: “Hope is like a rose with many petals, each petal different and each petal unfolding in its own time. Initially the rose is just a bud, but eventually each petal will open and a new beauty, never before envisioned, will be seen” (Herth, 1993, p. 544). Like caregiver hope, patient hope at the end of life is also documented to evolve from a focus on “having” or “doing” to “being” (Herth, 1990).

If hope can bloom like a rose, unfolding from hope for cure to living in hope, how can health providers nurture this process? A rose needs to be fed and allowed to establish strong roots in order to bloom; therefore, perhaps the first health provider obligation is to do no harm to the initial budding of patient hopes. Keeping the Hippocratic Oath in relation to the evolution of a patient’s blooming experience of hope may be a formidable challenge for providers who do not have access to the patient’s reality. In a hope-theory review arguing for health-provider re-conceptualization of hope for dying cancer patients, Yates (1993) predicted the likelihood that patients and providers will naturally experience the relationship between “reality” and prognosis differently, and provider expectations for patients to content themselves with “realistic” hope are unfair to patient realities and potentially damaging to patients. According to Yates, provider care will likely be influenced by the provider’s own beliefs, and providers can unconsciously prescribe their
own beliefs for patients, creating burdensome expectations for how the cancer patient ought to act in relationship to death. Yates (1993) quoted Hall to describe a “conflict” that can arise between a patient’s initial budding hopes and provider failure to cultivate the blooming process while patient hopes unfold. Yates wrote that “Hall aptly describes the dying person’s plight as a continuous and difficult ‘struggle to maintain hope,’ because the actions of many health professionals often erode hope and generate fear.” Hall continued by noting that

The diagnosed must see [dying] as their fate. If they do not, they are accused of wishful thinking or denial. As a result, they must struggle against everyone’s belief about what their reality should be. Although their life could be as full and rich as anyone’s life, they are not expected to live a normal life, but to prepare for death. (as cited in Yates, 1993)

Citing Koopmeiners et al. (1997), Owen (1989), and Benzien and Saveman (1998) to support the conclusions of their own qualitative study, Mok, Lau, Lam, Chan, Ng, and Chan. (2010) state that “health-care professionals are able to enhance, maintain, or destroy hope in patients through their attitudes, behaviors, and ways of communication” (p. 877). Furthermore, like Yates, Mok and colleagues suggest that health-care professionals’ views on their patient’s reality may not correspond to the views of the patient, and therefore “health-care professionals should be encouraged to actively reflect on personal values, beliefs, and experience that may affect their own hopefulness towards their work and perception of patients’ hopefulness, for the benefit of their own well-being as well as [the] patients” (Mok et al., 2010, p. 882).
If patient and family hopes can begin with small budding hope for a miraculous
cure and, in time, unfold into a full bloom of ever-deepening hope experiences, and
providers are in a position to destroy patients’ initial budding hopes or cultivate the
blooming process, then Mok and colleagues’ recommendation for provider self-reflection
may be key to upholding the Hippocratic Oath in caring for the dying body and soul.
This blooming of hope requires confirmative relationships, but encounters with health-
care providers are “not always considered confirmative but as an encounter where a
person stands in front of them, physically at their disposal, but not spiritually” (Benzein
et al., 2001).

One of the difficulties of being spiritually available for a confirmative relationship
with patients or families hoping in God for miracle healing is that health care providers
may struggle with the fear that they are doing the patient harm by perpetuating false
hopes; however, Penson (2000) differentiates between a hope and a promise, allowing
providers to compassionately engage existing patient hopes while remaining open to
cultivating, in continuance of the above-referenced rose analogy, the blooming of hope’s
many petals.

Is there then a hope analogue for “stages of grief” research where each stage of
hope is important to the unfolding process and should be supported as such? Is an
instinct to shy away from patients who unrealistically hope for a miracle cure as
misguided as an instinct to avoid or too quickly seek to calm a patient or loved one
suffering from acute grief? Rushton and Russell (1996) draw a direct parallel between
the path of hope and the path of grief, suggesting that giving up hope for a miracle cure
requires painful movement down the “path of grief.” While understandably challenged on the grounds of being overly prescriptive, stages of grief research suggests that acute grief is a vital stage in the grieving process which, left unsupported, will likely fester beneath the surface and/or resurface in a more tortured form or in the future (Buglass, 2010; Kubler-Ross, 2005). Could providers hesitant to support false hopes unknowingly abort the blooming evolution of those hopes and ironically contribute to the likelihood that certain religious patients and/or families will seek to prolong the dying process at all cost, to their own detriment, having never progressed to the place of full-bloomed hope?

According to Miller (2007), “how hope is conceptualized [by health care providers] underpins our view about appropriate strategies to use at varied stages in health and illness to inspire hope” (p. 13). Differentiating between hope for specific outcomes that may seem futile and a “generalized sense of hope,” Miller acknowledged the challenge when “unrealistic hopes lead to futile therapies, which increases a person’s suffering at the end of life” (2007, p. 15), but she stresses the importance of cultivating understanding for another’s “sense of desperation” and conceptualizing hope for oneself in a way that can sympathize with outcome-oriented hopes while also offering “alternative hopes,” helping the patient to “move from a particularized view to a generalized state of being view of hope” (p. 15). If health care providers’ conceptualization of hope is critical to developing and executing strategies for facilitating the blooming of patient hope, then hope theory may provide valuable constructs for this conceptualization.
Hope Theory: Conceptualizing the Evolution of Full-bloomed Hope at Life’s End

According to hope theorist Snyder (2002), “hope is defined as the perceived capability to derive pathways to desired goals, and motivate oneself via agency thinking to use those pathways.” For Snyder, agency thinking pertains to one’s ability to achieve goals, and pathways thinking pertains to one’s ability to pursue various routes to goal achievement. Snyder identifies agency-thinking as the source of motivation in hope theory, and he emphasizes the importance of agency-thinking to channel motivation to alternative pathways when obstacles are encountered. Pathways thinking is understood to differentiate hope theory from self-efficacy theory in that pathways thinking is less tied to confidence in the specific situational contingencies of a particular pathway and more focused on self-assessment of one’s capability to produce alternate routes to goals (Snyder, 2002).

While not directly linking the external influence of others to his theory of hope, Snyder (2002) suggests the importance of relationships in influencing hope. Bernardo (2010) formally extends Snyder’s theory to account for the importance of external agents in the generation and sustenance of hope. Bernardo’s extension of Snyder’s hope theory may still not be enough for the theory to escape criticism from members of health care community that its philosophical foundations in cognitive-behavioral psychology “with a narrow emphasis on examining self-motivation and mental events” calls into question its applicability to palliative and end-of-life health care contexts (Penz, 2008).

Clearly the development of a hope theory specifically for end-of-life health care is to be desired; however, in the absence of, and en route to, such a theory, Snyder’s well-
established paradigm proves useful for conceptualizing the conclusions reached thus far, and Snyder himself identifies end-of-life health care as one of the two most important areas for future application of his hope theory (Snyder, 2002). In contrast to self-efficacy theory, Snyder’s theory notably includes not only outcome-oriented but also “enduring” goals, like, for example, hope itself. The theory also understands agency and pathways thinking to be symbiotic and synergistic, especially emphasizing the importance of agency in providing motivation for pursuing alternate pathways when obstacles arise.

With Bernardo’s (2010) extension of Snyder’s (2002) theory to include external agents, could health care provider support in the unfolding process of patient hope (even, and especially, at its initial budding stages, sometimes focused particularly on a miracle cure) be conceived as a source of, and encouragement for, agency thinking which could then provide a relational context for continued support of pathways thinking as patients begin to explore alternative routes to achieve an enduring goal of full-bloomed hope?

In “The Art of Good Hope,” McGeer (2004) uses the unfolding of hope at life’s end as an example of Snyder’s (2002) pathways thinking:

it is a characteristic of those who hope well to resolutely shift their target of hope [through alternate pathways] when the world proves adamantine with respect to some hoped-for end (Shade, 2000; Snyder, 1995). Under particularly difficult circumstances, when choices of ends are highly restricted this may even involve shifting the focus of our hopeful energy onto the manner with which things are done. For instance, a terminally ill patient may give up the hope of prolonging his
or her life, only to invest this energy in meeting the challenge of dying well—with courage, say, and at peace. (McGeer, 2004)

For McGeer (2004), as for Snyder (2002), agency provides the motivation for pathways thinking, fueling a terminally ill patient’s reinvestment of hoping energy in alternative pathways, away from hoping for an impossible cure at all costs and toward “living in hope.” Like Bernardo (2010), however, McGeer goes one step further in emphasizing the necessity of external support for the sustenance of agency, holding that maintaining hope usually requires support from others who recognize the meaning and value the hopeful has invested in her hopes. According to McGeer’s theory, an environment conducive to the maintenance of hoping agency and the resultant ability to retarget pathways requires a dynamic inter-subjective hoping partnership. By inter-animating one’s hopes with another, one shares a scaffolding of agency from which the other can pursue a new vista of pathways:

The way of good hope involves actively contributing…to a dynamic of interaction in which one’s own hopes become interanimated with the hopes of others, thus creating a stable and productive environment in which these can be pursued—or of course, retargeted when specific hopes fail….By providing this scaffolding so far as possible oneself, one reinforces and supports the meaning and value they give to their own hopes, allowing them to become more energized by the world and therefore more open to seeking alternatives for directing their hopeful energy in it. (McGeer, 2004)
Addressing Balboni’s (2010b) concern for end of life soul-care in the medical environment, McGeer’s (2004) hope theory puts the soul back in to that four letter word so frequently attached to health:

*C-a-r-e* [emphasis added] is without a doubt the paradigm…but properly understood, it is neither blind nor self-abnegating. For instance, caring for others’ capacity to hope as an effective peer scaffolder does not mean simply endorsing everything they say or do. Rather it means inviting them to articulate and pursue their hopes in a way that supports their own sense of effective agency. Sometimes, this also means challenging them to better articulate their goals or the means they pursue to achieve them. Sometimes, it means challenging the meaning and value they have invested in particular hopes. However, such challenges must take place against a backdrop that encourages their own agential initiatives since the very point of peer scaffolding is to support these initiatives as critical to their continuing sense of efficacy and purpose. To care for the hopes and hopeful agency of others is thus to care about the clarity with which they pursue their own hopes while endorsing the value of their own hopeful activities as such. To care in this way for others’ capacity to hope is in effect to support their efforts to take better care of their own hopeful agency. (McGeer, 2004)

By entering into the *agency* of a patient and/or family’s budding hopes for a miraculous cure or extension of life, health care providers may better care for patients and families, cultivating possibility for *pathways* hope that empowers patients to eventually bloom in a direction that will lead to a more peaceful, and perhaps, as a result,
less costly death. McGeer’s theory also promises a quality of life reward for providers of the hope-care she envisions: “Hence, the responsive sympathetic scaffolding one gives to others invites responsive sympathetic scaffolding from them in turn, allowing their hopes to become synergistically interanimated with one’s own” (2004). According to McGeer, providers stand to reap personal benefits of hope well sown by being granted emotional access, through their investment in the inter-subjective hoping agency partnership, into the beauty of the patient/family’s eventual full-bloomed experience of “living in hope,” a pathway that is difficult to access outside of near-death or end-of-life experiences.

While the theoretical focus thus far has been on the possibility that provider hesitancy to support patients’ “false” hopes may destroy patients’ hoping agency and decrease patient capacity for pursuing alternate pathways for “truer” hopes, it may also be possible for providers to err in the opposite direction. Snyder (2002) hypothesizes that some providers communicate a more positive prognosis than they actually believe so that patients may remain hopeful. In this case, rather than destroying hope, the provider is fabricating it. Snyder predicts that when doctors attempt to fabricate patient hope, patients will intuit their doctor’s disingenuousness and/or learn the truth of their prognosis online, or from family or another source, resulting in a rupture of trust, damaging the doctor-patient alliance. Snyder suggests the importance of an “honest alliance” between doctor and patient as the starting point for caring for patient hope. Provider destruction or fabrication of patient hope, then, theoretically threatens the agency thinking that motivates pathways thinking necessary for patients to evolve from hoping for a cure at all costs to “living in hope,” come what may.
Modern Scientism or Premodern Spiritualism?

At issue in provider destruction and fabrication of patient hope is the ancient wisdom unearthed in Balboni’s (2010) history of health care: while science is a useful tool for destroying disease, the Enlightenment values that gave birth to the scientific method become problematic when employed outside of the realm proper to science. The objectivity required for good science, if carried outside the domain of science and into the domain of human communication, may be an obstacle to good care. When providers react negatively to patients’ “false” hopes or attempt to fabricate their/medicine’s own false hopes through a deceptively positive prognosis or an unqualifiedly mortality-denying treatment plan, these apparently opposing approaches may in fact stem from shared roots. Erring on different sides of the same post-Enlightenment, scientistic paradigm unveiled by Losev (2003), Marchenkov (2009), and Mattingly (2010) and critiqued by Balboni (2010), both approaches reduce human hoping agency to a phenomenon to be objectively manipulated rather than subjectively known.

While the destruction and fabrication of patient hope are criticized both in the literature and this analysis, the real critique may fall not so much on health care providers themselves as on the paradigm of immanentist infinitism in which they find themselves operating. By insisting that an exclusive focus on material reality is harmful to patients, Balboni (2010b) suggests that there is a limit for the proper use of science, and pushing that limit is a misuse of science as an elixir for realities far beyond the vital but limited domain of science, such as the doctor-patient relationship. Whether reacting against patients’ “false” hope or attempting to fabricate their own false hope in the heroics of
modern medicine, health care providers may be operating with the best of intentions, given the scientistic paradigm in which they are trained, using the resources at their disposal to tackle difficult issues. To the extent that the modern medical paradigm imposes scientific reductionism as not just a valuable tool but also a totalizing worldview, health care providers may need a different philosophical paradigm for the doctor-patient relationship. Certainly a great deal of progress has been made in recent years with the introduction of a “bio-psycho-social-spiritual” medicine, but as we will explore in the following chapter, the question remains how the bio, the psycho, the social, and the spiritual are balanced with the less universalizing particularities of religion, culture, and lived community remains open.

In any case, the “honest alliance” that Snyder envisions and the “peer scaffolding” that McGeer (2004) describes both suggest that supporting human hoping agency requires not objective manipulation of, but subjective entrance into, the patient reality. In our context of communication surrounding futility, exercising both the courage to look a patient/family in the eye and name the likely reality of impending death and the humility to sit down, take that patient/family by the hand (if so-welcomed), and endeavor to access the instinctual, naked hope against all hope, of a fellow human being yearning to somehow miraculously escape death’s fearsome grip, may not be possible within the post-Enlightenment paradigm that Balboni (2010b) critiques or the secularly qualified “bio-psycho-social-spiritual” medicine that Bishop (2011) finds still wanting.

The “honest alliance” and “peer scaffolding” critical to supporting the human hoping agency necessary to empower the full bloom of alternate hoping pathways may
require a return to, or nuanced re-appropriation of, a premodern spiritualist paradigm. While the ultimate ideal may in fact be modern physician-theologians, like Byzantium’s Basil of Caesarea, whom Balboni (2010b) describes as approaching medicine as a sacrament reflecting larger spiritual realities, a first practical step may be physician openness to, and even participation in, a patient’s spiritual reality. Short of becoming clairvoyant saints and mystically radiating divine energy, how can physicians and other health care providers employ a pre-modern spiritualist paradigm to cultivate the hoping agency of a patient or family member holding out for a miracle at all costs?

**Miracle on 34th Ward: From Cynicism to Hope’s Loving Embrace**

Admitting the sad propensity toward dismissal and rejection of patient and family hopes for a miraculous cure, and recognizing the strain that this conflict places on the provider-patient/family relationship, Rushton and Russell (1996) suggest for providers to empathize with hopes for the miraculous. By acknowledging the legitimacy of such a perspective and allowing for it to be a respected aspect of the provider-patient/family relationship, providers can explore the meaning patients and families assign to miracle-hopes, and look for opportunities to “join with the family in their hopefulness” without feeling compelled to insist that either hope must immediately submit to prognosis or prognosis must categorically submit to hope.

There is a diverse continuum of degrees to which providers may choose to employ a spiritualist paradigm to protect hoping agency while building a relationship conducive to the exploration of alternative hoping pathways. DeLisser (2009) emphasizes exercising patience while humbly working to earn trust through respectful,
non-assuming communication, en route to actively pursuit of exigent opportunities to
share differing perspectives on how patients and families might reframe the meaning of
miracles in their particular context. Orr (2007) goes a step further, providing
appropriately nuanced spiritual care when it is welcomed:

It is not inappropriate for a physician or other health care professional to support a
family’s belief in God’s ability to miraculously intervene in seemingly hopeless
human situations. This should not, however, translate directly into an expectation
of a miracle in a given situation. Miracles are rare, by definition. (Orr, 2007)

Orr’s (2007) description of his own practice provides a poignant image of the
“honest alliance” and “peer scaffolding” that may constitute care for hoping agency in a
premodern spiritualist paradigm: “I grieved with his wife as we contemplated his ‘less
than 1% chance’ of survival. They were people of faith, and I prayed along with her that
he would survive.” In another instance where Orr faced a mother whose refusal to
abandon extreme measures could reasonably be contradicted on ethical grounds for the
best interest of the child, Orr, while unafraid to advance his perspective on the plan of
care, did so with empathy rather than adversarialism: “I felt particularly pained for
Joshua’s mother. She felt a huge burden.”

Salient in Orr’s testimony is a willingness to deliberately complement objective
thinking with subjective feeling in the context of care for the dying body and soul: “I
grieved with….I prayed along with….I felt….She felt…” If health is properly defined as
a continuum of holistic well-being (Shi & Singh, 2004), how might this soul-care impact
well-being? Would providers and recipients of end-of-life soul-care integrating a pre-
modern spiritualist paradigm with the modern scientific paradigm by combining objective thought for proficient science with subjective emotion for meaningful connection, report different health experiences and reach different health outcomes than their counterparts? And what has all of this to do with “narrative medicine?”
CHAPTER SEVEN: AN EXAMINATION OF, AND PRESCRIPTION FOR, NARRATIVE MEDICINE

“Sickness and healing are, in part, narrative acts” begins Charon (2001, p. 83).

As we will revisit briefly in Chapter Eight, Charon (2001, 2004, 2006) helped to pioneer the notion of “narrative medicine,” which she describes as “medicine practiced with the narrative competence to recognize, interpret, and be moved to action by the predicaments of others” (Charon, 2001, p. 83). Through the pioneering work of Charon and others, the concept of “narrative medicine” created a new universe of discourse for the role of health communication as a leading “art” of medicine for the twenty-first century.

After identifying five “genres of narrative writing in medicine,” Charon turns to what may be the most poignant aspect of the article, describing her personal experience of reflecting on clinical conversations, writing patient narratives, and subsequently sharing what she had written with the patients and inviting feedback. This practice had not gone on for long before Charon was confronted with two patients who noted that something was left out of their narrative. They both proceeded to disclose past experiences of suffering abuses, one as a child and another as an adult. Describing these missing “chapters” as “clinically significant” to both the emotional health and the physical health of these two patients, Charon notes that her process of writing, sharing, and inviting feedback seems to have catalyzed, or at the very least, hastened such disclosures. Even before sharing her writing with patients, Charon was already convinced that the act of narrative writing alone granted “access to knowledge—about the patient and about [her]self—that would otherwise have remained out of reach”
(Charon, 2001, p. 85). Combined with the exponential addition of new knowledge from newly disclosed narrative-transforming life-chapters in response to her solicitation of patient feedback, Charon’s narratival knowledge may be or become a force capable of challenging the epistemological paradigm of modern medicine.

Calling into question the value of dichotomizing medical “art” and “science,” Solomon (2008) disputes the notion that narrative challenges the epistemological paradigm of modern medicine. After identifying narrative medicine as the leading representative of medical humanities, Solomon begins her critique in earnest with a trajectory of questions attempting to complicate the dichotomization of medical art and science. Without exploring possible answers raised in the interrogation of dichotomization, Solomon turns to what will be shown to be her underlying agenda: defending the scientific epistemology of modern medicine by legitimately complicating if misleadingly masking its hegemonic role. Solomon’s defense of scientific hegemony by means of obfuscation through qualification begins with a cogent reminder that according to four decades of scientific studies “science is not a science” in that physics and biology, for example, “do not follow a precisely stated method, do depend on practical skills and on contextual factors, produce local rather than general claims, involve much fallibility, and so forth” (Solomon, 2008, p. 408). So “if physics and biology are not science,” why then, asks Solomon, should we “bother to point out that medicine is not a science?”

Having established that medicine “is not a science,” Solomon then notes her preference for the characterization of the scientific aspects of medicine as “technoscience” given their applied nature, but she remains content to use the more popular term “science.”
Maintaining that “the talk about ‘science’ versus ‘humanities,’ ‘art,’ or ‘nonscience’ is not helpful,” Solomon proceeds to explore three texts in “humanistic” or “narrative” medicine (2008, p. 409): Halpern (2001), Montgomery (2006), and Charon (2006).

Solomon’s (2008) preference for “the epistemic role of narrative medicine in health care” to be limited to the service of (“unscientific”) “technoscience” is deemed safe in the hands of Halpern (2001), unsuccessfully challenged by Montgomery (2006), and truly threatened by Charon (2006). In Halpern (2001), Solomon finds a philosophically acceptable argument in favor of “professional” empathy as a replacement for Osler’s untenable “detached concern,” unwisely advocated in medical education (as cited in Solomon, 2008, p. 409). Based on her tragic experience of watching a despairing patient die after forgoing recommended treatment, Halpern’s notion of empathy includes a “sophisticated understanding of autonomy, in which respect for autonomy requires more than simply refraining from interference with the patient’s stated wishes” (2001, p. 410). While implicitly challenging the objectivity of scientistic human relations through her critique of the “detached” aspect of Osler’s “detached concern,” Halpern appeases Solomon (2008) by not framing the transition “from detached concern to empathy” in science-rebuffing terms. Halpern arguably succeeds beyond Montgomery (2006) in implicitly identifying a legitimate epistemological challenge to Solomon’s perspective, but ultimately lets science off the hook, trading an epistemological battle for a practical focus on the value of empathy. If potentially less well armed, Montgomery is not so forgiving in the epistemological battle.
Like Halpern (2001), Montgomery (2006) also roots advocacy for humanistic medicine in a traumatic personal experience of her daughter’s breast cancer. But unlike Halpern, Montgomery deems science, according to Solomon, patently “inadequate to serve as a basis for individual decision making” (p. 410). Framing her notion of “clinical judgment” as patently unscientific, Montgomery’s characterization does not pass Solomon’s (2008) muster. Pointing out that Montgomery’s notion of clinical judgment is rooted in an anecdotal assurance she received from a breast-cancer surgeon that he had only lost one patient like her daughter in 30 years of clinical practice, Solomon is understandably puzzled at the crowning of such an experience as the “je ne sais quoi of medical practice” (2008, p. 410). Is Montgomery’s need for assurance really “an epistemic need for certainty, or [merely] a psychological need to stop worrying, that is addressed by the sympathetic physician?” wonders Solomon (2008, p. 410-411).

Like Montgomery (2006), Charon (2006) was not as forgiving of scientitism’s transgressions as is Halpern (2001). Unlike Montgomery, however, Charon, being bolder and clearer with epistemic claims, is not so easily called to task. While Solomon is generally comfortable with Halpern and Montgomery’s tendency to focus on the psychological value of narrative, she becomes unsettled by Charon’s explicit “claims that narrative methods are needed for effective treatment of both the body and the mind” (2006, p. 411). Charon agrees with Halpern’s understanding of the difference between empathic reasoning and logical reasoning. Positing narrative reasoning as a logic distinct from “logicoscientific” reasoning, Charon “explicitly challenges” the “‘two worlds’ view” where “humanities and the science of medicine are [seen as] non-overlapping
magesteria” in that “the humanities are needed to heal the mind/soul while science is needed to fix the body” (Solomon, 2008, p. 411). Solomon sees clearly that, for Charon, “humanities techniques” bear on both the healing of the body and the development and application of “technological achievements” (p. 411). Understanding well the epistemic implications of her advocacy for narrative, Charon is fixed on the ultimate epistemic prize: in Charon (2006)’s words, a “new philosophy of medical knowledge.”

Solomon takes pains to acknowledge the multi-faceted value of Charon’s (2006) narrative approach, summarizing in explanatory form many facets of Charon’s case for narrative’s impact on medicine, not the least of which was Charon’s confession that narrative exploration corrected her tragically unjust assumption that a woman escaping sexual abuse was actually nothing more than a conniving manipulator (2008, p. 412). The skills necessary to successfully employ narrative to these ends include, for Charon, not just the willingness to listen for, write down, and reflect on narratives, but also a formidable grasp of narrative genre and theory, which Charon labors to instill in participants in a narrative medicine training program at Columbia University.

Summarizing some of Charon’s (2006) storied examples of narrative medicine, Solomon finds something short of the makings for Charon’s “new philosophy of medical knowledge.” For Solomon, stories conveying meaning and psychological healing akin to the examples employed by Halpern (2001) and Montgomery (2006) are Charon’s norm, whereas narratives “crucial to diagnosis, treatment, and research” are scant (Solomon, 2008, p. 413). The fact that a Dominican man suffering from back pain breaks down weeping in the middle of his complex narrative, overwhelmed by the emotion inherent in
his realization and confession that nobody “has ever let me do this before,” is epistemologically irrelevant for Solomon. Emotion seems to have no bearing on health outcomes in Solomon’s view. The emotional pain spilling out in the Dominican man’s tears is a “non-overlapping magisteria,” most certainly unconnected to the merely coincidental pain in his back. It might not be too much to assume from this analysis that Solomon is either unfamiliar with, or unsympathetic to, the growing claims of integrative medicine that emotionally well-being is a factor vital to physical health (Snyderman & Weil, 2002). For Solomon, stories of “affiliation” and “psychological healing” remain as walled off from the medical realities of diagnosis and treatment as myth is from fact. It is no surprise, therefore, that Solomon wonders if Charon has “perhaps exaggerated the epistemic benefits of narrative analysis” (2008, p. 413).

Solomon’s (2008) culminating analysis reveals that her plea against the dichotomization of medical “arts” and “sciences” is not so much a move beyond the limits of art and science as it is an attack on the growing threat that the art of narrative medicine presents to the exclusively scientistic paradigm of modern medicine, a paradigm which Solomon takes great pains to defend. In a discussion of how emotion should be understood in medicine, Solomon’s guardianship of supposedly “unscientific” medical “technoscience” becomes unmistakably clear. Acknowledging empathy’s not merely intellectual but also emotional reality, Solomon wants not so much to transcend the boundaries of emotion, intellect, art and science as to subordinate emotion and art to intellect and science. She accomplishes this by carefully if not subtly pulling emotion in under the banner of science in a description of emotion as a “not unscientific” “tool,” or
stated more plainly, a tool of science: “Use of human emotion as a tool to learn about patients is not inherently unscientific; in fact, it is scientific to use the tools that are suitable to whatever domain is under investigation” (Solomon, 2008, p. 414). Even more tellingly, “if using empathy yields reliable results,” continues Solomon, then “it is an important tool in the human (and perhaps also higher animal) sciences.” The value of empathy as a tool is contingent upon the “results” that it produces. By what measure are the “results” produced by empathy deemed legitimate? The suggestion of applying qualifying, and assumedly scientific, criteria to the use of human empathy in health communication begs the question: By what criteria might science judge the reliability and legitimacy of empathy’s “results?” This vital question invokes an examination of Frank’s (1995) distinction from Charon (2006) and how that distinction unearths a deeper level of Solomon’s implicit argument.

For Solomon, the criteria for judging the reliability and value of empathy’s “results” is seen in the “results” valued by medical “technoscience.” Reminiscent of Mattingly’s (2010) genre of healing as “machine repair,” Frank’s (1995) “restitution narrative” sums up the results pursued by technoscience and according to which the value of empathy might be judged. As suggested by the narrative title, the results can be summed up in one word: restitution. Just as Mattingly observed the protagonist in restitution narratives to be the medical scientist, Frank noted that “restitution stories bear witness not to the struggles of the self but to the expertise of others: their competence and their caring that effect the cure” (Frank, 1995, p. 92). Not only is the self not the protagonist of the story, but, recalling Losev’s (2003) critique of the myth of matter, the
self is dualistically divorced from the body such that the “body is a kind of car driven around by the person inside, ‘it’ breaks down and has to be repaired” (Frank, 1995, p. 86). The identification of the body as an “it” invokes Buber’s notion of the “I—thou” versus the “I—it” relational framework. Separated from Buber’s “thou” of the living person and reduced to Buber’s “it” which can be nothing more than Losev’s (2003) “dead matter,” the body is a mechanism owned by the self. The extent to which “I—thou” empathy is deemed to produce reliable results, then, must be judged by the extent to which it can be shown to mediate the truly meaningful “I—it” relationship of the protagonist mechanic to the broken, literally depersonalized (given that the person is described as merely the owner) car. Lest such a harsh characterization of person and body as owner and car seem to exaggerate Solomon’s conceptualization of patient identity in medical “technoscience,” this is precisely the framework she implements. Defending her classification of empathy as a tool of technoscience, Solomon (2008) compares physician-patient empathy with the empathy that veterinarians and mechanics show to pet and car owners because “car owners have sentimental attachments to their failing machines, and the decisions they recommend about car care take these into account” (Solomon, 2008, p. 414).

Among the multitude of issues raised by this disturbing analogy, the person does not own a body in the same way that she owns a car. While cars may be expensive, they are infinitely replaceable. The wonders of modern medicine notwithstanding, bodies ultimately are not. Because the owner therefore will not exist without the car, it is not possible to categorically, dualistically separate the two. Therefore the physician has a
great deal more power over the person than the mechanic has over the car owner. The problematic power of the physician-mechanic over the “owner-embodied-as-car” is demonstrated through the legal definition of human death as “brain death” for the purposes of organ transplantation. Bishop (2011) discusses the curious modern phenomenon of organ transplantation and its implications for the philosophy of medicine.

By creating a new legal declaration of death as “brain death,” transplant surgeons are given the authority to harvest salvageable car parts from the “dead” owner who Bishop calls the “living dead.” Bishop’s definition of what Solomon calls the “car owner” as the “living dead” is an effort to struggle with the perplexing reality that in order to salvage “living” parts from the (legally declared) “dead” “car owner,” it is necessary to keep the “dead” person “living,” so that the car parts can be harvested “alive” and therefore workable in other “living” cars, as medicine would have it, cars with “living” “owners.”

If this all sounds confusingly twisted, let us then add a further complicating factor. Recalling “Mr. Jones” from Chapter One, it is clear that Mr. Jones was not an organ donor. If Mr. Jones had been an organ donor, then his wife would not have been present during the removal of life support to watch him “die” (where death is understood as cessation of heartbeat rather than technoscientific calculation of brain activity). His wife would not have been present during the removal of life support to watch him “die” because before life support could be removed, transplant surgeons would be harvesting “living” organs from his “dead” body. If his wife was then brought back in to the room to watch him “die” after the removal of “living” parts from his “dead” body, then the “person” she was watching to “die” would no longer be the “owner” of a “car,” the parts
of which were already removed, and therefore would not be a “person.” Without getting bogged down by the curious and complex philosophical notions of personhood at stake here, we should at least contemplate the bearing all of this may have on our clinical context of interest, and more specifically our story of Mr. Jones lying on his deathbed, blurting out to his friend, “Your breath stinks,” and walking out of the hospital.

It seems that Mr. Jones either was not an organ donor, or the organ harvesting authorities rejected him for medical reasons such as, perhaps, the negative impact of his oxygen levels on organ health. In either case, had Mr. Jones been an organ donor, and had his organs been desirable for transplantation, he might never have had the chance to utter those alarming words, “Your breath stinks,” and miraculously walk out of the hospital the next day. The “practice” of “unscientific” “technoscience” would have had bigger and better things in store for the ownerless car that was Mr. Jones’s “living dead” body. To shed further light on the problematic nature of technoscientific epistemology, however, it may be helpful to explore some possibilities for the scenario in which a chaplain may have been called to pray at the bedside of the legally “dead” car owner, Mr. Jones, just before he was turned over to wrecking company for organ harvesting. What if Mrs. Jones had called for the chaplain to come and pray for a peaceful “death” while Mr. Jones was still on life support, just before he was whisked away for organ harvesting? After the “technoscientifically-declared” “living dead” Mr. Jones had somehow heard the prayer and cried, would the crying alone have been enough to have halted the transplantation process? In the real life story, Mr. Jones’s act of crying after the prayer was dismissed as a common reflex not indicative of brain activity. What if (in our
hypothetical transplant scenario) after crying, Mr. Jones had made the decision to come out of his coma as he was being prepped for transplant surgery? What if, instead of his friend having the bad garlic breath, this fateful role had been played by the transplant surgeon? What if, just before, or even during transplant surgery, Mr. Jones had said to the transplant surgeon, “Your breath stinks”? What then? A “dead” owner of a living car speaks to the junkyard mechanic.

Reflection on this scenario invokes a disturbingly amusing scene in *Monty Python and the Holy Grail* (Gillam & Jones, 1975). A hearse-meets-garbage-truck serviceman carts a wagon of corpses through the village streets shouting, “Bring out ye dead!” Having just been thrown on to the top of the heap, the newest body cries out “I’m not dead yet!” The person having presented the body for removal replies, “Yes he is!” The body replies, “No I’m not!” The punch-line comes when the person who delivered the “body” up for removal turns his attention to the corpse-cart operator and says, “Well, who are you gonna believe? It’s just his word against mine.” At that fateful moment, the transplant surgeon has no legal liability to Mr. Jones, who, having been declared brain-dead, is legally dead. The title of an ownerless car has been transferred over to the transplant surgeon, but like “Herbie” from “The Love Bug” film, the unsalvageable car, having been given over to the wrecking company, is somehow alive. “Dead matter” defies the egocentric gaze. This brings us back to Solomon’s positioning of empathy as a potential tool of technoscience if it proves to produce “reliable results” for the objectives of the regime under which it serves as a tool. What “reliable result” would empathy produce for the objectives of technoscience in this case? An interesting if
provocative question to ponder. The purpose of the question is not really to ponder what a transplant surgeon might do in such an extreme case. To be sure, even the most ambitious transplant surgeon would respond to the line “Your breath stinks” by canceling transplant surgery and returning the “car” to the “owner.” The purpose of the question is to ponder the problematic nature of an epistemological frame subjecting the art of medicine to the technoscientific dictates that allow for such questions to be asked at all. Even though no transplant surgeon would ever consider such an inhumane act, the epistemological hegemony of scientistic technoscience creates an environment in which Monty Python’s (Gillam & Jones, 1975) scene could hypothetically play out on the transplant table where, according to the scientific definition of death, Mr. Jones could have said “Your breath stinks,” and the transplant surgeon could have legally smiled and lifted his knife for the transplant incision. At this point, Mr. Jones could have hypothetically tendered the plea, “I’m not dead yet!” And the remainder of the above conversation quoted in the movie could have played out quite similarly: “Yes you are.” “No I’m not.” “Well who are they going to believe? It’s just his word against mine.”

While it may be rather far-fetched and arguably extreme to suggest an analogy between the “car-owner” metaphor employed by Solomon and the “Not dead yet!” line from Monty Python and the Holy Grail (Gillam & Jones, 1975), there is significant precedent for this line of questioning. Indeed, there exists a social movement built precisely around this very analogy. Not Dead Yet: The Resistance (2014) is a grassroots movement led by disability activists, many of whom are alive only because their parents refused to follow their doctor’s advice that their lives were not worth saving.
Uncomfortable with “mercy killing” for those “whose lives are seen as worthless,” the “Not Dead Yet” movement questions the epistemological frame underlying the rhetorical stance of self-determination employed by euthanasia advocates (para. 1).

If the epistemological frame of modern technoscience can be accused of promoting a notion of “self-determination” that devalues the continued existence of human “owners” of “cars” that may never again be fit for driving on the highway, the same paradigm ironically markets an industry ideal to the contrary. Invoking earlier discussions of medicine’s false hopes in immanentist infinitism, Frank points out that in restitution narratives, restitution is “commoditized” which allows for an infinitist “deconstruction of mortality” so that one can “sustain an illusion of permanence” (Frank, 1995, p. 85). Frank points out that clinical ethics in such an environment of modernist assumptions become reduced to the same kinds of cold self-interest that market immortality while devaluing human life, ultimately boiling down to legal protections of financial concerns through designing policies procedures around limiting liability.

For Frank, however, a profit-driven illusion of permanence and the employment of narrative tactics for the purpose of sustaining such an illusion as long as possible is not the purpose of narrative medicine. “Being open to crisis as a source of change and growth and valuing contingency even with its suffering are the bases of the communicative body” in Frank’s conceptualization of the “wounded storyteller” (1995, p. 126). Acknowledging the potential value of narrative for Charon’s (2006) interests in better diagnosis and treatment, Frank seeks out the higher calling of a “narrative ethics” to guide people, clinician and lay, in “the moral commitments that illness calls them to”
such as Frank’s notion of a physician “being for” rather than just “doing” things for her patient (1995, p. 157). Ultimately, Frank (1995)’s vision calls for a “renewal of generosity” which becomes the title of Frank’s (2004) later work. The generosity inherent in “being for” another person rather than simply performing procedure, however kindly, for a patient invokes images of an epistemology of medicine in which science serves as a tool of art rather than the other way around as Solomon prefers.

The profundity of Frank’s (1995) vision for the humanity of medicine calls into question whether his high ideals are being, or can be, achieved under the banner of Charon’s (2004) “narrative medicine,” and if so, whether “narrative medicine” is in fact an art worthy of sharing or seizing science’s perch atop the epistemological throne of twenty first century health care. For this question, Solomon’s (2008) challenge to “narrative medicine” may be as on-target as her defense of medical technoscience is off-base. In this sense Solomon may have unwittingly accomplished her stated goal of challenging both the notion of an “art” of medicine and a “science” of medicine, if in the process failing her agenda of promoting the continued epistemological hegemony of modern technoscience.

The wisdom of Solomon (2008) lies not so much in her subtle campaign for the epistemological hegemony of medical technoscience as in her challenge to the identity and solvency of Charon’s (1994) “narrative medicine.” Exploring the implications of Solomon’s challenge requires a brief foray into the philosophical underpinnings of the narrative theory Charon uses to train clinicians in the art of narrative medicine. For Solomon, the identity of narrative medicine remains mysteriously elusive. Vital to
penetrating the mystery of narrative medicine is McKeon’s (2000) observation of eminent literary critic, Northrop Frye’s contention that the ascendency of “narrative” is rooted in narrative’s adoption of the mode of the modern novel. Referencing another of McKeon’s works, Marchenkov (2009) describes the modern novel as a “sober” genre unlike the life of a saint because miracles are not allowed on the grounds that they would appear to be “‘unmotivated discontinuities’ in the plot” (Marchenkov, 2009, pp. 118-119). Marchenkov notes McKeon’s (1987) observation that while modern critics see miracles as “discontinuities,” medieval literature views them as “logical consequence[s] of ‘the tacit intrusion of the otherworldly’” (Marchenkov, p. 119). According to Marchenkov, it is no accident that the modern novel is unfriendly to miracles. Quoting Bakhtin (1981), Marchenkov shows that the modern novel, as a genre, is a reflection of modern thought as “the only genre that was born and nourished in the [modern] era of world history and therefore it is deeply akin to that era” (as cited in Marchenkov, 2009, p. 118).

For Bakhtin (1981), the novel genre is a product of modernity’s scientific epistemology along with its approach to both time and reality. Scientific epistemology is seen in the novel’s previously mentioned rejection of miracles. Just as scientific epistemology does not allow for miraculous intersections between the spheres of immanence and transcendence, modernity’s approach to time does not allow the past to function as a reference point for authority in the present. The loss of a notion of time that allows for authority to emanate from past to present creates a “‘radical revolution in the
structure of the artistic image” leading to “an intense focus on the present.” Bakhtin (1981) opines:

The present in its so-called “wholeness” (although it is, of course, never whole), is in essence and in principle inconclusive; by its very nature it demands continuation, it moves into the future, and the more actively and consciously it moves into the future, the more tangible and indispensable its unfinalized character becomes. […] The temporal model of the world changes radically: it becomes the model of a world where the first word (the ideal principle) is non-existent, and the final word has not yet been spoken. (as cited in Marchenkov, p. 119)

Marchenkov next traces how scientific epistemology and an intense focus on the present create a “hypothetical nature of reality in the novel” characterized by what Bakhtin (1981) calls “‘an eternal re-thinking and re-evaluating.’” In the novel, the “center of activity that gives meaning to and justifies the past is transferred to the future” making reality “one of [many] possible realities;” therefore reality is “not necessary but accidental, and is pregnant with other possibilities.” Drawing on Kuhn (1962), Marchenkov notes that, by presenting unlimited possibilities, all of which fall short of capturing reality, the novel is akin to a scientific hypothesis as an infinitely replaceable “tentative account of reality.” While tentative, hypotheses are required to account for everything within their sphere, and “the presence of facts that [a hypothesis] cannot accommodate is a sign of its inadequacy.” Marchenkov sums up that a hypothesis “is required to possess formal completeness while remaining provisional in essence.”
Similarly, for Bakhtin, a novel’s “absence of inner finality and exhaustiveness,” creates a “much stronger demand for the external and formal finality” within, as Marchenkov qualifies, an “individual specimen” although the opposite is true of the genre as a whole (Marchenkov, 2009, p. 119).

If McKeon (2000) is correct in observing that narrative, whether consciously or not, perpetuates the novelistic mode, and if Bakhtin (1981) is correct in emphasizing the hypothetical and provisional nature of novelistic prose despite its external tidiness, then Solomon (2008) may have reason for concern in questioning the identity and substance of narrative medicine. Ironically however, Solomon’s investigation may not serve its ultimate aims. If Bakhtin is also correct in his identification of the novel, and by extension narrative, with modernity’s scientistic approach to epistemology, time and reality, then Solomon’s effort to probe the identity of narrative medicine may result an interrogation of the extent to which narrative medicine is yet enough of an art to serve as a true complement to the science of medicine. Is the novel, and therefore narrative, vulnerable to the same adolescence as the scientism that characterizes modern medicine? According to McKeon (2000), the novel is, reminiscent of adolescence, “possessed of a tyrannical freedom,” and, reminiscent of modernity, “figured as...an imperial invader, usurper, and colonizer, at once totalitarian and leveling.” It seems that the novel genre is not immune to characterizations reminiscent of adolescence, of modernity, and of what we are here calling the adolescence of modernity. Why then is the postmodern darling, “narrative,” anonymously extending and perpetuating the conditions of the modern novel
under its own genreless banner? And how does narrative’s extension of the adolescence of modernity bear on the art of medicine?

Postmodern narrative unwittingly extends the philosophical conditions of the novel genre because postmodernism extends the adolescence of modernity as a result of its inability to move from valid critique to viable resolution. Rooted as it is in the scientific paradigm of modern medicine, “narrative” cannot escape Solomon’s (2008) charge that it lacks the identity and solvency necessary to vie for epistemological authority in twenty first century health care.

**Narrative and the Extended Adolescence of Postmodernism**

While it “lays bare the irrationality of modernist conceptions of personhood and teleology” that reduce humanity to dead matter fit to be dissected into parts with functional mechanisms to be understood and manipulated, postmodernism fails to build on the validity of its own critique (Marchenkov, 2009, p. 130). Marchenkov observed that postmodern mythology fails to evolve beyond modernity’s arid mythology of immanentist infinitism because it “clings to the Enlightenment’s thaumatophobia” (fear of miracles) and completes modernity’s expulsion of immediately given reality (2009, p. 130).

The postmodern fear of miracles extends the disunity of a universe characterized by immanentist infinitism because it preserves the parallel planes of immanent and infinite reality that do not allow for miraculous, perpendicular intersections of immanence and transcendence, ideal and real, historical being, and ultimate purpose. The postmodern critique, therefore, amounts to a functional finger pointing rather than a
movement toward resolution: “Postmodern critique is modernism’s own last attempt to surmount the dichotomies in which it has wedged itself. But rather than seeking to reconcile these dichotomies, poststructuralist thought invites one to acknowledge their artificial character” (Marchenkov, p. 130-131). In this sense, postmodern thought can be compared to an extended adolescent who knows, names, and despises everything wrong with his parents, but still refuses to pick himself up off their couch and move out of their basement. As a result, postmodern consciousness is, reminiscent of extended adolescence, a “generating chaos.” “Postmodern chaos,” notes Marchenkov, “desperately resists the immediate synthesis of the immanent and the transcendent… [preferring] ambiguity, indeterminacy, and unfinalizability. The only trace of reality that remains any longer is a thoroughly immanentist, rhizomic spreading of what appears to be real but is, in fact, constructed by discursive practices pursuing irreconcilably diverse agendas” (2009, p. 130). Furthermore, continues Marchenkov there is no “nature” to contrast with this artifice, no immediately available reality, and no innocent ear that can hear things “as they are.” There is, above all, no simple, singular subjectivity that can say unequivocally “I am that I am” in order to reveal the untruth of things that are what they are by virtue and for the sake of something else. Everything is equally contrived and instrumental, and music becomes a means of pragmatically navigating in the labyrinths of culture—navigating, however, without any final destination or hope of leaving the increasingly intricate passageways. (p. 131)
Seeking to simultaneously escape systemic influence and excel in methodic form, Birtwistle composed *The Mask of Orpheus* opera which signals immanentalist infinitism’s victory over immediately given reality. In place of immediate reality, the opera employs music in “pure play uninhibited by any suggestion of the art’s transformative potential or task.” The postmodern riff on reality is distinguished by play sans purpose where “the powers of music accordingly become purely formal, having to do with ‘the telling of the story’ rather than what the story tells” (Marchenko, 2009, pp. 130-132).

In a world where the content of stories is elusive, Solomon may be right to question the identity and solvency of narrative medicine. Barthes’s (2012) “Death of the Author” describes a narrative space “where our subject slips away, the negative where all identity is lost, starting with the very identity of the body writing” (as cited in Marchenko, 2009, p. 136). Like other postmodern art such as the opera and its music discussed above, postmodern narrative prefers external form to inner content and identity. “In the multiplicity of writing,” [Barthes] continues, “everything is to be disentangled, nothing deciphered; the structure can be followed…. but there is nothing beneath…. [W]riting ceaselessly posits meaning ceaselessly to evaporate it, carrying out a systematic exemption of meaning” (as cited in Marchenko, pp. 136-137). Barthes describes this exemption of meaning in postmodern narrative as an “anti-theological activity…since to refuse to fix meaning is, in the end, to refuse God and his hypostases—reason, science, law” (as cited in Marchenko, p. 137). The loss of identity and meaning in narrative places the onus on the reader to make of the text what he will. Like the active penetration of the viewer’s glance in egocentric art and the physician’s gaze in Bishop’s (2011)
critique, modern narrative subjects the text to the objectifyingly exclusive interpretation of the reader who functions as a disembodied, impersonal space for narratival unity to manifest. Like the objective physician in relationship to the patient, “the reader is without history, biography, psychology; he is simply that someone who holds together in a single field all the traces by which the written text is constituted” (Marchenkov, p. 137). This connection between medical history taking and the reading of postmodern narrative illustrates and expands Solomon’s critique of the solvency and epistemological viability of narrative medicine. As described by Mattingly (2010) above, modern medicine transfers meaning and interpretation from the patient/family-centered reality to the objectification of the physician’s gaze, replacing the patient as protagonist on journey of personal transformation with the physician as protagonist in the triumph of science over mortality. If Barthes similarly transfers the task of meaning making in postmodern narrative “from the author to the reader,” then what art has narrative theory to add to modern medicine’s parallel transfer of meaning and interpretation?

Postmodern Narrative and the Art of Medicine

Complementation requires distinction. For an art of medicine to function as science’s vital complement, it must bring something to the table that science lacks. Whatever Charon’s narrative medicine brings to the table for the future of health care, telling answers to Solomon’s questions around the identity and solvency of narrative medicine raise significant issues for the possibility of “narrative” to function as an art that challenges science’s epistemic hegemony in modern medicine. As we have seen, the extended adolescence of postmodern narrative unwittingly perpetuates the very same
conditions underlying the adolescence of modernity that it so convincingly critiques. McKeon (2000) observes that while poststructuralism seeks to dispel the novel genre, what it ultimately accomplishes is a demystification of genre as a category in its effort to “replace the arbitrary dogmas of genre theory by the transhistorical sweep of narratology.” The transhistorical sweep of narratology, by virtue of its war against genreness, invites Solomon’s critique by sabotaging the very literary identity that creates structure for content, meaning, and solvency. While fitting nicely under the postmodern myth of a generating chaos, narratology ultimately perpetuates the novel’s preference for literary innovation free of external imposition. Liberated from the bonds enabling coherence, narratology frees literature to frolic in the postmodern waters of art for art’s sake.

The art necessary to challenge science’s epistemic hegemony in modern medicine must be something more than art for art’s sake. While dismissing delusions of divinity as childlike foolishness from the enlightened perspective of modernity’s adolescent libido where medical science rules, Freud consigned spiritual illusion to the foolishly fanciful fantasies of toddler finger painting, otherwise known as the realm of art. But in so doing, he makes a vital admission: “Art, which certainly did not begin as art for art’s sake, originally served tendencies which today have for the greater part ceased to exist” (as cited in Marchenkov, 2009, p. 121-122). The tendencies art originally served might be summed up by Hegel’s “theurgic” notion of art as a medium for accessing a higher, truer plane of transfigured reality granting spiritually revealed self-knowledge (Marchenkov, 2009, p. 99). Similarly, as appropriated by Losev, Solov’ev rejects the notion of art for
art’s sake and sees art rather as a vehicle for life’s “realization of that fullness” of beauty that art invokes. In diametric opposition to the postmodern notion of form en lieu of content and meaning, Solov’ev conceives of art as intimately connected with the content, reality, and meaning of life. Solov’ev’s vision of art enacting a “genuine or positive all unity” imagines “such a state of affairs in which unity exists not at the cost or to the detriment, but for the benefit of all” (as cited in Marchenkov, p. 111). This vision of art seems worthy of vying with science for epistemic hegemony in healthcare. But where is such notion of art preserved and nurtured? Certainly not in postmodern secular culture.

Far from realized, the human need for art as a positive, meaningful vehicle for solidarity-based unity and wholeness is only exploited by postmodern secular culture. This need is shrewdly grasped by the culture industry, and exploited at a grandiose scale. Yet this industry by its design cannot produce any genuine unity. Mass music can only substitute manufactured and mechanically reproduced ersatz answers to questions about the purpose of human existence. The flaunted optimism of mass music is not supported by a deep grasp of the human condition; when it is not used to accelerate consumption, the optimistic major mode is no more than a pose instinctively struck by the modernist subject as it shrinks away from its own inner vacuum. When it does muster the courage to look into the abyss inside the subject becomes a forlorn [postmodern] aesthete, who marks, now with bitterness, now with melancholy resignation, the extinction of its early hopes. (Marchenkov, 2009, p. 144)
For Marchenkov, postmodern art is stuck in the conflicted, despairing ambivalence of, on the one hand, seeing itself as an alternative to modern scientism, but on the other hand, having no hope for producing anything other than art for art’s sake in postmodernism’s self-loathing “aesthetization” of reality. Consigned to the meandering oblivion of irrelevance except as another means of modern exploitation as described above, art seeks a rebirth as something other than “art for art’s sake.” The despair-driven playful meanderings of the extended adolescence of postmodernism beg for an approach to art, and with it, an art of medicine, that yields the meaning, purpose, wholeness, and unity art once served in the childhood of humanity before being consigned to the realm of irrelevance by Freud’s “libidinous evolution” of humanity narrated from the libido-driven vantage point of adolescent modernity. En route to the rebirth of art’s relevance and purpose for humanity seeking to evolve beyond the extended adolescence of postmodernism, it may be necessary to poke a small hole in immanentist infinitism’s mythical construal of reality as merely probable. Such an endeavor, however brief, may help to tip the scales away from health communication’s imbalance in favor of probabilistic orientations seen in PI theory’s observed “ideology of uncertainty reduction” and toward a viable conceptualization of the art of medicine.

**Black Swans Consume the Carnage of Exclusively Probabilistic Reality**

Solomon (2008) may be correct in challenging the viability of narrative to constitute a banner for the art of medicine capable of challenging the epistemic hegemony of science. However, Solomon’s dehumanizing objectification of patients and families as car owners, conceiving of human bodies as machines according to the
mythology of matter and mechanism is problematic in its own right. Solomon’s objectification of humanity demonstrates the epistemological limitations of medical science. Solomon’s telling slip into the car-owner metaphor invokes Taleb’s (2007) critique of probabilistic orientations and the modern “epistemic arrogance of the human race” (p. 138). In *The Black Swan: The impact of the Highly Improbable*, Taleb asks why we have become so obsessed with probability and prediction. He observes that our obsession with understanding the world in terms of probability is so strong that we even engage in dishonest hindsight rationalization of major historical events. Such hindsight rationalizations according to notions of probability fail to admit the truly unpredictable nature of major historical events. And, according to Taleb, it is these “black swans,” these unlikely, unpredictable major events that change history by consuming the carnage of exclusively probabilistic reality and ultimately governing the universe much more so than the things that we succeed in predicting. If statistics understands probability along the lines of what it can supposedly predict with 95% certainty, Taleb will grant that success rate and continue to maintain that the 5% of phenomena unaccounted for will have at least as much impact on the world and human life in it. “Let us examine” opines Taleb, “what I call epistemic arrogance, literally, our hubris concerning the limits of our knowledge….True, our knowledge does grow, but it is threatened by greater increases in confidence, which make our increase in knowledge at the same time an increase in confusion, ignorance, and conceit” (2007, p. 138).

Reminiscent of Marchenkov’s (2009) depiction of what we call the adolescence of modernity through the role of music in opera, Taleb (2007) shows how the same
adolescence that characterizes operatic music also characterized the process leading up to the building of the Sydney Opera House. Designed by leading scientist and planned according to airtight conceptions of probabilistic forecasting, the Sydney Opera House was finally completed in a timeframe and on a budget that fell short of expectations by embarrassingly unfathomable orders of magnitude. A poignant “symbol of the epistemic arrogance of the human race,” the “Sydney Opera House was supposed to open in early 1963 at a cost of AU$ 7 million. It finally opened its doors more than ten years later, and, although it was a less ambitious version than initially envisioned, it ended up costing around AU$ 104 million” (Taleb, 2007, p. 138).

“Why on earth do we predict so much?” asks Taleb (2007, p. 138). “Worse, even, and more interesting,” continues Taleb, “why don’t we talk about our record in predicting? Why don’t we see how we (almost) always miss the big events? I call this the scandal of prediction” (Taleb, 2007, p. 138). Taleb’s critique may have fascinating implications for questioning the rationality of infinitism’s excessive optimism for medical quasi-miracles, and its categorical rejection of genuine miracles.

The notion of talking about our record in predicting invokes the seldom discussed disparity between clinical efficacy as determined by clinical trials and clinical effectiveness as observed in real life. Designed around scientific notions of objective knowledge, clinical trials remove experimenters from reality so that they can be adequately objective about their impact on it. The problem with removing oneself from reality for the purpose of objective manipulation is that the newly objectified reality constitutes an unreal setting. This disparity between objectified reality and actual reality
accounts for the discrepancy between efficacy measured in clinical trials and effectiveness measured in real, everyday clinics (Cook & Campbell, 1979).

Supporting Solomon’s (2008) notion of science’s growing epistemological sophistication, but simultaneously demonstrating how far this trajectory remains from reaching any kind of fruition, Sacristan (2011) calls for “a new reasoning model in the era of patient-centered medicine” (p. 1). Suggesting for a radical reversal of the common practice of exploratory observations and confirmatory trials, Sacristan sees the patient-centered paradigm moving toward a revolution in the epistemology of modern medicine whereby medical science deems randomized clinical trials merely exploratory and individual observations confirmatory. Were it to be realized, Sacristan’s radical reversal could be interpreted to support either Solomon’s contention of medical science’s newfound epistemological agnosticism or Charon’s (2004) notion that some of the practices pursued under the banner narrative medicine are in fact succeeding in their goal to establish the preeminence of the art of medicine, however felicitous they may or may not be to the problematic realities of postmodern narrative theory. In either case, what Sacristan’s (2011) recommendation seems to suggest is that Taleb’s (2007) critique of the epistemic arrogance of prediction within modernity’s mythical universe of merely probable reality may be relevant to healthcare.

In one sense, Sacristan’s (2011) suggestion that a patient-centered paradigm requires an approach to medical knowledge that prizes subjectivity over, or even alongside objectivity deals a major blow to the mythical underpinnings of modern medicine. As Marchenkov (2009) observes,
modernism prized above all else the goal-driven unfolding of the creative potential of the subject whose progressive march assured the unity of human experience. But contradictions within modernist subjectivity and the impossibility of resolving them by abstract-rationalistic means eventually give rise to the postmodern critique that lays bare the irrationality of modernist conceptions of personhood and teleology. (pp. 129-130).

Solomon’s (2008) conceptualization of the patient’s relationship to her body as analogous to a car owner’s relationship to a car is evidence enough of the “epistemic arrogance” and concomitant “irrationality of modernist conceptions of personhood and teleology.”

While the postmodern critique succeeds in laying bare the epistemic arrogance and irrationality of adolescent modernity, it fails to offer a viable alternative to the non-intersecting planes of merely probable, objectified reality in immanentist infinitism. This is so because postmodernism clings to modernity’s defining motivation of liberating immanent humanity and modernity’s defining rejection of meaning, identity, authority, tradition, and ultimately God. As a result, postmodern narrative is a genreless, anti-theological enterprise. Stuck in the postmodern milieu unconsciously extending modern aims, even Sacristan’s (2011) radical reversal of research priorities under the banner of patient-centered care employs subjectivity not so much as an end unto itself as advocated above by Frank (1995), but rather in the service of PI theory’s observed ideology of uncertainty reduction. Fixed as it is in the horizontal planes of immanence and infinitism, postmodern, patient-centered health care risks advancing an art of medicine as incapable of truly challenging the epistemological hegemony of medical technoscience as
postmodern art has proved incapable of slowing the soul-fracking materialistic leviathans of modern culture and industry.

Like postmodern narrative, the postmodern bio-psycho-social-spiritual spiritual model of health care can also be experienced as an anti-theological enterprise. Reminiscent of other aspects of the postmodern project, the palliative/hospice movement critiques the limitations of ICU culture only to, as Bishop (2011) would say, “cloak,” or, using Marchenkov’s term, “aestheticize” death as a “natural part of life” for the immanent human subject. Marchenkov observes poststructuralism giving up on positivist aims without positing a philosophical alternative, bound by the despair of what is not to be and content to frolic in the play of what feels right in the moment that is defined by the impossibility of ultimate ends. For palliative care and hospice, the most obvious answer to the question of what feels right in the moment is relief from physical pain. Spirituality is allowed in on the same terms that Cadge (2012) noticed it is welcome in the ICU: as long as it does not violate the dogmatic dictates of aestheticized reality void of transcendence. While Cadge observed waterfalls, puppy dogs, and any number of pseudo-religions symbols of aestheticized reality passing for spirituality in the clinical setting, Dover (2008), a hospice chaplain, reported being interrogated and castigated by a hospice supervisor for including forgiveness in prayers for a dying patient who had previously confessed his sins. Rather, the job in the aestheticized plane of postmodern hospice, according to Dover’s experience, is to provide what she called a “spiritual morphine drip” conducive to the admirable, if limited, hospice goal of providing
multidimensional comfort for a pain-free death on “your terms” for the immanent human subject (Dover, 2008, pp. 36-40).

**The Art of Medicine, a Pro-theological Activity**

As previously quoted, Wachter (2012) insists on scientific criteria as imperatively preferential to “hope, theology, or magical thinking” in a health care environment where costs must be cut. Contrary to Wachter and in fulfillment of Charon’s vision, might it be paradoxically possible that nothing short of theology can claim the authority necessary to carry health care’s epistemological banner as a genuine *art* of medicine and even, as an accidental but convenient consequence, perhaps curb the financial unsustainability of the U.S. health care system? If postmodern narrative ultimately boils down to a rebelliously “anti-theological” activity, it may be that the only alternative for the art of medicine is an adult evolution beyond the extended adolescence of postmodernism back to the future of consciousness through a re-evaluation of Freud’s dismissal of childlike consciousness typical of religion. In short, it may well be time for some constructively “pro-theological” activity. Cognizant of both the historical exigencies giving birth to the notion of narrative medicine and the tendency of the postmodern myth of chaos to predominate in the indeterminacy of narrative approaches, might Charon be open to the possibility of theologically-driven genres for transformation of narrative medicine into a truly mythological epistemology? “That narrative medicine is flourishing now is no coincidence” opines Charon (2001, p. 86). In anticipation of narrative medicine’s future, Charon states that “It may be that out of our current, rather chaotic practices of narrative
writing will emerge new forms in which to examine, reflect on, and enact our ongoing commitments to patients” (2001, p. 86).

In a health care world dominated by the unacknowledged myth of immanentist infinitism, the only thing more unsettling than the long forgotten notion of religious authority may turn out to be Solomon’s (2008) comfort with human empathy functioning as an optional tool for achieving the narrowly technical, unreflective reflexes of medical technoscience. As discussed above, medicine’s concerns about the irrationality and financial unsustainability of “false” hope in divine miracles in the context of predicted medical futility is not only eclipsed but philosophically and, as a result financially, dwarfed by the exponentially growing cost of immanentist infinitism’s false hope in winning the war against human mortality. Modern medicine employs its own specious infinitist rationality to fabricate false hopes in the power of science to defeat mortality, selling its own form of indulgences: “the dream of better health and the possibilities of progress based on medical science have provided new opportunities for control of the sick, who, with their own personal hopes for care and cure, are transformed into new kinds of political subjects willing to undergo new kinds of subjugation” (Mattingly, 2010, p. 240). Once fabricated and exploited at the intersection of scientific progress and human desperation, human hopes are then ridiculed as unscientific forms of irrational, savage-like magical thinking (Cadge, 2012; Wachter, 2012). As a physician in Cadge’s study admitted, unrealistic family expectations in the ICU are often the result of the way that people have been cared for and communicated with up to that point: “I think the most difficult part is the end-of-life issues….They’re frequently difficult because things
have not been handled well before a patient gets transferred to us, and families arrive with unrealistic expectations” (Cadge, 2013, p. 157). Because its unreflectively insatiable appetite for waging war against mortality is conveniently masked under modernity’s “myth of no myths,” medical technoscience easily has its way with an unsuspecting populace. “The kind of coercion that medicine exerts,” notes Mattingly, “is very often a subtle kind. New opportunities for health care—new practices—help to shape people’s hopes, and these hopes may, in turn, betray them” (2010, p. 240).

This kind of coercion is aided by rhetorical reframing of reality. “When operation of modern industry is called ‘magic,’” opines Marchenkov, “it is implied that science and technology have accomplished by rational means what ‘irrational’ myth and magic could only impotently dream of” (2009, p. 143). In a precisely analogous vein, when the operation of modern medicine is called miraculous, as it so often is when it wins a battle in its war against mortality, it is implied that science and technology have accomplished by rational means what “irrational” religious myth and miracle could only impotently dream of. The recycled rhetoric of “magic” and “miracles” functionally proselytize immanent infinitist dogma through the subtle coercion of rhetorical reframing where the “term returns only as a means of celebrating a triumph over what it signifies” (Marchenkov, 2009, p. 143). If Solomon’s (2008) wishes for medical epistemology continue to be granted, could empathy be similarly recycled by medical technoscience for subtle coercion of “car owners” for purposes known only to unconscious and therefore unacknowledged pseudo-myth of immanentist infinitism? Solomon’s curious defense of science as “unscientific” is a tacit admission of the need for a truly unscientific force to
seize epistemological hegemony of medicine from the unreflectively insatiable infinitist instincts of technoscience before it is too late for the U.S. economy. Ironically, given its tacit extension of the adolescent modern epistemological paradigm of the novel genre, genreless postmodern narrative turns out to be more unartistic than science is unscientific. Both of these paradoxes, however, only serve to highlight health care’s vital need to discover medical technoscience’s paradigmatic complement and yield to it at least a shared yoke if not the exclusive reigns of medical epistemology. Only when this is accomplished can medical technoscience discover its proper identity as a tool—precisely the status that Solomon sought for empathy—rather than an unacknowledged, and therefore unquestioned, regime in which non-scientistic values like miracle-hope in the face of medical futility are “not tolerated” (Cadge, 2012, p. 148).

To harness the promise of empathy as an art used to regulate with conscious intentionality the utilization of medical technoscience, the banner currently held by narrative medicine must find a way to overcome Solomon’s (2008) apt interrogation of the identity and solvency of postmodern chaos and indeterminacy. In lieu of postmodern chaos and indeterminacy, the banner held by the art of medicine must be imbued with constructive, coherent, concrete content. To fulfill Charon’s (2001) vision for a “new philosophy of medical knowledge,” narrative medicine needs to evolve beyond the extended adolescence of postmodern angst and rediscover some long forgotten identity in the form of an explicit genre or genres and a transparently acknowledged guiding myth or myths. To honor the wisdom in Solomon (2008)’s instinct that the “art” and “science” of medicine should be united under a single banner in which various diverse dimensions of
healing serve as tools in service of a broader uniting vision, it may behoove us to take seriously that the need for an explicit genre, guiding myth, and broader uniting vision all point to Bishop (2011)’s closing question: “Might it not be that only theology can save medicine? (p. 313). The only alternative to the scientistic epistemology conceived in the “lateral sprawl” of the parallel planes of immanent infinitism is the genuinely mythological epistemology manifested in the perpendicular coincidence of immanence with transcendence experienced in the miraculously symbolic immediacy of divine revelation. Genuinely mythological epistemology, then, is articulated through the language of theology.

Eastern Orthodox Christian theology articulates a truly mythological epistemology worthy of consideration as an art of medicine and relevant to the exigencies of health communication, namely uncertainty and suffering.
CHAPTER EIGHT: ORTHODOX WISDOM FOR UNCERTAINTY AND SUFFERING IN HEALTH COMMUNICATION

The first question we will ask before attempting to hear the voice of Orthodox wisdom in response to uncertainty and human suffering is: why is this even a question in the twenty first century? Has not modern science solved or sufficiently shown itself to be on the verge of solving these problems of the human dilemma? Is not human suffering the exclusive domain of medical science? Will not theology get in the way of the progress of science toward these ends? For Bishop (2011), a physician, philosopher of medicine, and medical ethicist, the answer to these questions is a resounding “no.” Medical science not only has not eliminated the need for wisdom traditions to engage human suffering, but medical science itself may be among the human institutions in need of theological healing.

Bishop (2011) levels a pointed critique on modern end-of-life health care, observing that it abstracts us out of human community and estranges us from communal sources of meaning. In place of communal sources of meaning, modern medicine greets death with a “metaphysics of efficient causation.” Pointing out that scientific knowledge requires a level of objectivity, manipulation, and control that is not attainable due to the inherent flux of living human bodies, Bishop argues that medical science became epistemologically grounded in the human corpse as an “ideal type” and “firm ground on which to make truth claims.” Modern medicine’s epistemological grounding in the human corpse shapes its conceptualization of what it calls “care” of the terminally ill and the dying, and this conceptualization is so embedded that it is, like all languages flowing
from larger mythological structures (Bakhtin, 1981, p. 369), systematically masked and radically limited:

These forces both are possible and are deployed because of the implicit metaphysics already held by medicine; that is to say, medicine’s epistemology already holds the world and bodies to be objects that are primarily measurable, even before the measuring. The dead body is the measure of medicine, creating the sense that life is primarily matter ordered to efficiently move within space, both within the space of the body itself but also within the space of the body politic.

Acknowledging the kind-hearted intentions and pure motivations of medical practitioners and organizations, Bishop locates the problem he critiques not in individual clinicians or in collective forces but in the epistemology of the system in which they are engrained.

Recalling Dover’s (2008) description of the limitations imposed by her hospice’s “spiritual morphine drip,” Bishop sees, in both intensive care and palliative care, evidence of the “cold ground of their origins” in the metaphysics of efficient causation (Bishop, 2011, p. 21-22). Modern medicine’s “technologies of life” and “psychologies of death” are both grounded in the knowledge of dead bodies, making the relationship of medicine to death a complicated one:

Modern medicine is continually struggling to master death, only to have death return with a vengeance. Death is thus shrouded in technology, hidden in discourse, and finally cloaked in palliative care. And in its return, medicine tries more exhaustively to name it, to shape it, to control its uncontrollable features,
only for it to flit away. In this sense, death is medicine’s other, an other at its very heart.

The ordering of the inherently subjective care of the living according to the structure of the efficiency and utilitarian maximalization flowing naturally from the objectivity of scientific knowledge pulled death and the dying “out of communal contexts with various mythological, narrative, and liturgical meanings” into a mega-industry that, like the many other machines of modern progress, can be experienced with increasing ambivalence as meting out miracles of one kind while swallowing up miracles of another (Bishop, 2011, p. 22-23).

Bishop’s (2011) location of modern medical knowledge in the firm foundation of the immanently manipulable dead body can sound creepy if not open to accusations of conspiratorial paranoia. Any critique so ambitious will not be immune to valid concerns with overstatement and unproductively totalizing finger pointing. Time will not be devoted here to teasing out a balanced assessment of this critique, but there can be no doubt that Bishop is not alone in sharing a concern for the worrisome aspects of medicine’s keen interests in death and efficiency. These interests can be seen not only in the care of the dying but also in the disease prevention efforts of the medical mainstream. As previously quoted, a woman’s response to the dictates of breast self-examination, for example, recalls Bishop’s critique: “In my mind, the ‘routine’ breast exam is not routine at all: It's a grim, lonely ritual in which we probe our bodies, our womanliness, for death” (Schneider as cited in Babrow & Kline, 2000, p. 1809).
Bishop’s (2011) critique seems at least embedded enough that Babrow and Kline (2000) perceived a need to advocate for living, breathing women—and the ambivalencies observed in their experiences engaging the extent to which medicine’s unquestionable dogmas can be experienced as morbidly efficient and paradoxically inhumane imperatives—as something other than barriers standing in the way of the dictates of medical progress:

The thought and practice of BSE engenders [sic] various intense emotions and concerns. When one adopts a biopsychosocial perspective, these numerous and profound uncertainties are not merely barriers to be reduced and thereby overcome. If they are relevant to BSE promotion, their relevance is not so easily packaged and manipulated. On the contrary, these powerful and varied uncertainties suggest challenging and wide open questions. We must ask what BSE means to women, and whether, for whom, and how the practice is appropriate. By treating these issues as nothing more than barriers to a universally possible and desirable procedure, social scientists have ignored or discredited women's experiences and reinforced the ideology of uncertainty reduction. Perhaps more troublesome is that this ideology is perpetuated and transformed by the popular media through rhetorical strategies that are not in the best interests of the women who rely on these sources for information. (Babrow & Kline, 2000, p. 1808)

If medicine’s best, well-meaning efforts at preventing disease can make human beings sometimes feel less like recipients of care than like barriers to the enactment of
medicine’s social program, then we have all the more reason to carefully consider Bishop’s (2011) concerns for the tenuous place of the dying, whose living bodies may sometimes stand the risk of serving as the un-consenting battlefield upon which medicine wars, or the unwelcome mirror which medicine covers in its herculean struggle with death. Bishop concludes the critique with a series of questions leading to a plea for theology to re-enter the vacuum left by modern medicine’s epistemological stranglehold on the journey of uncertainty and human suffering often inherent in the dying process. Wondering if a “more careful attunement to fully embodied life” characterized by a better understanding of how “technology often distorts the being of the patient and replaces the function without replacing the purpose” would allow medicine to embrace more humility in its relationship with the body, Bishop asks whether human bodies have their own value separate from the values imposed upon them by the metaphysics of modern medicine. This begs the question of whether the “meanings and purposes” of a body transcend medical categories, and if so whether medicine “might be more respectful of the living and dying body if it took form and purpose as already always embodied.” Bishop believes that these questions transcend the limits of philosophy and science, opening “into an arena of uncertainty where meaning cannot be limited to what is true and transferable to all other bodies,” where the “content of meaning is the truth” (Bishop, 2011, p. 313).

This arena of uncertainty where meaning cannot be limited to what is true and transferable to all other bodies is reminiscent of the potential posed by problematic integration (PI) theory for a rebalanced approach to uncertainty that no longer assumes
the subservience of “evaluative orientations” to “probabilistic orientations” (Babrow 1992, 2001, 2007). Bishop’s plea for medicine to take a more embodied form seems to suggest a new paradigm for de-industrializing and de-politicizing medicine by somehow re-inscribing the tools of modern medicine back into pre/postmodern communal structures. Just as rigorous consideration of problematic integration in contexts of intractable uncertainty organically leads efforts at problematic integration to the doorsteps of reality reframing often pursued through the symbolic logic of wisdom traditions (Babrow 1992, 2001, 2007), so also Bishop’s critique of modern medicine’s objectivistic epistemology also leads back to the subjective sphere of myth and religion:

It might be that we can learn once again from the places at the margins of contemporary life, at the margins in the spaces created by liberalism and biopolitics. It might be that we can learn once again not from history—a static past—but from living traditions. It just might be that the practices of religious communities marginalized in modernity and laughed at as unscientific are the source of a humane medicine. Perhaps there, in living traditions informed by a different understanding of space and time, where location and story provide meaningful contexts to offer once again hospitality to the dying as both cura coporis and cura animae, we will find a unity of material, function, form, and purpose. (p. 313)

Recalling Toulmin’s suggestion that philosophy was saved from the oblivion of obscurity by medical ethics, Bishop ends his book wondering if perhaps only theology can save medicine.
Toward a Twenty-First-Century Conversation

The notion that perhaps theology may save medicine begs the question: “What is the current status of the relationship between theology and medicine?” In *Heal Thyself: Spirituality, Medicine, and the Distortion of Christianity*, Shuman and Meador (2003) probes the recent scholarly exchange between religion/spirituality/theology and medicine. While the late twentieth century “spirituality and health” movement succeeded in initiating a long-forgotten conversation between religion and medicine, Shuman and Meador observe that the embedded theology guiding the “spirituality and health” research discipline is one of transactional exchange: God grants good health in exchange for good faith. Much of the groundbreaking “spirituality and health” research of the late twentieth century boils down to an attempt to scientifically demonstrate that people who attend religious services and participate in spiritual practices benefit from longitudinal health outcomes that are demonstrably superior to the general public. While there is value in this research re-igniting the “religion and medicine” conversation and creating a platform necessary for more fruitful exchange, Shuman and Meador leave little question as to whether this theology of exchange carries the transformative power necessary to “save medicine” as Bishop (2011) prescribes. The theological image of God as obligated to the crude logic and instrumentality of a contract trading physical health for spiritual devotion is nothing short of a theological tragedy. Whether or not the formula “works” from the standpoint of scientific investigation, “something is lost when the relationship of faithfulness to healthfulness is reduced to exchange (Shuman & Meador, 2003, p. 91).
Shuman and Meador (2003) observe that the theology of exchange undergirding the late twentieth century efforts of religious physicians to stimulate conversation between faith and medicine is ultimately rooted in scientific epistemology. In a world where “true” knowledge is limited to one exclusive method of observation and measurement, “theology ceases to be taken seriously as a means of inquiry” because it does not fit the epistemological paradigm. In order to avoid marginalization as mere speculation, Protestant theology made a science out of biblical interpretation that paralleled the “book of nature” read by natural science. The shift to understanding revelation as a product of systematic investigation re-formed God into an object of scientific investigation (Shuman & Meador, 2003, pp. 46-47). Tracing Newton’s role in effectively making theology into yet another domain of science, Shuman and Meador take note of the caveat that a god objectified as a subject of scientific inquiry or another tool of science, used to make sense out of the mechanics of the natural world, is ultimately an ineffective fabrication, precisely the fabrication that modern atheism observes him or her to be.

While religious physicians steeped in the norms of medical science are to be credited for initiating a dialogue that has found voice in the halls of medicine, the task for the twenty-first-century chapter of the religion-and-medicine conversation is for religion to speak not the language of science, nor even the language of generic spirituality, but its own language, the language in which it comes into being, evolves, and thrives: the language of theology. Theology’s engagement of human suffering lies not in subjecting itself to, and locating itself within, the strictures of medical science but rather in
articulating a cosmic vision that medical science yearns to subject itself to and locate itself within⁵:

The task of such a theology, says John Milbank, “is not apologetic nor even argument. Rather it is to tell again the Christian mythos, pronounce again the Christian logos, and call again for Christian praxis in a manner that restores their freshness and originality.” Such telling, proclaiming, and calling, if they are faithful, will not simply pose Christianity as a story or stories among others, which women and men might use to negotiate the world more successfully or with greater sense of fulfillment. Rather, they will pose the stories of Christianity as actually creating the world in which teller and hearer live—the same world. “These stories are not situated within the world: instead, for the Christian, the world is situated within these stories. They define for us what reality is, and they function as ‘metanarrative’ . . . in the sense of a story privileged by faith, and seen as the key to the interpretation and regulation of all other stories.” (as cited in Shuman & Meador, 2003, pp. 99-100)

One challenge in telling again the Christian mythos, pronouncing again the Christian logos, and calling again for Christian praxis in the twenty-first-century—quasi postmodern—context, is that, at least in the West, all of these things changed in the modern era. Complicating any effort at moving from Bishop’s (2011) critique of modern medicine to his call for theology and “living traditions” is the question of whether these

⁵ Lest this arrangement strike the reader as too broad a proposal for a pluralistic society, it is expected that the more success any one spiritual tradition finds in incorporating medicine as a tool in its healing community, the more inspiring this will be for other traditions to engage in the same enterprise.
traditions are, in fact, living—in the sense that they have not been totally co-opted by the modern knowledge paradigm—and whether they actually preserve forms of knowledge emanating from premodern—and relevant to postmodern—epistemologies. This is particularly problematic for a discussion of Christianity in the context of modern medicine as experienced in the U.S. because the dominant form of American Christianity, Protestantism, was founded in, and is a product of, as we have already noted to some extent, the same epistemological movements that gave rise to modern science. For example, Hacking (2006) the modern notion of probability evolved from a shift toward the scientific study of bare nature, as manipulated by mathematics, rather than the previously sociologically based emphasis on the witness of trusted authorities.

This shift is concomitant with the move from church authority to the bare text of scripture. Just as Protestant theologians discovered true knowledge straight from the source through methodological reading of scripture, so medical science discovered true knowledge straight from the source through direct observation and manipulation of the natural world. As both a product and harbinger of modernity, Protestantism’s knowledge paradigm was not only modeled after, but also a model for, modern science. Many modern scientists were known as the “Luther” of their discipline (Hacking 2006), referring to Martin Luther, the Catholic monk, who rejected church authority in favor of individual investigation. This co-identification of American Protestant Christianity with the roots, aims, and methods of the modern project may be one reason why Christianity does not always come to mind in discussions of healing traditions or wisdom traditions.
relevant to postmodern rediscoveries of premodern sources of healing, meaning, and spirituality.

Just as twentieth century religious scientists were apt to engage medicine through scientific studies subjecting the divine realm to investigations aimed at measurable, scientifically valued outcomes, so also twentieth century theologians were apt to engage theology proper using scientific means. One of the most popular apologetic texts of the twentieth century, for example, betrays its debt to the scientific paradigm for knowledge in the unambiguous title by best-selling Evangelical Protestant apologist, McDowell, *Evidence that Demands a Verdict* (1979). Attempting to prove, among other things, the miraculous physical resurrection of Jesus Christ, McDowell gave voice to a form of Christianity perhaps appropriate to its era. This distinctively modern strain of Christian apologetics became so prominent in the mid-twentieth century that the late twentieth century “theology of exchange” we have dismissed as inadequate to a twenty-first-century religion-medicine conversation was actually the more nuanced of the twentieth century religion and medicine exchanges. Studies demonstrating the health outcomes of religious observance followed the first wave of religion’s interface with modern medicine through a series of double-blinded clinical trials aimed at alternately proving or disproving the health outcome effectiveness of intercessory prayer.

For the dogma produced by modern Evangelical Protestant apologetics, the uncertainty and suffering inherent in the experience of advanced illness could be countered by the unquestionable certainty found in any “objective” inquiry into Christian origins and the scientific law-rebuffing supernatural power found in historic Christian
miracles. By the end of the twentieth century, however, the solutions of certainty and power began to ring hollow in discerning ears. One of the more popular examples of the dissolution of certainty-based Christian apologetics is the personal story of Ehrman (2005), a popular religious studies scholar. A passionate proponent of McDowell’s apologetic “evidence,” Ehrman set off for graduate study at Princeton in the 1980s, seeking to become an American hybrid of McDowell and Cambridge’s (more intellectually viable) C.S. Lewis, a Christian apologist in a secular professor’s clothing. After careful study of early Christian manuscripts, Ehrman came to the eventual conclusion that the verdict was sadly lacking for McDowell’s so-called evidence. Over the last 20 years encompassing the turn of the twenty first century, Ehrman has written prolifically on the challenges for certainty-based apologetics posed by critical inquiry into Christian manuscripts and origins. With New York Times best-selling books such as Misquoting Jesus (1995), Ehrman has reached an ever-increasing cross-section of both scholarly and popular audiences with the declaration that the certainty fueling modern Christian apologetics was misguided and unfounded.

While perhaps more hopeful for postmodern alternatives to modern Christian apologetics than Ehrman, continental philosopher, Caputo (1996), is at least as disillusioned with the value of the theology emanating from modern Christian apologetics for engaging human suffering as Ehrman is with the epistemological efforts of the same to sidestep human uncertainty in the search for Christian origins. Caputo’s (2006) appraisal of modern Christian apologetics recalls Bishop’s analogously unsparing appraisal of modern medicine: “If you think of God in terms of power, you will be
regularly, systematically confounded by—let us say, to put it politely—the unevenness of God’s record on behalf of the poor and the oppressed, the irregularity of the help that God gives when my enemy [or a devastating illness] oppresses me” (Caputo, 2006, p. 91). For Caputo, the God of certainty-based modern Christian apologetics falls far short of his contractual obligation in the logic of exchange, twentieth century health outcomes research notwithstanding.

A Philosophical Prescription for Modern Theology’s Ailment: Divine Weakness

In his book, The Weakness of God: A Theology of the Event, Caputo (1996) critiques the manner in which the same forces of strength and unlimited, unchecked, overrun agency that overtook modernity and modern medicine in particular also overtook modern Christian theology. Arguing against the “strong theology” of modern Christian apologetics, Caputo draws upon philosophical compatriots Derrida and Levinas to make a poignant plea for a Christian mythos rooted in what he calls the weakness of God. For Caputo, the very name “God” is understood phenomenologically as a word for “our hope in something unconditional but without sovereign power.” If God possessed an infinite amount of the kind of power that humans wield, then, because God is good, there would be no injustice in the world. But for Caputo, “the name of God is the name of a promise, a weak force, not a worldly power.” This weak force of God “declares the good in things, calls for an age of messianic joy and peace, but it does not have an army to keep peace.” And Caputo points out that worldly armies attempting to keep the peace through force on God’s behalf tend to do more harm than good. The notion that God has any kind of higher purpose for innocent suffering is, according to Caputo, a blasphemous
misconception about God and the true nature of God’s power which is not determinative but “invocative, provocative, and evocative, seductive and heuristic, luring and alluring, because it is the power of a call.” The rape and murder of a child are not some mysterious aspects of God’s overarching plan for “long-term good” or Job-like tests but instead a “violation of the ‘good’” (Caputo, 2006, p. 90-91).

Intellectually rigorous Orthodoxy embraces Caputo’s imperative against glossing over unjust suffering. Contemplating the 2004 tsunami in Asia, Hart (2005), an Orthodox thinker, distinguishes between providence and determinism or universal teleology by showing that, unlike a deterministic view that assumes divine affirmation of evil for some greater purpose, providence instead sees divine grace active in redeeming evil that occurs as a result of human freedom. Most importantly, Hart emphasizes that God’s relationship to the reality, causes and consequences of suffering is made clear through the actions of Christ: “Sin he forgives, suffering he heals, evil he casts out, and death he conquers. And absolutely nowhere does Christ act as if any of these things are part of the eternal work or purposes of God” (Hart, 2005, p. 87).

The kind of omnipotent power Caputo sees in religion is the “genuine power of powerlessness,” the power of “our hope against hope.”

That is why the irreducible truth of religion, which rises up from an affirmation of the world, from celebration and bottomless joy, arises no less from the abyss of suffering, from the tears of the exiled and persecuted, from the lament of the lame and the leper, from the cry of the victim, and also—this is a part of today’s religion—from the abyss of a suffering earth that cries out against
exploitation. *De profundis clamavi ad te, Domine.* From these depths, where I am, from these depths, which I am, I cry out to you, in the depths. That is the groan of every living thing (...). (Caputo, 1996, pp. 90-91)

Somehow, the affirmation of the world tends to rise up most poignantly precisely from the depths of suffering. Why do human suffering and powerlessness seem to breed a uniquely powerful hope against hope? This is a question to which we shall return. For now, it suffices to observe that the problem of theodicy is often paradoxically less troubling for those living in the abyss of suffering than it is for those of us who merely contemplate levels of heinous suffering experienced by others. For Caputo (1996), a strong God invokes all the wrong questions concerning human suffering, but a weak God need not be argued “off the hook” for the problem of evil. Rather than being abandoned to question the injustice of a strong God, humans are called, intimately invited to join (weak) forces with a weak God and all who cry out from the depths in hope against hope, unquenchable love, and unconditional affirmation of the good: “The only answer [to the problem of evil] is to have the strength to countersign Elohim’s *yes* with our own *yes*” (Caputo, 1996, p. 92). Elohim’s *yes* is Caputo’s shorthand for God’s evaluative declaration at the completion of creation that what he had made was, come what may, somehow, in fact, “good.”

Faith, then, is neither a blind eye toward human suffering nor a condescending assumption that every evil serves a greater purpose, but a clear-eyed, intentionally hopeful embrace: “Faith moves the mountain of hopelessness, while the physical mountain stays hopelessly put. Hope raises hearts dashed by the cruelty of events with
the prospect of a coming day, but what is done is done... God is a hope, not a magician” (Caputo, 1996, p. 94). While Caputo sees the past as irremissible, he believes that the weak force of forgiveness can at least change its meaning. Rather than deterministically preventing events such as Auschwitz and outcomes such as the terminal illness of a child, weak forces can change their meaning. Turning specifically to Jesus, Caputo maintains that the “weak force” of God is seen in the reality that he exercised his power differently than the human forces of this world. When the Romans chided Jesus with the question why his army had not saved him since he was a king, they ironically exposed the ultimate weakness of worldly power versus the strength of weak force.

He was a king ironice, in a way that worldly might mocked and that in turn makes a mockery of worldly might. The Romans could extinguish Jesus but not his memory, the primal scene of suffering’s most dangerous memory. The dead are the stuff of dangerous memories, constituting a weak force, harnessing all the power of powerlessness. (Caputo, 2006, p. 94)

Caputo needs not stray far from the heart of Christian dogma to find support for his philosophical imperative. Fundamental to Caputo’s location of God’s weakness is the cross, the symbol of an impaled, dead, bloody man as the very symbol of Christian spirituality:

The weak force of God is embodied in the broken body on the cross, which has thereby been broken loose from being and broken out upon the plane of the powerlessness of God. The power of God is not pagan violence, brute power, or vulgar magic; it is the power of powerlessness, the power of the call, the power of
protest that rises up from innocent suffering and calls out against it, the power that says *no* to unjust suffering, and finally, the power to suffer-with (*sym-pathos*)

innocent suffering, which is perhaps the central Christian symbol. (p. 43)

Caputo challenges the twenty-first-century telling of the Christian mythos to consider how seriously Christianity is going to take the fundamentality of the cross: “The question” says Caputo, “is, when it comes to that defining scene of the crucifixion, how Christian we are willing to be and how radical our theology of the cross will be. How genuinely, how seriously are we to take this central Christian vision?” (Caputo, 1996, p. 43).

Caputo’s (1996) challenge strikes not only at the root of small-minded and small-hearted theological approaches to suffering but equally, and connectedly at the need for certainty demonstrated by the apologetic project aimed at establishing proof for divine miracles. The problem for modern minds with forsaking the “strong theology” of modern Christian apologetics is this dilemma: if certainty is not to be found in airtight notions of divine providence that trivialize human suffering and naively so-called scientific evidence for the resurrection of Christ, this calls into question whether science-rebuffing power can be claimed for the miracles performed by Jesus during his earthly life and strikes at the core of the modern epistemological approach to faith that gave rise to conservative literalism, liberal agnosticism, and strident atheism. If strong theology is untenable and God works through weak forces, then what is left to believe? For Caputo, the question of what is left to believe after strong theology is bid adieu misses the point
of the Gospel narratives which are properly read not as modern historical or scientific text but rather as a “poetics of the impossible:”

The impossible does not depend upon a metaphysical heavyweight or a theological super-power but upon the weakness of its unconditional claim upon us, the strength, not of its sovereign force, but of its unconditional call. That is why it requires a poetics, why it is expressed in parables and narratives that stretch logic’s credence. For the possibility of the impossible does not describe the domain of what is, but of what calls. It does not articulate what is there, but something soliciting what is there, groaning and sighing for birth, something that longs to happen, a dangerous possibility, endangering what is and the powers that be. It summons up the irruption of an event simmering in the heart of what is there. So if in a poetics someone walks on water or is raised from the dead, that is not supposed to send the physicists and the biologists scurrying back to their computers to crunch their numbers once again to check this out, but to send our hearts soaring with a desire beyond desire for transformation, renewal, rebirth, for which we pray and weep. The world is what is there, the kingdom [of God] is what calls, or is called for, or calls us. (Caputo, 1996, p. 105-106)

Because God is understood as a word calling for, and through, the poetics of the Impossible, creation for Caputo is a divine risk, where God inscribes a “coefficient of contingency into life, a placeholder for the unpredictability and uncertainty and creativity” of historical human being. God’s covenant with humanity, then, is as the
source, warrant, and seal of good that he affirms in Elohim’s yes which we are called to countersign (Caputo, 2006, pp. 73-74).

**Eucharistic Reality**

In what follows, an effort will be made to differentiate Orthodox wisdom from what Caputo calls the “strong theology” that can only speak tritely to human suffering and to show how Orthodox wisdom opens itself up to an interpretive stance for engaging Caputo’s “radical uncertainty” at the heart of human existence. After all, what would a wisdom tradition have to offer in human contexts as raw as uncertainty and suffering if the springs out of which its wisdom flows are antithetical to the exigencies of such contexts? Any effort to engage Caputo’s challenge risks an overly simplistic categorization of Orthodox wisdom into one of the polar modern theological categories of literalism or metaphor. In the second appendix to his classic work of liturgical theology, *For the Life of the World*, Schmemann (1973) offers a third way that avoids this polar characterization and challenges the modern assumptions upon which it is based. Pointing to the debate in the West over “transubstantiation” that ultimately came to delineate the Catholic understanding of the Eucharist from the Protestant understanding, Schmemann challenges the false distinction between reality and symbol. If for Catholics the modern notion of reality posited the Eucharist as the literal, historical, physical body and blood of Jesus Christ, for Protestants, the modern notion of symbol establishes Communion as a present-day reminder of Christ’s sacrifice in the past. For Orthodoxy, argues Schmemann, spiritual reality need not be subjected to modern objectification or relegated to second class citizenship. Reality is not limited to what might be confirmed in a lab
workup, and relegating symbol to the realm of imagination or memory misses the (powerless) power of symbol as an entrance into a reality that symbol both points to the fruition of and simultaneously makes truly present, if only as alluring foretaste, in the moment. For Christian theology seeking to recover from modern preoccupation, this experience of symbol as reality is a radical proposition.

Orthodoxy is not so much articulating itself as a response to the modern dilemma as taking stock of itself in the context of coming to terms with its conspicuous absence from the modern conversation and resultant transformation. If Orthodoxy has preserved a notion of spiritual reality largely forgotten in, and/or forbidden by, modernity, then this preservation may be less a result of Orthodoxy deliberately tying itself to an epistemological mast to resist the sirens of modernity than a providential accident of socio-political history. Orthodoxy struggled under captivity throughout the modern era. First, the Byzantine Empire, broken by Turkish invasion, was reduced to a desperate struggle for survival and city-state identity redefinition. Second, the Russian Church, broken by attempted extermination and ongoing violent oppression under the Communist regime, was reduced to its own desperate struggle for survival. Simply put, by lacking, for sociopolitical reasons, the necessary conditions, agency, and resources to engage the modern milieu, Orthodoxy remained, in many ways, cryogenically frozen throughout the modern era.

The radical epistemology of Orthodox wisdom that Schmemann (1973) applies to the question of transubstantiation applies equally to every facet of modern theological polarity, from the literalism versus metaphor debates over Scriptural interpretation to
interpretations of miraculous phenomena both past and present. This epistemology, having not engaged the modern era where we would rather learn “about” things than “of” them (another epistemological distinction that Schmemann draws) is best experienced in the liturgical life of the Orthodox Church, and, for many members of the Orthodox community, may not be understood in formal epistemological terms, but simply received as a child receives language without yet having learned grammar.\(^6\)

Now that Orthodoxy is entering into the modern theological conversation, one of its challenges is finding its voice as distinct from what Florovsky (1979) and others decry as a Western theological captivity, wherein the brightest Orthodox minds receive their scholarly training at one or another modern Catholic or Protestant institution of theological scholarship, and then, unwittingly read foreign Western scholastic and systematic paradigms back in to the therapeutic healing tradition of Eastern Orthodoxy. Louth (1983) introduced fellow Patristics scholar, Behr’s (2001) volume as the most promising twenty-first-century example of the living Orthodox tradition, incarnating the theological flesh of Christ the eternal Word as experienced in the Orthodoxy. In the years following this first of two seminal volumes on the evolution of early Christian

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\(^6\) For example, while many of the Orthodox faithful may not be in dialogue with either Caputo’s “weak theology” of the cross or the “strong theology” of modern Evangelical Protestant apologetics that preceded and elicited it, they would still be drinking spiritual water from the same well of life that Caputo struck in his philosophical endeavors as evidenced by these weak theological words from the Orthodox daily hymnographic readings on the day of this writing:

Kontakion in the Third Tone:

To the wise Eulampius and brave Eulampia with him, to those siblings in the flesh and Martyrs valiant in courage, we now offer praise and honour, for with the power of Him that dies on the Cross, they have shamed and vanquished all the tyrants’ schemes; for they are the Martyrs’ glory and their rejoicing and boast.
experience and thought, Behr was subsequently ordained to the priesthood and moved up the professorial ranks to Dean of St. Vladimir’s Orthodox Theological Seminary, the most prominent Orthodox school of theology in the U.S., where Schmemann (1973) had also served as Dean. In *The Mystery of Christ: Life in Death*, Behr (2006) gives voice to a Christian theology potentially well-suited to Bishop’s (2011) hopes above (for theology to inform medicine) in that it is not rooted in the epistemological paradigm that plagues both modern medicine and modern theology. Presenting historic Orthodox Christianity as a “premodern faith for a postmodern era,” Behr offers a cogent articulation of the formation and essence of Christian theology that grants Ehrman’s (1996) observations of Christian origins and addresses Caputo’s critique of strength by locating divine revelation in mystical experience guided by subjective interpretation and demonstrating how all Christian dogma is rooted in the weakness of the cross as an interpretative lens for reality.7

7 Behr’s effort to rescue Christian origins from modern certainty and recreate a space for genuine Orthodox faith is epistemologically consonant with the apophatic aspect of Orthodox theology that envisions all words of dogma and prayer as steps up a ladder that must ultimately be unsaid as the ladder is traversed both up the path of words and down the path of renouncing all human logic as anything prescriptive of the divine which can only be known through unknowing. St. Isaac the Syrian imparts an Orthodox understanding of the epistemological weakness and unknowing proper to divine knowledge:

Do you see how the fathers interchange appellations for spiritual things? For the exactitude of designations holds valid for things here, while there is no perfect or true name whatever for things of the age to come, but a simple [state of] knowing only, surpassing every appellation, every rudimentary element, form, color, shape, and compound name. For this reason once the soul’s knowledge is raised out of the visible world, the fathers employ whatever appellations they please to indicate that [state of] knowing, since no one knows its name with exactness. But to make the soul’s deliberations steadfast therein, the fathers resort to appellations and parables, according to Saint Dionysius, who writes: ‘We use parables, and syllables, and permissible names, and words, on account of our senses; but when our soul is moved by the operation of the Spirit toward those divine things, then both our senses and their operations are superfluous when the soul has become like unto the Godhead by an incomprehensible union, and is illumined in her movements by the ray of the sublime Light….

….Then the understanding does not pray with prayer, but it gazes in ecstasy at incomprehensible things that lie beyond this mortal world, and it is silenced by its ignorance of all that is found there. This is the unknowing that is inseparable from prayer,’ of which may we be deemed worthy by the grace of the only-
The Gospel According to Luke begins with a statement from the author that, while others have already written about the events concerning Jesus, his eyewitness experience enables him to render an accurate/orderly account. Through a close reading of Luke:24, introduced above in Chapter Two, Behr (2006) shows how the Lukan account offers an interpretive lens for narrating an Orthodox approach to Christian origins and an Orthodox understanding of divine revelation. In Luke 24, two disciples meet the Risen Christ on the road to Emmaus. Dejected by the crucifixion of their hoped-for messiah, the disciples do not recognize Jesus when they encounter him on the road. When he inquired into their conversation, they scolded him for not knowing about Jesus who they had hoped would “redeem Israel” and how he was tragically given up by their leaders to the Roman authorities and crucified. Jesus proceeds to demonstrate to them, not through any objective evidence of his scientific law-rebuffing miraculous resurrection, but through a subjective interpretation of the Hebrew Scriptures, how the Law, the Psalms, and the Prophets showed that it was “necessary that the Christ should suffer” (as cited in Behr, 2006).

In other words, Jesus uses the Scriptures they are already reading to make an interpretive case to the disciples that the sort of redemption for Israel that they were hoping for, and grieving the loss of, was different in form and content from the redemption that he brings, accomplishes, and offers. While they were hoping for a political messiah to deliver them from the Roman yoke, as Moses had delivered the people from Pharaoh—in which case the crucifixion could only be interpreted as a sad

begotten Son of God, to Whom be all glory, honor, and worship, now, and always, and unto the ages of ages. Amen. (St. Isaac, p. 241, 245).
defeat and loss of hope for power over their circumstances—Jesus has a different purpose. The same Scriptural context in which they are interpreting his crucifixion as failure is reinterpreted to show the power of powerlessness, how crucifixion can be something other than failure in a bid for power over the Romans, how it was “necessary that the [weak] Christ should suffer in order to enter in to his glory.” By reinterpreting to them the Scripture, Christ reinterprets their entire context. His unexpected solution reconstitutes their interpretive matrix for reality by revealing a deeper, previously unacknowledged problem. The necessity of his suffering reveals to them that their real problem is not political repression by the Romans requiring the strong forces of violent restitution. Rather, their real problem is their own sin: their pollution of the matter, the flesh he entrusted them to steward through their voluntary corruption, their violence against the gift of existence, their unsustainable efforts to construct a false identity around a delusional notion of existence separate from their subsistence on divine love (Behr, 2006).

How could such a radical reinterpretation on the road to Emmaus have occurred? Which Hebrew Scriptures did Jesus use to show how it was necessary that the Christ should suffer, and how did they connect this necessity to a relocation of their primary problems as spiritually internal rather than politically external? The Scriptural texts revealing the surprising spiritual power of the otherwise powerless, crucified messiah are numerous; Behr directs our attention to a passage of the “suffering servant” from the prophecy of Isaiah:
Behold, my servant shall prosper, he shall be exalted and lifted up, and shall be very high. As many were astonished at him—his appearance was so marred, beyond human semblance, and his form beyond that of the sons of men—
So shall he startle many nations; kings shall shut their mouths because of him; for that which has not been told them they shall see, and that which they have not heard they shall understand…. He was despised and rejected by men… and we esteemed him not. Surely he has borne our griefs and carried our sorrows; yet we esteemed him stricken, smitten by God, and afflicted. But he was wounded for our transgressions, he was bruised for our iniquities; upon him was the chastisement that made us whole, and with his stripes we are healed. All we like sheep have gone astray; we have turned everyone to his own way; and the LORD has laid on him the iniquity of us all. He was oppressed, and he was afflicted, yet he opened not his mouth; like a lamb that is led to the slaughter, and like a sheep that before its shearers is dumb, so he opened not his mouth. (portions of Isaiah 52 and 53)

Having subjectively re-interpreted for them first his true identity as a glorified, weak Messiah rather than a failed, strong Messiah, and second, their unanticipated spiritual reality illumined in light of his surprising identity, still without being recognized by them on this road to Emmaus, Christ accepts their invitation to join them for dinner, and their encounter ends: “When he was at table with them, he took the bread and blessed, and broke it, and gave it to them. And their eyes were opened and they recognized him; and he vanished out of their sight. They said to each other, ‘Did not our hearts burn within us
while he talked to us on the road while he opened to us the scriptures?’” (Luke 24:30-32, as cited in Behr, 2006). Let us briefly explore two aspects about this encounter with Christ.

First, it was not until he broke the bread and gave it to them that they recognized him. This pattern of searching the scriptures for the risen Christ and encountering him in the breaking of bread continues in the liturgical tradition of the Church to this day. Interpretation is not enough; to recognize the Christ who we hear guiding our reading in such a way that reinterprets our reality and convicts us of our true condition, we cannot remain on the sidelines as mere external observers. Rather, would-be disciples must not only be willing to hear Christ’s reinterpretation of the truth of our situation, but also to eat it. Christianity is voluntaristic; we must not only ponder Christ’s reinterpretation of reality, we must personally ingest it. Only by opening our mouths and hearts to be fed by the true Manna from heaven and healed by the Eucharistic salve can we begin to see with the eyes of faith the presence of Christ in our midst. By inviting Christ into our inner being, we can see how his radical reframing of external reality applies to our personal, internal reality. Only by swallowing Christ’s re-framing of our self-understanding can we then see God, others, and the world in a new light (Behr, 2006).

Second, when the disciples finally recognize the risen Christ in the breaking of bread, this recognition does not follow the patterns of emphasis common to modern Christian apologetics. By disappearing from sight immediately upon being recognized, Christ does not seem overly focused on emphasizing his capability of breaking the laws of silence. Similarly, for the disciples, not only do they not recognize anything
scientifically miraculous for the entirety of the encounter until the final instant, but even after recognizing the risen Christ, it is not the scientifically miraculous nature of his resurrection that captures them. Instead it is his reinterpretation of both his newly-revealed identity and their-newly revealed reality that moves them as they reflect on the encounter: “Did not our hearts burn within us…while he opened to us the scriptures?” (Luke 24: 32, as cited in Behr, 2006).

The purpose of taking such great pains to make this simple observation must not be either overlooked or misinterpreted. Following the epistemological method of science and its objective approach to knowing, modern Christianity too often interprets Christian origins with the same false either-or hermeneutic that Schmemann (1973) challenged in the debates over transubstantiation. Just as the Eucharist must either be, according to the scientific pattern of knowledge, objectively transubstantiated flesh and blood or merely a symbol, the resurrection of Christ is either an objective scientific miracle about which we may conjecture and build a case (and subsequent army of strong forces), or merely a metaphor. In contrast to modernity’s tree of objective knowledge which leads us out of paradise, the crucified Christ hangs on the cruciform tree of life. The miraculousness of his self-offering does not bow to modernity’s methods of knowledge aimed at efficient manipulation of matter for the purpose of human control: as soon as we recognize him, he disappears from our sight. When we are met on our road to Emmaus and guided to hear a reinterpretation of the text or our lives, and ingest the self-interpreting symbol, we taste and see the unmitigated divine reality with whom we have intercourse, and as the vision
then vanishes from our sight, we are redirected back to the voice of the One who spoke to
us on this path that led us to this unexpected experience of His presence (Behr, 2006).

This observation is not made to deny either the miraculous nature of divine
revelation or to suggest that it is anyone other than the Risen Christ who opens the
Scriptures to guide our reinterpretation of reality. Rather, this observation is made to re-
establish the content of revelation in the divine reality that it reveals rather than in the
mundane processes that it may transcend. The purpose of the cross is not so much to
shed light on the miraculous nature of the resurrection as the purpose of the resurrection
is to shed light on the miraculous nature of the cross. Likewise, the content of Scriptural
revelations such as the one to Moses at the burning bush is not that a bush was burning
per se, but the reality and meaning of what happened between God and Moses at the
burning bush. If it were the other way around, if the purpose of the cross was to reveal
something more powerful, more manipulable, more subject to our verification and
control, then that graven image, so revealed, would not be capable of mediating divine
reality because, as an object subject to our control, it would no longer be capable of
calling us outside of ourselves. As Caputo (1996) states: “For a call, to be is to be heard;
esse est audiri. Indeed, I would go further and say that it is a condition of our hearing it
that we cannot identify it further. The confession that we cannot identify it is constitutive
of it” (p. 97). This is why as soon as they recognized him on the road to Emmaus, he
disappeared from their sight. If he had submitted to a DNA test, “we would have begun
to master [Him] and make [Him] our own and put ourselves back in the nominative. We
would no longer be in the accusative, put on the spot, de-posed by what [He] poses to us. We would…own it entirely” (Caputo, 1996, p. 97).

We…who have been called forth from the turmoil and the abyss, drawn from the deep, we who are an abyss and a question to ourselves, we who are made of such uncertain and unstable stuff, are in no position to locate its source or identify it. Abyss calls to abyss. The call calls from I know not where, from the deep, like a wind rustling above the waters, like the rush of the ruach Elohim sweeping across the darkness of the deep, like another breeze blowing out of Paradise. The question, my friend, is blowing in the wind, in the cross-currents of these winds out of Paradise. (Caputo, 1996, p. 97)

For Behr (2001), the question blowing in the cross-currents of these winds of out of Paradise is Christ’s question, “Who do you say that I am?”, posed to those eating from the tree of knowledge by one hanging on the tree of life. While this Christ is named, this naming is (randomly? Let’s call our dog “dog.”)functional rather than transcriptional, and this reality is evident in the fact that Christ the Word who poses this question in the Gospel narrative is presented in Orthodox poetics as a trans-historical image, having weaved on the cross (at the age of 33) the flesh he would take from his Mother as a fetus in the womb: “the Word of God, being fleshless, put on the holy flesh from the holy Virgin, as a bridegroom a garment, having woven it for himself in the sufferings of the Cross, so that having mixed our mortal body with his own power, and having mingled the corruptible into the incorruptible, and the weak with the strong, he might save perishing man” (Hippolytus, as cited in Behr, 2006, p. 137). As St. Gregory of Palamas is famous
within Orthodoxy for saying “If God exists, I do not; If I exist, God does not.” Christ’s question is not posed in any way that presents a “being” for us to examine but rather an image of a Word that calls, and a call to which we must respond. As Caputo reminds us, it is not our verification but our response that is the “first and only testimony to the call” (Caputo, 1996, p. 97).

The response to the call heard by the Orthodox tradition, as Behr (2006) shows, is, again, a response to a call emanating from the weak force of one impaled on a cross. Behr points out that for the first four centuries of Christianity, the resurrection was not celebrated separately from the crucifixion. Likewise, early Christian art depicting the risen Christ depicted him crucified, upright, with his eyes wide open, as, in St. Gregory’s words, “God revealed through the cross” (Behr, 2006, p. 37). Even now in Orthodox liturgical celebration of the resurrection, the hymn that we sing, “Christ is risen from the dead, trampling down death by death,” refers us not to any objective certainty revealed through the scientifically miraculous nature of the resurrection but, rather, back to the spiritually miraculous nature of the power of powerlessness revealed on the cross, the power of divine love to conquer through the weakness of voluntary suffering and death the frailty that results from the unsustainable nature of human corruption. The weak force of the cross constitutes the beginning and end of all Christian reflection, serving as the exegetical key to the meaning of both the text of Scripture, and the text of human existence:

By his most human action, an action which expresses all the weakness and impotence of our created nature, Christ shows himself to be God. The profundity
of this puts one at a loss for words. The transforming power of God is demonstrated through the death of Christ: not simply his death, by being put to death, but by his voluntary death…. This is the “mystery of the Lord,” as [2nd century writer] Melito put it, that the angel already beheld in the blood of the lamb slain at the Exodus. This is also, in Paul’s words, the “image of the invisible God (Col 1:15). It is, moreover, in the one who has reconciled all to himself, “making peace by the blood of his Cross,” that “all the fullness of God was pleased to dwell” (Col 1:19-20). As such… Those who stand in this tradition must follow the apostle Paul in refusing to know anything else apart from Christ and him crucified. Theology…begins by reflecting on the Passion of Christ, contemplating there the transforming power of the eternal, timeless God. (Behr, 2006, pp. 32-33)

As we learned from Caputo (1996), any inkling of objective knowledge of the divine caller is dangerous because it puts us in the accusative and gives us the delusion of ownership and control over the divine-human encounter. For Orthodoxy, this revelatory experience of divine love posits us not as the accusing (agent), but rather, as the accused. Only through this complete reversal of the modern epistemological paradigm can we discover any true knowledge of a God worth knowing and being known by, a God who does not fit under modernity’s microscope:

The transforming vision that the encounter with Christ effects with respect to the comprehension of the Scriptures effects a similar transformation in our own lives. Before the encounter with the Christ proclaimed according to the Scriptures, we
do not understand how we are sinful, nor even that we are sinful. We might know that we have some problems, but we usually think we can overcome them, should we want to (through the means offered us by various therapies and counseling, should we need them). Also clear to us is that the world is beset by problems; but if we are honest, we would probably say that, if only everyone were to agree with us, most of these problems would be resolved. That we are sinful, broken, and subject to death, to the very core of our being, is something that we can only begin to comprehend in the light of Christ, a light which simultaneously forgives, redeems, and recreates (Papanikolaou & Prodromou, 2008, p. 84)

For the Orthodox tradition, the response to the crucified Christ’s weak call is the response of a bride to her bridegroom, and the Eucharist is the consummation of the divine-human union of the caller and the called. This mystical union with divine love is the paradigm to which human eros points: “Love itself, the same capacity which manifests itself in impassioned physical love, should be directed towards the Lord: ‘Lucky is the one who loves and longs for God as a smitten Lover does for his beloved.’ Stated more generally by St. John Climacus, ‘Physical love (eros) can be a paradigm of the longing for God” (as cited in Behr, 2006, p. 165). It may seem, and certainly is, counterintuitive to characterize an encounter in which we stand accused as an erotic experience. However, the miraculous nature of this encounter is that this experience of standing accused is not one of having a admonishing finger shaken in our face, but rather one of the profoundly compassionate, empathic care of divine love which shines on us, purifying and illumining us. This revelatory light of Christ’s love not only reveals our
brokenness, but also “simultaneously forgives, redeems, and recreates” us (Papanikolaou & Prodromou, 2008, p. 84). While it is indeed, on some level, terrifying to open ourselves up to, the experience of being simultaneously unmasked and accepted is like no other (according to those who have been and/or are being transformed by it). From the standpoint of this transformative encounter, we can then re-narrate our personal history, the story of our lives:

The “self” that we are is constituted by all the various experiences that we have had, told from the vantage point of the present, and the past acting in the present—in ways of which we are largely unaware, and to which we are subject unknowingly and involuntarily. But an encounter with Christ provides a new, yet eternal, vantage point from which to narrate one’s own past: we are invited to see our own past retold as nothing less than our own “salvation history.” In this nothing is left aside or glossed over as being too shameful or painful, something that we would preferably forget, but which, even as “forgotten,” continues to act negatively in the present. Rather, just as in and through that which is all-too-human—death—Christ shows himself to be God, so also in and through our sinfulness and brokenness we come to know the transforming and loving power of God; not that we should thereby sin some more, as Paul warns (Rom 6:1-2), but to see ever more clearly how deep our brokenness extends. “It is,” St Isaac of Syria affirmed, “a spiritual gift of God to be able to perceive one’s own sins.” Indeed, he claims, “the one who is conscious of his sins is greater than the one who profits the world by the sight of his countenance. The one who sighs over his soul for
but one hour is greater than the one who raises the dead by his prayer while dwelling among human beings. The one who is deemed worthy to see himself is greater than the one who is deemed worth to see the angels, for the latter has communion through his bodily eyes, but the former through the eyes of his soul.”

To plumb the depth of our [polluted] condition is to scale the heights of divine love. (as cited in Papanikolaou, 2008, p. 85)

In contrast to the often objectivizing paradigm of modern medicine, the healing encounter with divine love is one of holistic, tender intimacy. According to Lossky (1978), the creator of the universe who has everything, voluntarily renounces divine omnipotence out of respect for the freedom of human will. As a naked powerless beggar to the human soul (Lossky, 1978, p. 73), God seeks to subjectively woo humanity by offering himself fully, weakly, and vulnerably in a romantic proposal to re-infuse the garden of human flesh, and through it, the cosmos, with the free gift of immortality through intercourse with divine love.

The Orthodox icon bearing the title “bridegroom” (Figure 4 below) depicts Christ’s romantic proposal as bridegroom to the human soul as perhaps the most abjectly suffering image of all existing iconographic representations of Christ. The Bridegroom icon is revered during the Bridegroom matins services of Holy Week in Orthodox Churches with hymnography urging the soul to prepare itself for, and open itself to, the heavenly bridegroom. In the Bridegroom icon, Christ is always depicted wearing a crown of thorns. The icon is commonly tagged with the description “extreme humility”, and the original Greek inscriptions on the icon are “O Nymphios,” or “the nymph,” which
we recognize as the root for our popular term nymphomaniac. In the Orthodox tradition, Christ, the Word, is a powerless beggar-nymph with a proposal to make a garden out of the human soul and through it, the cosmos. Christ the bridegroom embraces the extreme humility of human suffering to woo the soul in weakness, sacrificing divine omnipotence for the possibility of genuine love. Far from any naively airtight system of a just world, Orthodox theology hears the call of a weak messiah come as a beggar-nymph to an unjust world. This does not mean that the Orthodox do not fear judgment. Judgment is indeed feared, but the judge Orthodoxy fears is not a superpower embroiled in anger and wrath at people who must be much more explicitly evil than I am. Rather, the judge for Orthodoxy is a heavenly bridegroom calling all to a mystical union with divine love that we foolishly and delusionally reject to our own peril as we cut ourselves off from the source of life, choosing instead the unsustainable path of our own rebellious knowledge.

Figure 4. O Nymphios (The bridegroom). (Photo by author).
From the perspective of the divine encounter described above by Behr as the ultimate human experience, one may wonder whether health and certainty are either more or less conducive to this revelation than suffering and uncertainty. In discussing the ambivalence of health and illness, Larchet (2002) argues that health, while inherently good and to be hoped for by and for all, can in fact be, or function as, evil for a man if it “keeps him away from God by giving him the false impression that he is self-sufficient, and bestows on him that strength of the flesh which actually weakens, rather than giving him that weakness in which God reveals himself, which constitutes true strength” (Larchet, 2002, p. 55). Larchet’s emphasis on the strength of weakness recalls Caputo’s accent on the power of powerlessness, and Larchet manages to invoke divine Providence in a manner that allows room for this paradox. Illness and suffering, while categorically evil and against the will of God (Larchet, 2002), and certainly “not caused by God, can [still] become a part of his divine Providence” (Larchet, 2002, p. 49).

Hart (2005) similarly distinguishes between Providence and determinism or universal teleology by showing that unlike a deterministic view that assumes divine affirmation of evil for some greater purpose, an Orthodox notion of Providence instead sees divine grace active in redeeming evil that occurs as a result of human freedom. Most importantly, Hart emphasizes that God’s relationship to the reality, causes and consequences of suffering is made clear through the person of Christ: “Sin he forgives, suffering he heals, evil he casts out, and death he conquers. And absolutely nowhere does Christ act as if any of these things are part of the eternal work or purposes of God” (Hart, 2005, p. 87). Criticizing the common failure of advocates and detractors of
Providence to see how God, in his transcendence, can make room for real human freedom without being compromised, Hart invokes Caputo’s (1996) notion of God as a call, calling God’s “will” the “creative power that makes all things to be and the consummate happiness to which all things are called.” Hart argues that this “does not (indeed, must not) mean that everything that happens is merely a direct expression of God’s desire for his creatures or an essential stage within the divine plan for history” (2005, p. 97-98).

Lossky’s (1978) conception of divine omnipotence agrees with Hart’s (2005) insistence on a space for reconciliation with real human freedom. For Lossky, far from a threat to the power of divine omnipotence, real human freedom is a sign of true innovation proper to omnipotent creativity. Caputo’s (1996) risk of creation “must, paradoxically, register its presence at the very height of omnipotence. Creation, truly to ‘innovate,’ creates ‘the other,’ that is to say, a personal being capable of refusing Him Who created him” (Lossky, p. 73). Filling Caputo’s prescription 28 years before it was issued, Lossky contends that the “peak of all-powerfulness is thus received as a powerlessness of God.” The opposite of Tolkein’s elves who must sacrifice immortality to wed a mortal, the crucified messiah is a powerless caller who nevertheless proposes nothing short of unmitigated union with divine immortality. Quoting St. Basil as recorded by St. Gregory of Nazianzus, “God created man like an animal who has received the order to become God,” Lossky insists that to respond to this call, humans must be free to resist it:

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8 Caputo’s book was published in 2006, Lossky’s in 1978.
God becomes powerless before human freedom; He cannot violate it since it flows from His own omnipotence. Certainly man was created by the will of God alone; but he cannot be deified by it alone. A single will for creation, but two for deification. A single will to raise up the image, but two to make the image into a likeness. The love of God for man is so great that it cannot constrain; for there is no love without respect. Divine will always will submit itself to gropings, to detours, even to revolts of human will to bring it to a free consent: of such is divine providence, and the classical image of the pedagogue must seem feeble indeed to anyone who has felt God as a beggar of love waiting at the soul’s door without ever daring to force it. (Lossky, 1978, p. 73)

Returning to Larchet, as Scripture teaches, Christ “works all things together for good,” not by causing or justifying the evil of suffering, but by “granting to the afflicted person the power to use the suffering he experiences for his own spiritual good” (Larchet, 2002, p. 49).

In one sense, uncertainty and suffering are, for Orthodoxy, inherently tragic manifestations of the chaos humans create in our constant efforts to find ourselves outside of God’s love for us. In another sense, it could be said that, for Orthodoxy, uncertainty and suffering are, while never divinely inflicted, potentially auspicious fulcrums of our existence that can be leveraged to propel a search leading to a divine encounter. In perhaps an even more profound sense, however, it could be said that the human conditions of uncertainty and suffering are, as we have seen from the previous discussion of Christian origins, constituent of the crucible from which Orthodox faith has
been formed from the beginning and continues to germinate and grow. Uncertainty and suffering are usually not erased by strong forces of unquestionably verifiable certainty and instantaneous utopian ease. Orthodoxy survives as a needed reminder that, the myth of modernity notwithstanding, neither was this the case for the origins of Christian faith.

Much like the rest of humanity, the first Christians were immersed in a context rife with uncertainty and suffering. Having suffered the loss of whom they thought was a promising political leader and stood on the precipice of joining him in his fate, the journey leading to Christian faith was rife with perplexingly curious interpretation and reinterpretation for the first disciples. And the hard truth of revelation, far from self-evident, had to first be swallowed before it could be fully recognized. Even the Eureka moment of Christian revelation proved rather uncertain from the vantage point of modern verifiability. In the same instant that it occurred, the moment of clarity simultaneously dissolved while somehow still beckoning the disciples’ resolute journey down a road of continued, and, indeed heightened, but somehow miraculously transfigured, uncertainty and suffering. The same political messiah who they, in fear for their lives, denied having ever known as he suffered on the cross, revealed himself worthy of a loyalty which ultimately led them to joyfully volunteer for a similar fate, with the majority suffering upside-down crucifixion in their martyrdom.

In perhaps the most profound sense for Orthodoxy, the human conditions of uncertainty and suffering are the very conditions that God voluntarily subjects himself to and also the conditions in and through which he reveals himself. In proclaiming that the one crucified on the cross is “homo ousiwn twν patr i” or “one in essence with the Father”
the Nicene Creed established for the Orthodox faith the notion that, while God remains unknowable in his essence, what can be known of his energies is seen in the cross of Christ. Indeed, as previously referenced, Behr quotes early Christian references to the “God revealed on the cross.”

The notion that God would subject himself to (and reveal himself in and through) the most seemingly powerless human conditions of uncertainty and suffering is paradoxically against the grain of human experience. The human truism that “power corrupts and absolute power corrupts absolutely” conveys a quite different image than the voluntary renunciation of power conveyed by the cross. The wisdom regarding uncertainty and suffering offered by the God revealed upon the cross is not delivered from a throne positioned powerfully ex cathedra on some privileged perch remote from the human condition. On the contrary, the word of wisdom spoken to human uncertainty and suffering by the God of the Orthodox faith is nothing other than Christ himself, the “Word of God,” the powerless “power and wisdom of God.” In contrast to the powers of this world, the Christ, the Word, power and wisdom of God reveals a divinity who voluntarily renounces the strong forces of manipulation and control, embraces weakness and vulnerability, grants total freedom and weakly woos his beloved creatures from a position of ultimate vulnerability, calling out as an impaled victim of our predilections, priorities and preferences. As Behr (2006) points out, confessing the Christian faith is on some level a confession of complicity in the crucifixion of Christ.

Renouncing his position at the top of the food chain, God does not express power by consuming the weak but instead embraces weakness, grants to humanity the power of
freedom to accept or reject his love, and upon being rejected and subjected to horrible suffering at the hands of his captors, destroys the consequences of their actions against the sustainability of their own flesh/matter, and reconfigures it, (flesh/matter) from the inside out, as a healing medium of divine love and, therefore, the sustainable stuff of immorality.

The unfathomably personal gift of healing that Christ offers humans facing the uncertainty and suffering inherent in human illness transfigures, and simultaneously remains conversant with human notions of medically granted healing. Larchet (2002) emphasizes the mystical reality of Orthodoxy’s insistence on Christ as the physician of both our souls and our bodies by which medically granted healings are revealed to be “signs, tokens of deeper and fuller healing brought about by Christ” (p. 125). Quoting St. Basil, Larchet describes medical healing as “a figure of the care that we owe our souls” (Larchet, 2002, p. 125). How does Orthodoxy provision for this “care that we owe our souls” which is inseparable from bodily care and holistic wellbeing that can transcend or at least transfigure experiences of uncertainty and suffering?

While being washed in the purifying waters of Baptism and anointed with the illuminating oil of Holy Chrism profoundly initiates Orthodox Christians into a community of those seeking to be healed by the love of the Great Physician, the ongoing “care that we owe our souls,” which we hope will culminate in the mystical union of “unknowing” described above, is provided in the spiritual hospital of the Church. Among the many communal services and texts of personal prayer provided by the Church, the two main sacraments are the Eucharist and Confession. For some, the very
words “Sacrament, Eucharist and Confession” connote a legalistic mindset conjuring up unsavory notions of guilt and small-minded questions of validity. For Orthodox theology, however, “Sacrament,” is not a legalistic transaction that “you had better” do with regularity to escape guilt and that the “priest had better” perform correctly to ensure validity. Sacrament is a translation of the Greek word, “mysterion,” and for Orthodox theology, sacrament retains its mystical identity. Far from legalistic transactions, Sacraments, for Orthodox theology, are sacred mysteries of integrative spiritual healing.

The Orthodox notion of the mystical reality of the sacraments is illustrated in Schmemann’s (1973) above discussion of the Eucharist that rescues it from modernity’s false juxtaposition of the real against the merely symbolic. Served in the main communal gathering of the Church known as the Divine Liturgy (literally translated “the work of the people”), the Eucharist is the consummation of the communal spiritual work where Christ the Word is read, proclaimed, hymned, entreated, paraded, and, ultimately, consumed. As a journey to this mystical encounter, the Divine Liturgy has been referred to as a “Road to Emmaus” where participants individually and communally seek to encounter Christ so as to recognize him in the breaking of bread as his disciples did in the account from Luke: 24. If the Eucharist is the ultimate consummation of this healing mystical union, then, on the medical level, Confession is the self-examination and spiritual self-diagnosis that opens one’s heart to an experience of the Eucharist as both a personalized prescription rather than a generic elixir. On the erotic level, Confession allows the Eucharist to become the loving consummation of a real relationship in which we open
ourselves up to the divine romance of being truly seen and known rather than a quasi-disembodied encounter.

Among the healing mysteries of Orthodoxy, Confession may be the most misperceived and underutilized. In Orthodox Confession, the confessant faces an icon of Christ, who alone can forgive sins, and the priest stands to the side as a “fellow sinner,” witness, and physical symbol of Christ’s forgiving presence. Far from a legalistic effort to live up to some arbitrary checklist of “dos and don’ts,” Confession is a profound opportunity for individuals to speak whatever may seem “unspeakable” about one’s experiences, longings, thoughts, or actions. This allows one to experience the healing balm of God’s co-suffering with, and forgiveness and unconditional love for, us right where we are, as well as His patient invitation to help us evolve on our journey of becoming truly human (Papanikolaou, 2008). How are the Orthodox sacraments of Confession and Eucharist relevant to medical contexts of uncertainty and suffering?

An Orthodox Physician’s Perspective

In Suffering and the Nature of Healing, Orthodox convert/layman and practicing physician, Daniel Hinshaw (2013) traces the role of Confession and Eucharist in medical contexts of suffering and uncertainty back to the early 12th century Pantocrator Xenon, a hospital connected to a monastery where confession played a vital part in the regimen of treatment for suffering patients. In “stark contrast to the fragmentation of care seen today,” patients were treated holistically as whole persons with the prevailing goal of physical cure complemented by a structurally evident awareness of and attention to what PI theory calls “intractable uncertainty” along with inescapable suffering, and human
mortality, and the indispensability of the human soul to true health and wellbeing both in this life and the next. The Eucharist was offered in Divine Liturgy served at least four days per week as an “integral component to the healing regimen.” Confession and prayers were the first treatments administered upon admission so that people would have the opportunity to unburden their souls which was viewed as the most vital dimension of both the good life and the good death, if and when it should come (Hinshaw, 2013). Why is Confession so vital to human flourishing in life rife with uncertainty and suffering?

Confession is a vital therapy in the human war against “passions” which can range from the classic vices to a broader notion of attachment characterizing anything to which we are so attached that it becomes a violation of the second of the Ten Commandments, “Thou shalt have no other gods before me.” Growth along the journey of struggling against the passions reveals levels of love-impeding attachment previously unimagined. The very name “passions” used to describe human attachments to false medication for the void that can only be filled by divine love raises the question: what are the relationships among 1) the “passions” understood here in a negative sense, 2) “passion” in the positive sense of whole-hearted commitment or excitement, 3) “passion” as understood erotically, 4) the crucifixion of Christ referred to as “The Passion,” 5) the obsolete definition of “passion” as suffering, and finally, 6) the modern medical re-characterization of passion’s root, “pathos” in medical “pathology?” By exploring the relationship between the “passions” that Confession is designed to assuage to the other meanings of the word “passion,” we may be in a better position to understand the relationship between Confession and human suffering as well as the importance of
Confession as a health-communication therapy vital to holistic health and human flourishing, the relationship of all of this to human freedom, and, finally, a better understanding of how this line of inquiry relates to the philosophical implications of modern medicine’s focus on “pathology.” Hinshaw’s (2013) reflection on the meaning(s) of (the) passion(s) will inform this inquiry.

How is it that the greatest act of divine healing and the most unsavory acts of human infirmity are both called by the name, “passion(s)?” What is it that both the “Passion” of the Great Physician and the “passions” of infirmed humanity have in common, and what does this have to do with the other meanings of the word? The word, “passion,” is rooted in the Greek word, “pathos,” the same root for the word “suffering.” Hinshaw (2013) makes note of the ancient meaning of passion relating to passivity and the evolution of the meaning of the word in the early Christian era, but he focuses on the later definition of pathos that came as a result of the Christian era, “that which is endured or experienced” (p. 231), and the even more recent re-definition of pathos that came about as a result of the modern medical era, “pathology, the study of disease” (p. 58). As a scholar of the early Christian writings, Behr (2004) explores the theological significance of the fact that the definition of pathos/suffering in the early centuries of Christianity was understood not in terms of “feeling” but rather “in terms of ‘passivity,’ being acted upon” (p. 227). How is it that both “The Passion” and “the passions” relate both to early notions of “passivity” and “being acted upon” as well as later notions of feeling and “that which is experienced or endured?”
The Passion of Christ has a complicatedly nuanced relationship with the notions of “feeling” and “being acted upon.” Early Christian theologians argued that the Christ could not have suffered. Modern exegetes took this to mean that Christ’s divinity was somehow separate from his humanity on the cross, allowing the Divine essence to escape the feeling of pain in the crucifixion of Jesus. Behr (2004) argues otherwise. For Behr (2004), the early contention that the Christ could not have suffered has a radically different meaning: Because the early Christian notion of suffering pertained not to the feeling of what is endured or experienced but rather to the passivity inherent in being acted upon, what the early theologians were contending by arguing that Christ did not suffer is precisely the opposite of the modern interpretation. By maintaining that the Christ could not be acted upon, early Christian writers were contending that Christ could not have suffered passivity and therefore, that the pain and anguish that God endured on the cross was not brought on against his will but rather endured voluntarily (Behr, 2004). While to an outside observer it may have appeared that Christ was involuntarily enslaved in His Passion, he was instead voluntarily suffering and, paradoxically, utterly free.

A related contemplation of “the passions” offers a yin to the yang of the above paradox. While it is not uncommon for us to think and speak in terms of having the “freedom” to indulge our vices, or as Orthodoxy would say, our passions, the spiritual writings of the ascetic mystics remind us that our perspective on freedom is wrong-headed and upside down. While seductively selling freedom like the serpent in the Garden of Eden and the cocaine dealer looking to score a profit, the passions reduce us to the level of an “involuntary bondsman” who is totally “enslaved to the passions” quite
“against his will” (Isaac, 2011, p. 277). While the crucified Christ impaled on the cross might be thought to have involuntarily sacrificed his freedom, He remains unable to suffer passivity and therefore utterly free to indulge his passion as he voluntarily suffers the pain of physical violence, emotional scorn, and the spiritual weight of taking on and shouldering all of humanity’s passions (this is hubris). Likewise, while a person indulging the vices or passions might be thought to be voluntarily exercising human freedom, he remains utterly enslaved against his will as an involuntary bondsman.

For the symbolic universe of Eastern Orthodoxy, then, there are, in a theological sense, only two paths in this life: “The Passion” or “the passions.” The modern notion of individual freedom is truly an illusion. Persons do not exist in isolation. The question is not whether to commit to some form of self-limiting or self-defining/freeing attachment, but to which attachment(s) the self will consciously or unconsciously become enslaved: “The Passion” or “the passions”? Life according “the passions” is involuntary enslavement: “For whoever would save his life will lose it” (Matthew 16:25a). Life according to “The Passion” is voluntary enslavement that brings true freedom: and whoever loses his life for my sake will find it” (Matthew 16:25b). Life according to “The Passion” is a “sacramental” life where through the spiritual mysteries including the above-explored Confession and Eucharist, we embrace the way of the cross that paradoxically turns out to be the choice of utter freedom:

Freedom of choice is a crucial aspect of the person for Christians, but only within a great paradox is it actually operational. For choice is only truly free in obedience to the Other—the way of the Cross. Fundamentally, Christians are
persons to the extent that they live in relationship with God. This relationship has at least three foundational characteristics that define and nurture the human aspect of the relationship.

1) Eucharistic—giving thanks to God;
2) Doxological—giving glory to God; and
3) Prayerful—cultivating the continual awareness of the Presence of God in all places, situations, and other persons. (Hinshaw, 2013, p. 54-55)

Initiation into the life of The Passion begins with the sacrament of Baptism. As Dr. Hinshaw puts it, “Baptism is the entrance of each Christian into the living and suffering Body of Christ through sacramental participation in his passion. Christians have already died with Christ in the mystery of baptism before their physical death” (Hinshaw, 2013, p. 242). According to St. Ignatius of Antioch, “Unless we willingly choose to die through him in his passion, his life is not in us” (as cited in Hinshaw, 2013, p. 242).

Dying with Christ in his Passion is not a glorification of suffering and death for suffering and death’s sake. Always an evil in and of themselves, suffering and death are embraced in the way of The Passion not as masochistic ends but as active, transformative means to realizing voluntary freedom. The alternative is passive, involuntary enslavement found in “the passions.” Hinshaw (2013) points out that, for Orthodoxy, “the passions” are understood in close connection to the Orthodox understanding of sin through the Greek word “hamartia.” Drawing upon the ancient notion of “missing the mark” understood in terms of a spear throw, Hinshaw (2013) distinguishes between a Western Christian emphasis on volitional notions of sin according to the legal paradigm
with an eye toward guilt, and the Eastern Orthodox understanding of sin in a “more ‘medical’ frame of reference—diagnosing what is wrong that requires healing with less immediate concern about establishing blame” (Hinshaw, 2013, p. 56). This distinction proves vital to the Orthodox understanding of Confession as a healing therapy for the often paradoxically counterintuitive working out of the relationship between various forms of attachment, medication and (dis)-ease.

Narcotic abuse and addiction are commonly referred to as “self-medication” and “false-medication.” While narcotic abuse, and even addiction, can provide temporary relief from deeper levels of emotional pain/dis-ease, the self-medication of narcotic abuse can eventually turn into addiction characterized by an involuntary enslavement to a false-medication. The underlying pain that self-medication through narcotics is attempting to treat often stems from tremendous suffering experienced in broken human relationships characterized by, to put it nicely, imperfect, impure, and conditional love. While the narcotics can serve to dull the pain resulting from the emotional suffering, involuntary enslavement to an addictive and destructive substance can simultaneously create new levels of emotional pain from a life deteriorating to theft and prostitution for some, and for others, simply mask the pain thereby making it harder to address and heal. This analogy serves as both a specific example of, and an imperfect analogy for, the understanding of the passions within the context of Orthodox Confession.

9 This analogy admittedly breaks down, as all analogies do, and is not meant to suggest or endorse a judgmental or totalizing perspective on illegal street drugs as “always bad” as opposed to legally prescribed drugs as “always good”…
First, it illustrates the Orthodox understanding of the sin confessed in Confession in medical terms focused on diagnosis and healing rather than legal terms focused on guilt and blame. Who bears the guilt and the blame for the drug addict? Is it the addict himself or his abusive father? If blame and guilt lie with the addict himself, is this conclusion a fair assessment of his life’s journey and an honest analysis from outsiders who assume they would perform differently under similar conditions? If blame and guilt lie with the abusive father, hat father has his own narrative, his own journey of suffering and pain that influenced his actions as well? The wrong questions always lead to unsatisfactory answers. For Orthodoxy, each journey is unique, and there is no magical matrix, checklist, or profile that constitutes anyone’s level of morality or holiness in comparison to anyone else. That humans are sinful does not mean, for Orthodoxy, that we are fundamentally evil as a result of inheriting the guilt of Adam’s “original sin” but that we are prone to gross error as a result of both the infirmity inherited from the symbolic reality mediated in the narrative of “Adam’s sin” and our own duplications of the same while still retaining the fundamental goodness as creatures called into being by a good and loving God. Far from wrong guesses on some divine sadistic multiple choice game of life, human falls into the passions are understood by Orthodoxy to be human distortions and misuses of the virtues characterized by perilous detachment from the source of good gifts and unhealthy attachments seen in and leading to poor stewardship of the gift(s) of life. While the Tree of Knowledge is humanity’s individualistic pursuit of going it alone, the cruciform Tree of Life on which “The Passion” is suffered is the divine destruction of death resulting from the unsustainability of human-ism, and the
Eucharist is offered back to dying humanity as the fruit of the journey back to paradise. Hinshaw quotes Orthodox hymnographer, Romanos the Melodist, mythologically personifying the domain of death as an entity destroyed by the voluntary self-offering of God on the Tree of Life. Death cries out:

‘My ministers and my powers, who has fixed a nail in my heart? A wooden lance has suddenly pierced me and I am being torn apart.

My insides are in pain, my belly is in agony, my senses make my spirit tremble, and I am compelled to disgorge Adam and Adam’s race. Given me by a Tree, a Tree is bringing them back again to Paradise.’ (Hinshaw, 2013, p. 58)

True to the finest point of Orthodox theology, this personification of death being “trampled down by death,” as Orthodox sing in Pashca, is embodied in every instance of diagnosis and healing of sin through Confession and Communion that constitutes the Sacramental life.

Second, the narcotics analogy sheds light on the infinitely multi-layered nature of Confession as a therapeutic modality. Standing before the icon of Christ with the priest as self-declared fellow-sinning brother, witness, and imperfect guide, one may confess the use of narcotics with some gut feeling that misses the mark of one’s ultimate calling,
purpose and destiny, while at the same time thinking that this narcotic use is a small blot on an otherwise happy, good life. Only after confessing the use of narcotics in sacramental Confession and consummating the forgiveness received through intercourse with divine love in the Eucharist does one start to feel the underlying pain that led to the narcotics abuse in the first place, locate other forms of attachment that serve as false medications of the same pain, slowly begin to metabolize the pain of broken relationships and tragically conditional love that characterize one’s life experience, and even over time, in some cases, begin to recognize one’s own unhealthy reactivity in response to, and/or complicity in, the very relational dynamics that constitute and perpetuate the source of pain and the need for medication. In contrast to the involuntary enslavement “the passions” characterized by an increasing addiction to destructive narcotics, the voluntary enslavement to “The Passion”—characterized by a spiritual journey of Confession and Eucharist, self-diagnosis of spiritual illness stemming from experiences of various forms of invariably conditional human love and the therapeutic healing of intercourse with divine, unconditional love—leads to a relationship with suffering that traverses down the path to true human freedom.

Both paths, “the passions” and “The Passion” paths remain rife with uncertainty and suffering; both paths have their highs and their lows. Contemplating the erotic definition and sense of the word “passion” referenced in our initial list above, it could be said that both paths include their own form of erotic passion. A recent article in GQ magazine surveyed the various emotional, productivity, sociological, and health outcomes of pornography and masturbation as compared to real relationships,
encouraging men to unplug from the screen, take that picture of their right hand out of their wallet, and ask a real woman out on a date. It might be said that one way of conceiving the difference between “the passions” and “The Passion” could be along the lines of the difference between masturbation and intercourse. Both allow for an erotic experience of passion. One holds out the possibility for a real relationship compared to which the other is exposed as a farcical experience of human freedom: “*For whoever would save his life will lose it, and whoever loses his life for my sake will find it.*” -- Matthew 16:25

Regarding the above definition of passion as “whole-hearted commitment and excitement,” the question posed by Orthodoxy is simple: “down which path of commitment and excitement will we traverse this moment and this day? Winston Churchill has been quoted as saying something to the effect of: “Democracy is the worst form of government…except for all the others that have been tried.” Whether or not this is true, an analogous statement could be made about the way of the cross. While, on the one hand, voluntarily dying to oneself and seeking from God an ever-increasing experience of the resurrected life may seem in some senses to be the worst form of existence imaginable, on the other hand, it could be said that taking up one’s cross is indeed the worst form of life…except for all the other forms of life that have been tried. To which Chesterton’s (1908) famous line could be added: “Orthodoxy has not so much been tried and found wanting, as it has been found difficult and left untried.”

As Hinshaw points out, the most recent historical evolution of pathos is seen in the modern medical notion of “pathology” as the study of disease. Rooted in the study of
“dis”-“ease,” or human suffering as its own “pathos-logic,” the study of modern medical “disease” known as pathology has morphed into a discipline where, as Hinshaw quotes Cassell: “‘Doctors pursue symptoms because of the belief that they are the direct manifestations of disease. Diseases are the “real” things—the things that count…Sick persons, as persons, are an agglomeration of “soft” data—feelings, emotions, values, and beliefs—in these terms, not as real as their diseases’” (Hinshaw, 2013, pp. 58-59). While the “pathos-logic” of any person’s “dis”-“ease” is experienced in the context of, cannot be separated from, and can on some level be a manifestation of, human relationships, modern medicine prefers the microscope and the CT scan to the more wide-angle diagnostic lenses needed to capture images of the personal reality of suffering persons. Reflecting on Cassell’s seminal work on “diagnosing suffering,” Hinshaw distinguishes between pain and suffering through his observation that the “emotional context in which the pain is experienced will often define the intensity of suffering” (2013, p. 60). He cites childbirth, for example, which while torturously painful, can, for some, constitute substantially less human suffering for that same woman than a much less painful form of physical harm or disease endured in, or resulting from, an emotional context in diametric opposition to the hope, optimism, and love of many expectant mothers. Unlike Cassell’s (2005) notion of suffering being centered in threats to individual intactness, Hinshaw explains that for Orthodoxy, suffering and healing are always centered in community and cannot be understood in terms other than through the self as constituted by, within, and through relationships (Hinshaw, 2013, p. 256). This distinction is vital to a fuller
understanding of the nature of Orthodox Confession as a therapeutic modality of health
communication.

From the mystical perspective of Orthodox spirituality, every person is a
microcosm of the entire cosmos, and all spiritual progress, no matter how seemingly
infinitesimal, has truly cosmic implications, both spiritual and physical, as the one is
inseparable from the other. Hinshaw (2013) connects this Orthodox spiritual reality to
the physical reality unveiled in Sulmasy’s analysis of recent developments in particle
physics and quantum mechanics:

[O]nce one arrives at the particle level, a fundamental rule emerges that is really
ture about everything, no matter how big or small, namely, that relationality is
ontologically prior to particularity, that the electromagnetic field is prior to
matter. That is to say that what matter, or anything else, is, at its most
fundamental level, is not a pile of unimaginably tiny bodies, but a set of
temporary yet dynamic relationships in the electromagnetic field that is already
given. (as cited in Hinshaw, p. 57).

Like matter, sin can only properly be understood in relational terms: “When hamartia
occurs, fundamental relationships that are woven into our material world, even perhaps at
the invisible level of subatomic particles, are disrupted” (Hinshaw, 2013, p. 57). Thus,
the individual passions manifest themselves most clearly in their impact on how they are
invisibly inseparable from human identity and thus how persons relate to each other.
Therefore the passions come to define the imperfections in all, especially the closest
human relationships as well as the relationship between the human body-soul microcosm
of the cosmos and the physical environment. “With this in mind, one can begin to understand the need for and the power of the Creator’s uniting himself to his creation in order to restore the right relationship, to bring healing to the cosmos” (Hinshaw, p. 57).

Confession, therefore, while deeply personal to the confessant, is far from an isolated instance of individual improvement and more of a cosmic event with the potential for levels of universal renewal and restoration. This is precisely why the Orthodox mystics who really want to change the world, and have succeeded in effecting the most meaningful change, often depart from the world into a desert of solitude engaged in a sustainability campaign for the one piece of the physical environment that they have been charged to most meaningfully serve as stewards of—their own bodies—and miraculously, through this seemingly individualistic effort, transform innumerable relationships, seen, indeed, not exhaustively, by their being pursued against their will, prevailed upon, and inescapably mobbed by disciples and supplicants seeking and receiving guidance and healing which embodies and is constituent of Christ’s transformative healing of the cosmos.

Because of the relational nature of reality, nature, humanity and sin, the impact of Orthodox Confession is even more powerfully manifested outside of the individual than the individual may perceive on the inside. As a reference point for this reflection, take the abusive father of the narcotics addict hypothesized above. Had this man engaged in Confession, perhaps he would have walked away thinking, “What an unsavory, embarrassing, waste of my time, I don’t feel any different now than I did before I confessed; in fact, I feel worse.” After leaving Confession with this feeling, however, he
had an encounter with his son that was on some level less perversely destructive than the tragedy that constituted their emotional relationship, and something about this somewhat purified experience of love gave the boy a glimmer of hope for a reality different than the one that normally constituted the nature of his relationship with his father. That glimmer of hope allowed for a changed trajectory for the young man resulting in a different possibility for his future. If the father continued to trade in his personal “passions” for a growing personal experience of unconditional love through the healing fruits of “The Passion,” he may in time receive some measure of healing from the most destructive element of abusive behavior that created the suffering in his son constitutive of the need for narcotics abuse rather than some good, healthy, non-addictive medical marijuana. If the reader can forgive a bit of light-hearted humor in service of a very serious point, this reflection may serve to illustrate how “Christ became a human person to enter into all human relationships and transform them.” Confession, then, can be understood to constitute the human entrance into the relationally, and indeed cosmically, transformative “labor pains” of voluntary death (Hinshaw, 2013, p. 57).

From this perspective, it can perhaps not unreasonably be asked, “if this hypothetical abusive father we are discussing presented in both a modern emergency room and the 12th century Pantocrator Xenon with fainting spells and shortness of breath, which therapeutic regimen would be most conducive to his individual healing and to the larger public health: the one from the hopelessly outmoded “dark ages,” in which confession would have been the first therapeutic modality administered, or the one from the “enlightenment” of modern medical progress? This question is not meant to provoke
a simple-minded competition between two quite valuable paradigms in their own right, or
to deny that there is much darkness to critique in every age and every person, community,
and organization, of which Orthodoxy and Orthodox persons and organizations are
certainly no exception, but rather to shed light on the potential value of Confession as at
least as complementary in contexts of uncertainty and suffering in the modern-medical
milieu.

Turning to modern medicine in a discussion of the tremendous therapeutic value
of the healing practices of patient journaling, biography, and life review, especially for
people with terminally illnesses, Hinshaw praises these practices as “secular cognates of
confession” (Hinshaw, 2013 p. 190). Hinshaw points out, however, that Orthodox
confession adds to such practices the dimension, and indeed, the focused purpose of
repentance which Orthodox believe carries the potential of bringing a deeper level of
healing. 10 This is not to say that the reality of what Confession is intended to be could
not be and is not often better realized by a patient’s instinctive focus repentance through
such modalities than in some instance involving an Orthodox priest and an Orthodox
patient where the formalities of Confession are attempted and much less substantive self-
diagnosis and, therefore, healing takes place. Hinshaw observed that patients often bring
the dimension of repentance to the practice of life review as well as discussions of pain
and its treatment, but the extent to which providers are willing and/or able to engage the
raw emotions and spiritual weight of patient repentance varies. For example, some

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patients who have committed heinous acts of violence and cruelty can experience high levels of pain as a welcome and purifying “just punishment” for their misdeeds, paradoxically reducing the “total pain” that constitutes their true, holistic suffering. But providers are often unable to witness this level of suffering and pain, and therefore, whether consciously or not, act less in the interest of the patient and more out of their own need to eliminate pain so that they do not have to witness the suffering. These contexts are, of course, more varied and nuanced than can possibly be explored here, but some brief clarification is warranted.

Acting out of their own need to eliminate pain, providers often dispute patient notions of God’s wrath and just retribution. While Orthodoxy agrees with the many clinicians insisting on the unconditionality of God’s love, and indeed it could be argued that Eastern Orthodoxy’s therapeutic framework could better articulate to physicians what is happening inside the confessing patient than the legal framework more common to the various forms of Western Christianity, Hinshaw (2013) does not allow questionable theology to function as an excuse for self-centered fulfillment of clinician emotional need at the expense of a patient’s holistic healing. Willing to engage the ambiguity of the gray area between his own self-centered terror in vicariously witnessing suffering and his God-given other-centered, good-willed desire to ameliorate the suffering of others, Hinshaw advocates a balanced, patient-centered pain treatment negotiation that allows for the possibility of degrees of unburdening from suffering that can paradoxically serve as much as a “friend” to some patients as it is an “enemy” to virtually all clinicians (Hinshaw, 2013, p. 130-131, 222-223).
Let us expand upon the above comparison between the 12th century *Pantocrator Xenon* where the abusive father would have received Confession as his first therapeutic modality upon admission, and the modern medical emergency room where the same father could be discovering some form of purifying confessionesque experience in his pain. In his attempt to articulate this these profundity to his doctor, his image of healing and *care*, he is argued out of his personal experience of spiritual reality and drugged into an oblivion by a physician who is unable and/or unwilling to co-suffer the paradoxical gift of his pain or care enough to witness the spiritual reality of his multi-layered suffering. What might be the comparative personal- and public-health outcomes of this “healing” encounter, this experience of humanistically enlightened “health care?” How might the healing balm of physical pain and the emotional release advocated by Hinshaw’s paradigm ultimately impact the physical health outcomes for this man’s son and others with whom both the father and the son relate? Even without mystical notions of spiritual connectivity, this missed opportunity may be rather significant given the interconnected web of human relationships that, constitutes a very small world often characterized in terms of “six degrees of separation.”

The nuances of Hinshaw’s distinction between life review and Confession, as well as his discussion of how this distinction can inform a truly patient-centered/negotiated form of balanced pain treatment, recall his notable affinity for, and considerable discussion and appropriation of, narrative medicine. Could Confession also offer a potential formational layer to the practice of narrative medicine, more broadly than the previously discussed intersection between life review and pain treatment? From an
Orthodox perspective, the answer to this question must be an unqualified “Yes.” There is no need to assume that this affirmation leads directly and exclusively to practical considerations of what a modern Pantocrator Xenon might look like, and how Orthodox sacramental Confession and Eucharist could feasibly be administered to patients from an American public uninitiated into Eastern Orthodoxy. It might suffice to continue to tease out the implications of the hypothetical father considered above in the context of Hinshaw’s observations of some clinicians’ low tolerance for patient suffering. Noting Cassell’s (2005) insistence that “Everyone has a secret life” and the reality that suffering can provoke, prevent, and/or be exacerbated by this secret existence (Hinshaw, 2013, p. 53), Hinshaw quoted narrative medicine pioneer Charon’s (2006) illuminating observation that, “Only in the telling is the suffering made evident” and observes among Charon’s list of narrative competencies the virtue of “tolerating uncertainty” (Hinshaw, 2013, pp. 99-100). Nowhere in Hinshaw’s description of Charon’s narrative medicine-training programs, however, is an indication of how clinicians are to cultivate within themselves an ability to go against the grain of the prevailing “ideology of uncertainty reduction” identified by Babrow and Kline (2000) in order to grow in the toleration of uncertainty and suffering required for Cassell’s diagnosis of suffering and Charon’s practice of narrative medicine.

If it is true that there are patients who desire repentance and purification so badly that they willingly embrace the purgative qualities of physical pain, and there are clinicians who have little tolerance for this process, then the question is not so much how to structure some kind of top-down system for whisking the abusive father into
Confession upon admission to the emergency room but rather how to form clinicians who are less likely to stand in the way of confessions that are already trying to happen. From the perspective of narrative medicine, the health communication question might be: “How can clinicians keep from getting in the way of, and even grow in serving as midwife to, the healing narrative of the abusive father who, having become ‘patient’ enough in distress to reflect on his story and take stock on how he treats his son, might be laboring to give birth to a profound healing experience if only he will be permitted to do so?” What can Orthodox wisdom offer to clinicians seeking to grow in the toleration of suffering and uncertainty correlative to the diagnosis of suffering and the practice of narrative medicine? Our effort to address this question will be clearer after first addressing why, from an Orthodox perspective, patients, whether Orthodox or not, desire and seek out opportunities for confession with their health-care providers. What is it about the process of suffering and the encounter with a symbolic healer that breaks down barriers of inhibition and naturally provokes attempts at and solicitations for confession?

Suffering provokes confession because suffering is confession or at least a form of, or powerful potential for, confession. Expanding upon Cassell’s (2005) connection between the diagnosis of suffering and the reality that everyone has a secret life, Hinshaw quotes victims of the extreme suffering of physical torture in the Romanian Gulag describing their suffering as a “spiritual privilege of great beauty” and “another path of confession” (p. 84). Reflecting on these revelatory statements, Hinshaw postulates that “[p]erhaps, when all of the props of our existence are pulled away, when all of our fond illusions about life are stripped from us, when we fully experience a true kenosis, the
substrate is exposed upon which real personal growth can occur” (Hinshaw, p. 84). Fr. Roman Braga looked back to his experience of torture in the Romanian Gulag with gratitude, declaring, “Bless you, prison!” because his suffering there afforded him his best opportunity to, as he put it, “know thyself” (as cited in Hinshaw, p. 84). Hinshaw reflects on this kind of suffering-induced self-knowledge as the spiritual epistemology proper to confession: “a sense of knowing everything is awakened in a person by that person’s considering the ways he (or she) has missed the mark whether by what was done or what was left undone (Hinshaw, 2013, p. 84-85).

By confessing, patients are not whimsically experimenting with some kind of thought exercise that is separate or removed from their suffering because they happen to have some extra time on their hands. Rather, confessing patients are simply giving voice to their story as understood through the lens of their suffering and seeking in clinicians the deepest level of health care which turns out to be a task as difficult as it is simple: a functional priesthood, the willingness to be present and give witness to the painful profundity of their unfolding narrative. Because suffering is, or at least can be, a confession that begs to be articulated in words, heard, and witnessed, narrative medicine may require a spiritual stance from clinicians that allows therapeutic confession narratives to unfold. Short of participating in sacramental Confession or embracing some level of ascetic suffering, Orthodox wisdom offers a recommendation mystically constitutive of both Confession and suffering and accessible to anyone of any belief or no belief, the spiritual directives which Hinshaw quotes and to which he on multiple occasions returns: “Remember your death!” and “Think daily on your death!” Quoting
Moshos, Hinshaw suggests that intellection can even function as a barrier to the more fundamental insight of contemplating mortality: “That you are skilled in the use of words I am fully aware, but I do testify to you that you are not truly lovers of wisdom…. Let the object of your philosophy be always to contemplate death, possessing yourselves in silence and tranquility” (Hinshaw, 2013, p. 252). Clinicians who regularly contemplate their own mortality may be less likely to shield themselves off from human suffering that naturally unfolds through the therapeutic health communication medium of confession.

According to Hinshaw, “[u]nderstanding this, living this understanding, can then be our kenosis, the stripping away of the ‘noise’ so that real silence—hesychia—can be experienced…. With this as a foundation, then we can really begin to listen” (Hinshaw, 2013, p. 251). The foundation for beginning to listen in a way that allows for the diagnosis of suffering and the emotional/mythical midwifery of narrative medicine requires a subjective stance toward uncertainty and suffering inescapably inherent in the willingness to voluntarily suffer the contemplation of one’s own mortality. This is the “cross” that Orthodox wisdom challenges health communicators to “take up” in their efforts to evolve on the journey of embodying health care in contexts of what PI theory calls “intractable uncertainty” and suffering.
CHAPTER NINE: THEOLOGICAL REFLECTION FOR THE ART OF HEALTH COMMUNICATION: HOW TO PRAY FOR THE IMPOSSIBLE?

The doctors have their opinion, but we know that God has the final word. We have our church, our town, and thousands more people across the country praying for a miraculous healing. Will you pray for him to be healed now?  

What follows is an exploration of my process of constructing a prayer for miraculous healing through what Doehring (2006) calls a trifocal lens, utilizing premodern, modern, and postmodern foci. It will become apparent that, while Doehring’s trifocal approach inspired and informed my process of struggling to pray for miracles, my appropriation of Doehring is not without criticism. Incorporating my critical purchase of Doehring’s trifocal lens, and some of the historical, philosophical, and theological issues at stake, into my story of learning how to pray for miracles requires the reader to join me in zooming in and out between the particularity of the prayer I am constructing and the breadth inherent in my attempt to sketch, in dialogue with Doehring, an approach to the three great epochs of human history as they bear on my struggle to provide pastoral care in this context.  

One of the things I learned in this process is that I am so intent on figuring things out that I do not allow myself to feel. Bear with me as I describe my personal struggle to figure out how to pray for the impossible, culminating in the moment when rigor gave way to a miraculously irrational decision catalyzed by feelings of sadness and desire.

11 Quoted from my personal conversation with a patient’s spouse in a hospital.
Modernity and the Knowledge Problem

In a discussion of premodern, modern, and postmodern perspectives, it would seem logical to begin, in the beginning, with premodernity. The very nature of the term “pre-modern,” however, belies the fact that, like “post-modern,” our access into this epoch is granted only through the epoch that defines it: modernity. By forcing us to define preceding history as “pre” and subsequent history as “post,” modernity has identified itself as a problem, a perspective in which we are so stuck that even distance from it in either direction fails to escape its shadow. The foreboding shadow of modernity looms over Doehring’s introduction to the purpose of her book as an aid for pastoral-care providers who “face the challenge of keeping ‘alive’ in the post-modern world a religious vision created in a distinctly premodern cultural context” (Doehring, 2006, p. 1). What is it about modernity that makes it such a challenge for postmodern pastoral care providers to keep alive a premodern religious vision?

The knowledge problem of modernity threatens the possibility for living continuity between the past and present because modernity calls into question the validity of tradition as a vehicle for knowledge. Louth (1983) describes how the discoveries of the Renaissance created a “dissociation of sensibility” which shook the understanding of knowledge as something inherited and ultimately led to the subjection of knowledge to method. Fundamental to this idea of method was the notion of removing oneself from the prejudice of preconceived notions:

Man starts in ignorance and confusion, but by application of method is led towards light and truth. Doubt, a natural attempt to free oneself from prejudice
and preconception, an attempt to reduce the subject-matter to simple items which could be discerned clearly and distinctly, is then followed by a piecing-together of the simple items into a body of reliable knowledge. (Louth, 1983, p. 7)

The act of rejecting past knowledge as a potentially poisoning prejudice forms a clean break from the past and stops the flow of tradition:

Such an approach to knowledge involves a break with tradition, not only in the sense that it is a different way of proceeding from what preceded it, but also in a more fundamental sense, for it destroys the notion of tradition altogether.

According to Descartes, and even more Locke, man’s mind is a tabula rasa upon which ideas are freshly written. (Louth, 1983, p. 8)

For Louth (1983), part of the legacy of the Enlightenment is that the success of the scientific method created an inferiority complex for the arts/humanities, theology among them. As science progressed to great heights through the objective manipulation of data, the arts/humanities sought their own objective method for the pursuit of progress. The desire to keep pace with science by incorporating something of the exactitude of the scientific method into its own practice led the humanities to adopt the historical-critical method (Louth, 1983). The humanities increasingly relied on more scientific “research methods” promising more “results” (Scruton, 2013).

Louth (1893) emphasizes that theology, too, became interested in the “science” of exacting its truth through an objective method. Beginning with the Romantic notion of divining the original intent of Biblical authors and culminating in the pursuit of “what really happened,” theology sought the kind of objective knowledge that could establish
its subject as worthy of trust in the modern milieu. This is the context in which Protestantism developed. Having probed the depths of Scripture and salvation history for the objective truths of Christianity, Evangelical Protestants and Liberal Protestants turned up different results. The polar expressions of Protestantism in its “Evangelical and “Liberal” forms turn on their differing approaches to the knowledge problem of modernity.

Modernity is not the first time that traditional Christianity faced claims of special access to knowledge. In his book, Against the Protestant Gnostics (1987), Presbyterian minister, Phillip J. Lee (1987) traces the history of Gnosticism back to the 2nd century and argues that his own tradition of Protestantism, in both its “Evangelical” and “Liberal” forms, exhibits Gnostic tendencies:

Ernst Troeltsch found [in] the liberal Protestantism of his day [that]… “the sole value it assigns to Jesus is that of serving as the original stimulator of the religious consciousness.” This description could be applied accurately to many mainline churches in North America…. American liberalism requires secret gnosis to understand the workings of a nebulous, disconnected-from-Jesus Spirit. Evangelicalism also requires secret gnosis because, despite all its repetition of the Lord’s name, the content of the evangelical Christ remains undisclosed. One is to be converted to Christ, to come to Christ, to love Christ, to bring others to Christ, but the purpose of this Christ in the world is a mystery, except perhaps to those who have been born again. e e cummings picks up the mood of this mystifying religion in his lines:
no time ago
or else a life
walking in the dark
i met christ

jesus) my heart
flopped over
and lay still
while he passed (as
close as i’m to you
yes closer
made of nothing
except loneliness

The poet has caught the emptiness of modern American Christianity that offers no
hope to the person “walking in the dark” because its Word is formless and void,
“made of nothing except loneliness.” (Lee, 1987, p. 192)

If the goal of the modern theological project is to imitate the success of the sciences by
using objective methods of knowledge to discover truth about God, perhaps it is not
surprising that Cummings is lonely.

**Discussion of Premodern Lens**

Doehring’s (2006) discussion of the premodern lens places emphasis on a care-
seeker’s direct apprehension of God through premodern religious rituals:
Using a premodern lens, pastors assume for the moment that God or that which is sacred can be glimpsed and apprehended to some degree through sacred texts, religious rituals and traditions, and religious and spiritual experiences—the way transcendent realities seemed to be known within the ancient and medieval church prior to the use of critical approaches to knowledge introduced by the Enlightenment thinkers [emphasis added]. (Doehring, p. 2)

The knowledge problem of modernity looms large in Doehring’s (2006) choice of words. If in a pastoral-care relationship, we can only “assume for the moment” that God can be apprehended the way he “seemed to be known” before modernity, what does this mean for the care that we offer through the premodern lens? Is the premodern lens anything more than an obligatory condescension by the postmodern pastoral care provider to the antiquated attachments of ignorant savage care-seekers? My first responses to prayer for miraculous healing were not much more than that.

What means the most to me, however, about the prayer that I am about to describe is that it has enabled me to align my heart with the request of my neighbor, to join her in crying out to God for healing, to enter in to her hope for healing. This was a difficult place for me to come to because the temptation was to offer her the “premodern ritual” she requested without ever leaving my modern calculating mind. Entering into this prayer required repentance, metanoia, a change of heart, a willingness to become “vulnerable to the vulnerability of the other,” a willingness to have a heart, where heart, “kardia is precisely pathos and sensibility, a communication of flesh with flesh; it is a sensibility that triumphs over the universalizing impulses of reason” (Caputo, 2006, pp.
As I struggled to truly take on a premodern lens, one thing that helped me to get out of my head and into my heart was my conception of premodernity as an analogue to childhood.

Because I have for some time conceived of premodernity as the childhood of humanity, accepting Doehring’s (2006) invitation to care through a premodern lens, for me, meant looking through the eyes of a child. I needed access to the miraculously naïve reality of childhood visible only through the premodern lens. Childhood naiveté is the art that has not yet been complicated by what the Little Prince disparagingly calls “matters of consequence” (Saint-Exupéry, 1943). As Losev puts it:

For an artistic image is a return to naïve reality when the subject’s worries about finding the laws of accidental being are already over and peace is reached, after its endless effort to correlate its behaviour to the norm. The naïve equilibrium of intelligence is achieved again in pure feeling, in this subjective correlate of an artistic image, and the person becomes a child again, as it were, whose problems of knowledge and norms of behavior are all resolved. (Losev, 2003, p. 179-180)

How could I become like a child in order to find my way into this prayer? Thinking of my own little girl and how she makes her requests to my wife and me, it dawned on me that when she cries out her desires, she never filters her cries through any prediction of probability. The intensity of her request does not depend on her calculation of the likelihood of it being granted. When she wants for anything, she does all she can do: she directs every fiber of her being toward making her desire known to us. Using the following words, I set out to follow my daughter’s example:
Lord Jesus Christ our God, we come to you today as your little children, to you our heavenly father, doing all we can do as your children, which is to lift up the desires of our hearts and lay them down at your feet. Lord, ____’s desire right now is to be healed, to be able to go home to her family and continue on with her life. We lift up ____’s request for healing and we lay it down at your feet. We ask you to heal _____ and make her well. (pause) And we thank you that you hear our prayer (pause, prayer continued later). (Stonestreet, 2009)

When I name myself as a child before God, He gives me the heart of a child and the freedom to direct every fiber of my being toward making my desire known to Him. This freedom is more than a curb on my cynicism, more than a willingness to play along with an unrealistic request. I am not agnostically condescending to the request. While I do not have any of the certainty that is exhibited in some of the prayers that I would judgmentally characterize as Gnostic emotional performances, I do experience the gift of naked hope. This real experience of hope without expectation is so meaningful to me that it has changed my feelings around prayers for miraculous healing. My reluctance to pray for healing has been transformed to desire, even though my hope still hangs without expectation. This transformation took time as I slowly prayed my way into this prayer, offering it time and again, and growing into fuller participation in the words I uttered. An important part of my growing comfort with this prayer resulted from my deliberation under the modern lens.
Discussion of Modern Lens

Doehring’s (2006) discussion of the modern lens includes consultation of rational and empirical sources. This can include, among others, the medical diagnosis as well as psychological perspectives on where a care-seeker finds himself. In considering the modern lens for pastoral care, my question for Doehring is whether there is an extent to which we have uncritically allowed the “progress” of modernity to block postmodern access to the premodern lens. Before beginning to delve into this question, which will be more fully developed in the discussion of the postmodern lens, let us first revisit the knowledge problem of modernity and explore what we mean by modern progress.

If premodernity was the childhood of humanity, then the progress of modernity can be viewed as an analogue to the progress of adolescence. Both adolescence and modernity can be described as stages characterized by the development and harnessing of new powers of knowledge and concomitant physical capability. If modernity is the progression from the abacus to the computer, from horse and buggy to space shuttles, and from snakebite medicine to penicillin, then adolescence is the progression of human interest from listening to stories and coloring to calculating and copulating.

There is also an extent to which both moderns and adolescents have a history of being perhaps a little too taken with their own newly acquired powers and even struggling to access a reality outside of their obsession with the unbridled wielding of their new powers. If the American Pie (Weitz, 1999) movies demonstrate the tendency for adolescent man to treat women like objects and objects like women, then the phrase, “they paved paradise and put up a parking lot,” from Counting Crows’ song “Big Yellow
Taxi” suggests the same is true of modern man’s relationship to the earth. If a lovely young lady is walking through a beautiful field of flowers with a “for sale” sign in the center of town, then modern man’s mind moves as quickly to a calculation of profit margin on condominium development as adolescent man’s mind moves to another kind of unbridled wielding of powerful capabilities.

While we can all appreciate well located condos and the beauty of young love, there is something around the absoluteness of the powers of both adolescence and modernity that renders inaccessible the beauty of childhood wonder and premodernity. What about the beautiful field of flowers, as a beautiful field of flowers, not as a site for real estate development? What about the beautiful young lady as a beautiful young lady, not as an object of young man’s passion? An indiscriminately objective approach to all forms of knowledge results in the adolescent objectification of everything. This may be modern, but it is not progress.

Returning to my question for Doehring (2006) regarding the extent to which so-called modern “progress” blocks postmodern access to the premodern lens, let’s bring an aspect of the question into my personal experience of the topic at hand. If wielding the modern lens involves consulting rational and empirical sources, then how, in this case does the modern lens not preclude sincere granting of the care-seeker’s request? If the medical prognosis damns the care-seeker to certain death, how can my consultation of this empirical source help me to offer this prayer?

Ironically, an important part of my growing comfort with asking God for miraculous physical healing was that facing and naming the modern lens helped me to
work through my initial discomfort with making such a request. As I mentioned in Chapter One, my early experience of death in the hospital made my initial prayers for miraculous healing difficult. But it wasn’t just the experience of death alone, it was multiple conversations centering around narratives like the following:

Her heart stopped last Monday, but we had the preacher here praying, and she was revived. We’ve had several close calls since then, but each time, we prayed, and our prayers were answered. We were sure that God had healed her. They cleared her for discharge this morning, but her heart stopped suddenly a half hour before it was time to leave. This time, the doctors and the prayers couldn’t help. It feels like God was just toying with us, playing with our hopes all this time.

Part of my resistance to praying for miraculous healing was that I didn’t want to toy with people and play with their hopes. If, as a chaplain, I functioned primarily to facilitate and prolong a patient’s or family’s avoidance of the likely reality of death, and therefore prevent or diminish their process of grappling with, preparing for, and grieving the reality at hand, then how had I served them? Honestly incorporating the modern lens into my prayer, using the following words, helped me to process my moral dilemma and to clarify what I was and wasn’t doing in this prayer:

Lord, we confess that we don’t know what happens when we pray this prayer. We don’t know and we can’t control how or when or whether it might be answered according to our desires. (Stonestreet, 2009)

By naming the reality of our position of vulnerability, unknowing, and uncertainty, I faced the knowledge problem posed by the modern lens and parsed out my
agnostic\textsuperscript{12} hope from what I would like to call Gnostic expectation. If in historic Christian parlance Gnosticism is knowledge falsely so called, then the imperative of Christian hope must be parsed out from the heresy of Gnostic expectation. There is a fine line between entering into another’s hope through love and creating unhelpful expectations or feeding a false reality through manipulation. By separating my naked hope from false expectation, I found myself freer to participate more fully in the naked hope. The more I prayed the words from the modern lens above, the less anxiety I felt around the moral dilemma of toying with people’s hopes, and the freer I felt to fully engage in praying the words from the premodern lens.

Part of the challenge with parsing out hope from expectation is that there may not be a place for black swans of naked hope in this world if we continue our obsession with modernity by defining history in terms of its relationship to this era, as \textit{pre or post-modern}. This would be like elevating adolescence to the extent that we cease our references to childhood and adulthood in favor of referring to all humans as either pre-pubescent, pubescent, or post-pubescent. Rather than viewing everything in light of modernity, we need to allow ourselves to view the strengths and weaknesses of modernity in light of other perspectives.

As the adolescence of humanity, modernity is too taken with the tree of knowledge. Ashamed at the naïveté of naked hope, modernity seeks to escape the beauty of hope’s nakedness by covering it with fig leaves. As a so-called person of faith, I am ashamed to admit that the modern lens too often tends to color my view of everything.

\textsuperscript{12} Here, I am using the word “agnostic” not in its popular sense, but in its literal and what I believe to be its true sense, meaning “not Gnostic,” not a receptacle of special, secret, exclusivistic knowledge.
Before learning to pray in this way, a part of me despised the notion of participating in the prayerful hope for miracles. This hope didn’t fit into my system of calculations. If God heals one person and not another, He can’t be just. If fervent prayer really makes a difference, then it is murder for a chaplain to enjoy a lunch break. The only way out of that dilemma is the evil “P” word. There is no greater torture to my mind than neat and tidy notions of Providence:

Beyond obfuscation and mystification, it is in the end an outright blasphemy to say that God has some mysterious divine purpose when an innocent child is abducted, raped, and murdered. That is not a mystery but a misconception about God and about the power of God. God’s power is invocative, provocative, and evocative, seductive and eductive, luring and alluring, because it is the power of a call, of a word/Word, of an affirmation or promise. That murder is not part of a long-term good, a more mysterious good that we just can’t understand. That murder is a violation of the “good,” a contradiction of God’s benediction, which strains and stresses God’s word, puts it to the test, puts us to the test. God is not testing us like Job with this murder, but we are all of us—Job and God, God and God’s word, “good…very good”—being put to the test. (Caputo, 2006, p. 91)

I refuse to believe that any human suffering is the plan or will of God, and I will die believing that, yes, God can create a rock called human freedom that he cannot pick up because that is part of what it means to be Love. The vulnerability inherent in love is communicated through St. Paul’s Word of the Cross: “The question” asks Caputo, is, “when it comes to that defining scene of the crucifixion, how Christian we are willing to
be and how radical our theology of the cross will be. How genuinely, how seriously are we to take this central Christian vision?” (Caputo, 2006, p. 43). Strength through weakness, an unconditional, vulnerable, presence that calls out and woos but never compels. The only God that my calculating mind can accept is Caputo’s weak force, a God who, according to my modern, adolescent calculations, has not the power to perform miraculous physical healing.

These are still the conclusions of my calculations when I wield the modern lens, but what a gift—to be freed from enslavement to my own reasoning—to be “born again” into the art of naiveté and glimpse the Kingdom of Heaven through the eyes and cries of a child. Is it possible to imagine a little child with a burning desire that she would not voice to her parents? How could anyone face death and not ask God that this cup should pass? How can I be a chaplain to someone facing death without hopefully entering into this desperate plea? I set out praying my way into this prayer as a gift to others. The unexpected gift of participating in this naked hope, for me, was the air that it breathed into my own struggle for faith.

**Discussion of Postmodern Lens**

For Doehring (2006), the postmodern recognition of our subjectivity and contextuality forces us to let go of universalizing master narratives in favor of co-created meaning within given contexts such as a pastoral care relationship. As a chaplain in the cardiac center, the vast majority of the requests I received for miraculous healing came from Evangelical Protestant Christians with heart failure. Evangelical Protestant Christians have an understanding of salvation that is often articulated in terms of being
“saved” and “having Jesus in your heart.” Sometimes the first thing they told me when I enter the room is that they were “saved,” and some would even place their hand on their heart and say “he’s in here.” For a person with heart failure, the belief that Jesus is present in his heart presents an opportunity for the profoundly contextual meaning making that Doehring advocates through the postmodern lens.

In assessing the opportunity for contextual meaning making, Doehring’s first step is to identify the care-seeker’s “embedded” theology, “the theological presuppositions that shape their lives and practices” (Doehring, 2006, p. 112). Among those requesting prayer for miraculous healing, I observed that their meaning-making around the presence of Jesus in their heart most often centers around Jesus as their personal savior. The meaning around Jesus as savior is sometimes almost exclusively connected to the afterlife. Because they have asked Jesus to come into their heart and save them, they have accepted his death on the cross for their sins, and they have been saved from hell and secured their eternal destiny in heaven.

Doehring (2006) reports that many people, after expressing their embedded theology at a time of crisis, begin to engage in “deliberative theology” whereby they reflect upon their convictions and construct new beliefs in the process of seeking God in the midst of their experience of loss (Doehring, 2006, p. 112). For an Evangelical Protestant Christian requesting prayer for miraculous healing, this deliberation can include questions like: “What Jesus is doing here in my heart if He isn’t going to heal it? Is He just sitting there in my heart, watching it deteriorate, or is he even there at all?”
At this critical juncture of questioning and deliberation, Doehring (2006) describes a fork in the road where pastoral care providers and care-seekers must choose between “conserving traditional theologies and reconstructing them” (p. 14). For Doehring, “a conserving orientation is part of premodern and modern approaches to knowledge in which theological propositions are true in all times and places” whereas a postmodern approach to knowledge “assumes that knowledge about God must be continually reconstructed in order to be relevant in complex historical contexts” (Doehring, 2006, p. 114).

My question for Doehring is: to what extent are premodern meaning and modern theological meaning to be incorporated into postmodern efforts at co-creating meaning through reconstructing theology in pastoral care? Is postmodern reconstruction a re-entry into premodern meaning having integrated the lessons and perspectives of modernity, or is postmodern reconstruction a radical point of departure from the past?

Continuing the analogy that premodernity is the childhood of humanity and modernity is the adolescence of humanity, perhaps postmodernity is the young adulthood of humanity. If the childhood of premodernity is characterized by pre-critical wonder and the adolescence of modernity is characterized by the harnessing of, and attachment to, new powers, then what can be said for the young adulthood of postmodernity? For many postmodern young adults, early adulthood is either an extension of one-tracked wielding of the novel powers of adolescence (feverishly calculate your way to MD, JD, or “Associate” while copulating your way through the hookups available via the local club scene) or a relapse into an age inappropriate expression of childhood (move back in
with your parents and enjoy good food, video games, and clean laundry, while half-heartedly looking for a job in the local classifieds).

What do we stand to lose if premodern and modern meaning are not adequately, consciously, and qualifiedly reincorporated into our contextual creation of postmodern meaning? If as in life cycle development, “each stage is systematically related to all the others” and “each stage exists in some form before its decisive and critical time normally arrives” (Capps, 1983, p. 23), then do not our contextually created postmodern meanings stand the chance of being nothing much more than unconscious reactions against or attachments to the limits or the possibilities of premodern or modern knowledge, or, to transubstantiate my lifecycle analogy, our own childhood or adolescence?

Part of the task of young adulthood is to come to terms with our own childhood and adolescence and begin to learn how to responsibly incorporate both our powers and what we have learned about our limitations and patterns from adolescence back into the journey of being born again as children of the Father (Friedman, 1985). Eating from the tree of knowledge prepares us to return to the garden, of Eden/Gethsemane, and receive the tree of life. But to re-enter the garden, we must return as little children, or at least with the eyes and ears, the senses, of children. Yes, we have put away childish things and become as wise as serpents, but we are called to somehow also be as innocent as doves. Except a man be born again, and become like one of these little ones, he cannot see the kingdom of heaven.

The value of approaching postmodern knowledge as an opportunity to be born again into a nuanced re-entry into premodern knowledge is that, as Erikson’s (1997) life
cycle theory stresses for human development, it provides a context of orientation for deliberation and change.

All developmental theories are concerned with change for it is axiomatic that as persons develop they change. What makes Erikson’s life cycle theory distinctive is its strong emphasis on the importance of orientation in the process of change. Erikson asks: How does the individual acquire and maintain a sense of orientation in this ongoing process of change? Orientation language abounds in Erikson’s writings. He talks about continuity, succession, order, rootedness, perspective, stability, balance. He takes none of this for granted. He has no illusions about life in modern society. He knows it is often discontinuous, disruptive, disordered, uprooted, and fragmented. But he stresses the importance of having a clear sense of orientation in life, a steady image of where we have been and where we are going. He rejects the romantic notion that disorientation and disorder are more “natural” to the human species and therefore more desirable or worthwhile.

(Capps, 1983, p. 30)

If in the process of lifecycle change, it is critical to have a clear sense of orientation, a steady image of where we have been and where we are going, then what can be said for Doehring’s (2006) recommendation of reconstruction over preservation at the fork in the road of theological deliberation in times of crisis?

Doehring acknowledges that pastoral care givers have been described as “clinical theologians” (Doehring, 2006, p. 111). Is it advisable for postmodern clinicians in other practices to respond to patient crises by spontaneously reconstructing
their framework of care without recourse to the historical knowledge base that undergirds their discipline? This line of questioning may not be entirely fair to Doehring’s nuanced practice, but there is a sense in which the approach to postmodern pastoral care she advocates seems uncomfortable with the premodern roots of Christian theology, like modern medicine, with the concept of tradition as a valid vehicle of legitimate knowledge.

How can Doehring’s (2006) juxtaposition of postmodern reconstructing and premodern/modern conserving escape its “either/or” status? Louth’s (1983) reading of Gadamer’s *Truth and Method* argues that “understanding is an engagement with tradition, not an attempt to escape from it” (Louth, p. 33). In contrast to Doehring’s suggestion that conserving premodern and/or modern orientations will always yield simplistically proof-texted absolutes that are insensitive to the contexts of suffering people (pp. 114-115), Louth understands Gadamer to be saying that “tradition is the context in which one can be free, it is not something that constrains us and prevents us from being free,” because the “act of interpretation is one of the ways in which tradition is…passed on” (Louth, p. 35). Therefore, “tradition, as preservation, is an act of reason, and interpretation is engagement with what is presented to us by tradition” (Louth, p. 41). Part of that engagement includes the conscious exposure of our personal subjectivity to the challenge that tradition offers us. Gadamer argues for a genuine conversation with tradition where I must “allow the validity of the claim made by tradition, not in the sense of simply acknowledging the past in its otherness, but in such a way that it has something to say to me” (as cited in Louth, 1983, p. 41). In response to Doehring’s notion that a stance of
conservation will yield non-contextual, pat answers to complex contextual exigencies, Louth argues that an openness to tradition addressing us is part of what keeps tradition from being a closed set of outdated information. Rather than dismissing the naïve premodern myth, critiquing the modern grind, and seeking out our own postmodern narrative, tradition challenges us to embrace both the naiveté and the grind of giving birth to our true narrative within the continuing story of the life-giving myth.

If orientation is important for the life cycle development of individual human beings, and tradition is important for the historical development of humanity, then perhaps the orientation provided by the conservation of theological tradition has a place in the deliberative context of postmodern pastoral care.

In the pastoral care encounter described above, what strikes me about the context is that we have someone with a failing heart which, according to their embedded theology, is inhabited by the Son of God; they believe that God will take them to heaven when they die, and they hope that He will heal their heart at this time and grant them a longer life on earth. These beliefs and hopes beg the question: what if Jesus does not heal me and it takes me a while to die? Or what if I die tomorrow? What is Jesus doing there in my dying heart during the interim? What is the meaning of His presence in my heart in this instant as I lay here suffering?

Many patients are able to speak fluently on this subject. They reference God’s abiding presence and their experience of Jesus through prayer. A few have referred to the suffering of Jesus on the cross as an encouragement to them as they suffer. I suspect the reason more patients do not invoke the cross in reference to their own suffering may be
that many of them would gladly trade sixteen short hours on a cross and three days in a
tomb for the sustained suffering that they have endured.

It is not enough for Jesus to have physically suffered for a short time long ago.
Plenty of people have endured worse. Premodern Christian tradition, however, as we will
discuss in a moment, tells us that the cross is not only an event in the past but a revelation
of how God relates to us in the present as a bridegroom who suffers with us and for us.
My effort to meet this patient in her context of suffering heart failure, hoping for healing,
and holding on to the presence of Jesus in her heart, was to participate in the co-creation
of meaning in this context by appropriating the premodern confession that the Jesus who
suffered for her sins and lives in her heart is intimately united to her in her suffering by
actively suffering with her in this moment. This confession of faith materialized in the
following form:

   We thank you that we can know that when we suffer—whether we suffer from
illness, like ____ ’s heart disease, or from physical pain specifically, as _____
feels in her arms and legs as she lies in this bed with arthritis, or from emotional
pain, the anxiety of not knowing what will happen next— when we suffer in all
the ways that we suffer, you not only see us and care about us, but just like you
showed us on the cross, you suffer for us, and you also suffer together with us in
our suffering. Thank you that you are here, present in this room, suffering with
_____ and that you love her dearly. (Stonestreet, 2009)

What is Jesus doing there in your heart as you suffer, not yet wanting to go to heaven,
wondering if he will heal you? Jesus is suffering there in your heart. He is erotically
united to you through his intercourse in your suffering. The meaning of this prayer
softens my heart as I pray it, and I have experienced it softening the hearts of many who
have heard it. It means a great deal to me to believe that what we can know about God,
who remains unknowable in his essence, is revealed on the cross of Christ: God suffers
with us, and God suffers for us.

This premodern confession of Christian faith is perhaps most visible in the
Eastern Orthodox Byzantine iconographic tradition (Figures 5 and 6 below). As seen in
Figure 5, icons of Christ includes a cross in his halo; inscribed on the planks of the cross
are the Greek words [transliterated] “w” “on,” meaning, the “one who is,” or the “being
one.” God’s self-revelation as unconditional, co-suffering love is written on the planks of
his cross.

The icon of Christ with the crown of thorns on his head is usually inscribed with
the words “extreme humility” and “nymphios,” which is translated “bridegroom,” or, as
in Figure 6, [transliterated] “ide o anthropos” which means “behold the man.” According
to Behr (2006), Pilate’s words, en route to the cross “Behold the man,” and Christ’s
words from the cross, “it is finished,” complete the creation story from Genesis. With
Christ’s ascension onto the cross, crowned as the bridegroom of humanity with the very
thorns that resulted from man’s rebellion in the garden of Eden, God’s self-offering work
of creating man is finished and lifted up to behold. After completing the culminating
work of creation on the cross, God takes his Sabbath rest in the tomb. God assumes flesh
polluted by the unsustainable force of the human ego and fills it with the infinite purity of
divine love.
Figure 5. Christ. “Christ the Lifegiver,” by an anonymous Orthodox monk on Mount Athos. Copyright 1991 by Theologic Systems, Inc. Reprinted with permission.

Figure 6. Ide O Anthropos (Behold The Man). “Christ the Bridegroom,” by an anonymous Orthodox monk on Mount Athos. Copyright 1991 by Theologic Systems, Inc. Reprinted with permission.
The Eastern Orthodox iconic tradition bears witness to premodern Patristic theology (Behr, 2001, 2004, 2006), where theology is not an abstract academic exercise as it has become for many in modernity but a grammar for traditioning spiritual experience. Christ is known to be God in and through the spiritual experience of being known as bride by God, the suffering bridegroom, through communion with the fruits of the passion: “partaking of the Son himself, we are said to partake of God” (Knight, 2009a, para. 16). By taking a body and voluntarily suffering humiliation and death, Christ taught us about God and mediates our communion with God by enacting the form, aesthetic and physical presence of God’s love. St. Irenaeus of Lyon refers to Christ as the “interpreter of the Father” (Irenaeus of Lyons, sec. 4.20.11). In his 4th century tract, On the Incarnation, Saint Athanasius of Alexandria proclaims that, on the cross, Christ teaches us about the Father:

…he is the true Son of God, from whom he proceeds as very Word from the Father and Wisdom and Power; who in the last times for the salvation of all took a body, and taught the world about the Father, destroyed death and bestowed incorruptibility on all through the promise of the resurrection, as first fruits of which he raised up his own body and showed it as a trophy over death and over death’s corruption by the sign of the cross. (Knight, 2009b, para. 6)

On the Incarnation’s apology for the divinity of Christ is rooted in the spiritual experience of God’s self-revelation on the cross:

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13 See also John 1:18: “No one has ever seen God; the only Son, who is in the bosom of the Father, he has exegeted him"
For the sun turned back, and the earth shook, and the mountains were rent, and all were terrified; and these things showed that Christ who was on the cross was God, and that the whole of creation was his handmaid and was witnessing in fear to the coming of her master. So in this way God the Word revealed himself to men through his works. It is our next task to describe the end of his life and activity in the body, and to say what death befell his body, especially because this is the chief point of our faith and absolutely everyone talks of it, in order that you may know that particularly from this Christ is known to be God and the Son of God.

(Athanasius, 1977, p. 19)

That God suffers with us and suffers for us are the two forms of divine compassion revealed in the Passion of Christ, the first renewing us to experience God’s co-suffering loving presence in our suffering and the second destroying death as the ultimate result of human infirmity: “For in two ways our Savior had compassion through [His] incarnation [on the cross]: he both rid us of death and renewed us” (Athanasius, 1977, p. 16).

Far from a naively rigid relic outdated by modernity and requiring reconstruction for legitimacy in postmodern contexts, the core of premodern Christian theology, the gift of experiencing God’s compassion with and for us through Christ, is worth conserving, certainly for me, when praying for the impossible, and perhaps for any context of pastoral health care with Christian care-seekers.

Below is my prayer for the impossible in full. In situations where family members are conflicted or in disagreement over what to pray for, I have been told by
each of the conflicting parties that this was the prayer that they needed. These responses have encouraged me in my struggle with praying for the impossible and helped me to feel connected with others in the struggle for exigent expressions of faith. This prayer takes seriously the postmodern confession of subjectivity and contextuality and makes the conscious, subjective decision to prefer the Passion of Christ to modernity as an organizing principle or lens through which to interpret reality, addressing modernity in light of the Passion of Christ rather than addressing the Passion of Christ in light of modernity:

Lord Jesus Christ our God, we come to you today as your little children, to you our heavenly father, doing all we can do as your children, which is to lift up the desires of our hearts and lay them down at your feet. Lord, ____’s desire right now is to be healed, to be able to go home to her family and continue on with her life. We lift up ____’s request for healing and we lay it down at your feet. We ask you to heal _____ and make her well. (pause) And we thank you that you hear our prayer

Lord, we confess that we don’t know what happens when we pray this prayer. We don’t know and we can’t control how or when or whether it might be answered according to our desires.

But we thank you that we can know that when we suffer—whether we suffer from illness, like ____’s heart disease, or from physical pain specifically, as

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14 While it may sound odd to juxtapose the Passion of Christ with modernity as reality filters in this way, it does seem that their status as potentially competing meta-myths is seen in their alternate bids at organizing history (calendaring with BC and AD vs. historicizing with modernity, pre & post).
_____ feels in her arms and legs as she lies in this bed with arthritis, or from emotional pain, the anxiety of not knowing what will happen next—when we suffer in all the ways that we suffer, you not only see us and care about us, but just like you showed us on the cross, you suffer for us, and you also suffer together with us in our suffering. Thank you that you are here, present in this room, suffering with _____ and that you love her dearly. (Stonestreet, 2009)

**Conclusion**

If Mattingly’s (2010) observation that the patient/family-preferred genre of healing and illness as a “journey of personal transformation” is combined with Hinshaw’s (2013) suggestion that suffering is a kind of confession and therefore gives experiential and communicative birth to confession, how might this apply to the patient/family having just heard the above prayer in our medical context of interest? By naming the reality of their suffering and God’s presence with them, does this prayer paint an eccentric canvas, open to the possibility for confession to unfold? Breitbart, Gibson, Poppito, and Berg (2004) draws on Rousseau (2000) to identify confession as a potentially important end-of-life therapy suggesting that it may be vital to the “strengthening of relationships with loved ones” that was identified by Singer, Martin, and Kelner (1999) as one of five key aspects of end-of-life care. Will the prayer’s ending focus on their suffering evoke confessional recapitulation, whether spoken or not, of their journeys of personal transformation? Are these personal transformations important for Singer’s “strengthening of relationships with loved ones,” that itself becomes the miracle of
modified meaning for which miracle-hope for bodily healing serves as a physical container?

If so, what might this mean for communication surrounding health care decision making earlier in the disease trajectory? Geffen (2006) cites a moving experience where prayer “completely transformed” the family decision making process into a “healing experience.” Reminiscent of the “holistic reframing” called for by PI theory’s “evaluative orientations,” Geffen describes how the prayer miraculously diffused family conflict and created space for reflective consideration at a point in the disease trajectory that can too easily devolve into what The and colleagues (2000) described as a commonly unacknowledged fork in the road of treatment where PI theory’s “evaluative orientations” are never considered. In his 2010 coda to the classic, How We Die, Yale physician, Sherwin Nuland states that

Despite all the didactic courses, the hospices, the enlarging number of palliative care physicians, and the awards for compassion, the profession of medicine still does not think of end-of-life care—of either a patient or a family—as a priority on which to spend much time. In spite of every-increasing awareness and inculcation of our humanistic obligations, we have as yet failed to de-medicalize death. (Nuland, p. 277)

Wachter (2012) insists that health care decisions should be made “based on science,” but Scruton (2013) states “the sure sign of scientism” is “that the science precedes the question, and is used to redefine it as a question that science can solve.” Nuland confesses that his scientific instincts too often led him to push foolishly futile heroics on
not only his patients, but also his own brother (Gellene, 2014). Might it not be that Wachter’s dictum for health care decisions to be made “based on science” rather than “hope, theology, or magical thinking” has it backwards in many cases, even, and especially, outside of the narrow context of interest in this study? At the very least, it would seem that this preference might depend on how the tools of science, hope, theology, and magical thinking are being approached, understood, and wielded within the art of medicine.
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