

Critical Theology

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church
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Summer 2023 issue edited by Scott Kline

Introduction

By Scott Kline

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This issue of *Critical Theology* has a decidedly personal feel to it. The first article, by the philosopher Andrew Stumpf, is an example of a scholar wrestling with the foundational concepts and arguments used by proponents and opponents of Medical Assistance in Dying (MAiD). For instance, proponents of MAiD tend to prioritize autonomy (that is, the ability of a person to make informed and uncoerced decisions for themselves) while opponents tend to prioritize the sanctity of life and the intrinsic dignity of the human person. Among the provocative questions Stumpf asks are these: "Is it ever morally permissible to agree that someone else's (or your own) life is not worth living?" and "Is death a bad outcome?" His answers consider both the philosophical as well as the emotional and relational aspects of MAiD.

The second article, by the Jewish ethicist Yoelit Lipinsky, is a personal reflection on her training in Catholic bioethics and working in Catholic health care. Lipinsky recounts humorous stories involving Christian patients seeking spiritual support only to discover that she's Jewish. She also highlights instances where her Jewish worldview clashed with a Catholic worldview, most notably on the issue of women's reproductive health. Lipinsky's reflection is important because people in Catholic health care need to hear non-Catholics tell stories about their experiences in Catholic health care systems.

The third article is my attempt to understand the parable of the Good Samaritan in relation to our current health care systems. It rejects the notion of the parable as an example of "universal humanity." Instead,

it points out the subversive nature of the parable as it challenges the cultural and political status quo. At the centre of this article is a plea for increasing the number of community responder programs in the form of "Neighbours Saving Neighbours."

The final article in this issue is a reflection by Anglican bishop Riscylla Shaw on her journey as a Métis, which means she is a person of mixed European and Indigenous ancestry. Her identity also means she walks between worlds. She writes, "I walk between the settler world, the colonial world, and the Indigenous world, and I come from a long line of people who do and have done that." Her story speaks candidly about her Métis identity, her family, her work with the Truth and Reconciliation Commission, and her Canadian identity.

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Agreeing on the Worth of a Life: MAiD and the Logic of Sanctity

By Andrew Stumpf

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This article revisits the role of sanctity of life and the related notion of intrinsic dignity in the ethics of Medical Assistance in Dying (MAiD) and voluntary active euthanasia (VAE).¹ In many discussions of MAiD/VAE, considerations of autonomy and mercy (relieving suffering) carry the day. Who is not moved by tragic stories of individuals facing fearful and enduring suffering due to ravaging illness that cannot be relieved? And who has the right, if not the suffering individual, to make momentous decisions about exiting life when the burdens of continued living have become intolerable? Yet, it must be acknowledged that euthanasia, even if it supports autonomy in profound and important ways, and is motivated purely by compassion and the corresponding desire to relieve grievous suffering, also involves intentionally ending the life of another human person. Morality and law have, with good reason, understood intentionally ending the life of another person to be one of the most serious crimes anyone can commit. Since it involves ending a person's life, even the most well-meaning act of euthanasia remains a morally tragic action.

My goal is to consider the relational dynamics in which a person who performs an act of MAiD is implicated. The following questions delimit the space of my inquiry:

1. Is it permissible to perform MAiD without agreeing that the life of the person receiving MAiD is not worth living?
2. Is it ever morally permissible to agree that someone else's (or your own) life is not worth living?

I argue that the practice of MAiD is almost always morally indefensible because it requires agreeing that another person's life is not worth living and because (acting on) such an agreement is morally indefensible. I am not saying anything new here, but I am saying it in a way that has (to my knowledge) rarely been said. Opponents of MAiD have frequently deemed MAiD morally wrong because it violates the principle of the sanctity of life. So, in an attempt to make clear why such agreement is morally unacceptable, I offer a specific account of the way in which acts of MAiD violate sanctity of life (by involving the agent in agreement concerning the lack of value of the MAiD recipient's life).

Sanctity of Life and Intrinsic Dignity

In a series of publications, Daniel Sulmasy has presented an account of intrinsic dignity that expresses what is at the heart of the intuition that human life is sacred.² Sulmasy's account has roots in the thought of Immanuel Kant as well as in Christian theological traditions.³ In contrast to the worth or value we attribute to human beings in virtue of their perceived usefulness, intrinsic dignity is the "worth or value that people have simply because they are human."⁴ It is the kind of intrinsic value that individuals have by virtue of belonging to the natural kind denoted by the term "human being."⁵ As such, intrinsic dignity is both radically egalitarian and inalienable. Every human being has intrinsic dignity, regardless of socio-economic status or any other differences that might be taken as markers of value. Intrinsic dignity is not something that can be lost or taken away, so long as one remains a human being. The recognition that human beings are bearers of intrinsic dignity demands that we act toward them (that is, toward ourselves and others) in ways that are consistent with that recognition. Respect for intrinsic dignity, according to Sulmasy, is the basis for human rights and for the moral duties we have toward human beings, including the duties of health care professionals toward their patients.⁶

The moral principle of the sanctity of life, and the role it plays in accounting for the wrongness of killing, depend on the idea that all human beings possess an inalienable intrinsic value or dignity of the sort described above. Acting to intentionally end the life of a human being violates the sanctity of life by directly contradicting the respect for intrinsic human dignity that underlies our moral obligations toward ourselves and our fellow human beings. For this reason, it is at least *prima facie* seriously morally wrong to intentionally end the life of a human being. Understanding sanctity of life in this way improves on accounts such as that recently offered by Steve Clarke. According to Clarke, sanctity of life consists in the dual claim that "bodily human life is an intrinsic good, of irreducible value and that, as a consequence, it is always impermissible to kill an innocent human."⁷ In response to such a characterization, one might reasonably question the link between the two claims: why does the

intrinsic goodness of human life make it morally wrong to kill a human being? Great works of art can also be said to be intrinsic goods. But although it might deeply offend aesthetic sensibilities to ruin a great painting or delete every copy of a great symphony, the mere fact that these works are intrinsically good does not make it *morally* wrong (let alone seriously morally wrong) to destroy them. The situation is different with human beings. The specific sort of intrinsic value human beings have, as captured in the idea of intrinsic dignity as the basis of moral obligation, directly implicates the intentional destruction of a human being with moral wrongness. Human life is not simply an intrinsic good alongside other intrinsic goods; human beings are the bearers of intrinsic dignity, a type of moral worth or value that functions as the basis of our moral obligations.

Considerations of sanctity of life and intrinsic dignity entail that, at least ordinarily, it is gravely and morally wrong to intentionally end the life of another person or to help another person to die by suicide. But MAiD invariably includes one or more human persons acting with the intention of ending the life of another human person. *Prima facie*, then, MAiD is gravely morally wrong. In the next section, I raise three objections to the claim that MAiD is morally wrong. Following that, I address each objection and show how, even if true, they do not remove the underlying relational dynamics that make MAiD morally problematic.

Is MAiD an exception?

As noted above, on the face of it, MAiD seems to be morally wrong because it is an instance of an act that is morally wrong: namely, intentionally ending the life of a human person. Indeed, prior to 2015, Canadian criminal law prohibited euthanasia under the general prohibition of intentional homicide. But at least two things appear to make MAiD an exception to this general reasoning. One is that the person whose life is being ended has requested this, and the other is that they have done so in light of their experience of grievous suffering due to irremediable illness. If a person does not see continuing to live as a benefit to them because of the burdens of continued life, and has carefully and competently considered the matter and decided (without pressure or coercion) that they prefer not to live, one can reasonably suggest that (*ceteris paribus*) it is no longer morally wrong to assist them to achieve their desired outcome (death, as a means to avoiding continual suffering). Indeed, utilitarian accounts of morality may even *require* that we assist individuals to end their lives in cases where the individual authentically prefers death to continued life with suffering, sees MAiD as a desirable way to achieve death, and voluntarily requests MAiD.

Opposition to MAiD can also be questioned based on the apparent appropriateness of other practices that seem practically or morally indistinguishable from MAiD. One may (or even must) withhold life-sustaining treatment from a patient who refuses it or withdraw it from a patient who requests that it be withdrawn, even when one knows that the patient will die without the treatment. One may, at least in certain extreme cases, administer sufficient sedatives to induce unconsciousness and potentially hasten the arrival of death (a practice referred to as palliative or terminal sedation). These practices are accepted as morally legitimate by the same people who reject MAiD as morally wrong. But they involve acting in a way that leads to a patient's death and hence seem to violate the sanctity of life just as MAiD does. Furthermore, these other practices are rendered morally acceptable by the obligations to respect patient autonomy and relieve suffering, the same factors that proponents of MAiD point to in order to make their case. Consistency would seem to require that we accept MAiD along with these other practices or reject all such practices for the same reasons. But there is a strong consensus on the moral acceptability of palliative sedation and the rights of patients to refuse unwanted treatments. So, MAiD ought to be deemed morally acceptable along with these other practices.

A third traditional argument against MAiD makes use of the rule of double effect. Accordingly, while it can be morally permissible, under certain conditions, to bring about a foreseen bad outcome by one's action, it is never morally permissible to intend the bad effect, whether as a goal in itself or as a means to some other good outcome. Since MAiD invariably involves intending the death of the recipient, and death is a bad outcome, MAiD is not permissible.⁸ In fact, the distinction between MAiD and the practices of palliative sedation or withdrawing life-sustaining treatment has been drawn precisely on the grounds that MAiD violates the rules of double effect while these other practices do not. While it is *possible* to intend the patient's death when administering high doses of sedatives, or when withdrawing a treatment that supports a patient's life, one *need not* engage in those actions with that intention. One's intention might be solely to relieve pain or to respect the patient's right to refuse unwanted treatment. By contrast, it is not possible to perform MAiD without the intention to end the patient's life.⁹ All that consistency requires, then, is that we consider palliative sedation and withdrawal of treatment as morally equivalent to MAiD *if carried out with the intention to end the patient's life*.

But an important objection to double effect reasoning as applied to MAiD questions the legitimacy of describing death as a bad outcome.¹⁰ If death is what

the recipient of MAiD strongly prefers, that person arguably sees death as a good, at least relative to continued suffering. If death is not a bad outcome in these cases, then the rule of double effect would seem irrelevant, since in intending the patient's death one does not intend something that is bad. And if the rule of double effect does not apply, then it cannot be used to distinguish MAiD from other practices that lead to patient death. In summary, proponents of MAiD can acknowledge that MAiD involves the intentional ending of a patient's life and so—at least *prima facie*—violates the principle of the sanctity of life while reasonably arguing that MAiD is an exception to this rule. MAiD, according to the arguments presented above, is not a case of wrongful killing because in cases where MAiD is legitimate, the patient's death should not be understood as a bad outcome. Therefore, although the death of the patient is intended, MAiD is justifiable for the same reasons that justify palliative sedation and withdrawal of life-sustaining treatment: namely, respect for the autonomy of the competent person requesting help to end their life and the duty to help relieve grievous and irremediable suffering.

Is death a bad outcome?

The key issue on which the argument developed in the preceding section rests is the issue of whether the patient's death is a bad outcome. If it is, then MAiD remains morally wrong by the rule of double effect, according to which it is always wrong to intend a bad outcome, and the moral distinction between MAiD and legitimate instances of palliative sedation and withdrawal of life-sustaining treatment stands. To make progress in thinking through this matter, then, we need to carefully consider the reasons for and against considering a patient's death as a bad outcome in the sorts of situations the patient requesting MAiD may be in. We are assuming cases in which the patient is experiencing intolerable, grievous, and enduring suffering caused by an irremediable illness.¹¹

Clearly, in such cases, death can be a *desired* outcome. More strongly, death may be an outcome that the competent and uncoerced patient prefers to all the other available outcomes, after careful and sustained reflection and deliberation aided by a physician. This would, *ceteris paribus*, suffice to make death a good outcome on the assumption that the goodness and badness of outcomes is a matter that is properly and fully determined by the stable preferences of the patient.¹² Arguably, however, the goodness or badness of an outcome is not properly and fully determined by patient preferences. For one thing, we can make mistakes about what is good for us. We can, even after careful reflection, prefer and choose something that later on turns out not to have been the best, or not even good for us, all things considered. For another

thing, and most importantly for the purposes of the present essay, the notion of intrinsic dignity involves understanding the goodness, worth, or value of human life by contrast to attributed dignity, worth, or value. Unlike attributed dignity, we do not lose intrinsic dignity when others, or we ourselves, cease to perceive our life as something good or valuable. Because intrinsic dignity does not depend on any subjective assessment of value, it points to a goodness that human beings possess beyond what we imagine or experience to be good about ourselves.

The idea of intrinsic dignity is crucially important in end-of-life care, according to Sulmasy, because the circumstances individuals face as a result of life-threatening illnesses powerfully call into question their dignity, worth, and value.

The dying need to be reminded of their dignity at a time of fierce doubt. The dying need to understand that they are not grotesque because of the way disease has altered their appearance; that they are not merely bothersome because they are dependent; that they are not unvalued because they are unproductive; that they are worth the time, attention, and resources of others. In short, they need a demonstration that the community affirms their intrinsic dignity.¹³

Our attributed dignity can be marred by illness in various ways. Harvey Chochinov has shown that patients facing life-threatening illnesses commonly experience a loss of dignity on several levels, especially when they are not given good, dignity-conserving palliative care.¹⁴ Appealing to loss of dignity as a reason to request and/or offer MAiD only makes sense in relation to attributed dignity, the kind of dignity a human being can lose. If Sulmasy is correct, respect for a person's intrinsic dignity is incompatible with euthanasia. If human beings possess intrinsic dignity as long as they remain human, then we are obligated to respect and uphold their value and worth through our actions, which cannot be done by destroying their lives. So far so good, but the argument Sulmasy offers in support of this point is essentially a Kantian one. He reasons that "one can never act with the specific intention-in-acting of destroying the human being who is suffering these attributed indignities as a means of relieving that human being's burden, because this would undermine the intrinsic Dignity that gives force to the duty to build up attributed human dignities in the first place."¹⁵ Later in the same article he states, "It would seem to be a contradiction in practical reasoning to act in such a way as to undermine one's fundamental reason for acting."¹⁶

Of course, it could be argued that in certain circumstances, helping someone to end their life might be an

expression of respect for their intrinsic dignity, rather than a way of undermining it. To this sort of objection, Sulmasy replies,

it seems confused to suggest that one can restore or respect the intrinsic Dignity of something by intentionally bringing about its destruction. This is as hopelessly paradoxical as the alleged logic of the Vietnam War, “We had to destroy the village in order to save it.” Thus, if one says, “The only way we could respect his intrinsic Dignity was to euthanize him,” one is seriously confused.¹⁷

At this point, I find Sulmasy’s argument unconvincing. However paradoxical it may appear at the level of abstract argumentation, it does seem concretely possible to envision, under sufficiently severe circumstances, affirming a person’s intrinsic dignity even in the act of—even *by*—helping them to end their suffering by ending their life. To see this, imagine the following scenario. You are a police officer, and you witness a horrific car explosion. One of the passengers barely manages to crawl free from the burning wreckage. They are burned beyond recognition and are howling with pain. You are too far out in the countryside to get them attention from a paramedic. Becoming aware of your presence, the burned individual asks you to shoot them. They will surely die within the next hour, but that hour will be one of pure, excruciating pain. You could either do nothing and let them writhe in agony for an hour or mercifully help them to end their life now. At the very least, one could understand how someone in the position of the police officer could think they owed it to the person—out of respect for the person’s intrinsic dignity—to give them the only means available to relieve their suffering. If someone were to insist, in such a moment, that this action was unacceptable because it was contradictory to respect the individual’s intrinsic dignity by undermining it, the correct response might be to tell them, “Screw your consistency; look at what this person is going through!”

I suggest that the problem with thinking that one could respect a person’s intrinsic dignity by assisting them to end their life is not primarily (or at least is not best expressed by) the fact that it introduces contradiction into one’s practical reasoning. Rather, what makes such an act problematic is the relational dynamics in which it involves the agent. Specifically, acting intentionally to end another person’s life requires one to agree that that person’s life is not worth living. And it is morally problematic to enter into such agreement, even under the kind of circumstances that drive people to request MAiD.

Does providing MAiD require agreement that the recipient’s life is not worth living?

Embedded in the act of performing MAiD/euthanasia is the (explicit or tacit) assumption that the life of the individual requesting MAiD is no longer worth living. If one were to judge that the individual’s life was worth living, the proper response would be to take measures to dissuade them from attempting to end their life, as with standard suicide prevention, while helping to address the sources of their suffering as far as possible. The safeguards around MAiD support the same conclusion. The wrongness of ending a life that is worth living lies behind the requirements that MAiD be limited to people with intolerable, grievous suffering caused by an irremediable illness—suffering, in other words, that renders continued living an egregiously burdensome and hopeless affair. These safeguards recognize that it would be wrong to provide MAiD to a person whose condition was treatable or who did not have a condition resulting in intolerable suffering. But why would it be wrong? Why do autonomy and mercy not carry the day here, too, since it would still be a matter of fundamental self-determination for the individual, and even tolerable suffering arguably deserves compassion. The most plausible explanation is that in such cases, there is no basis for claiming that the individual’s continued life is not worth living. And if a person’s life is worth living, it would be seriously morally wrong to aid them in ending it; the Canadian Criminal Code continues to reflect this by classifying acts of euthanasia and physician-assisted suicide as illegal and punishable when the individual does not meet the eligibility criteria. If this is correct, then from the perspective of MAiD legislation within the context of Canadian law, the general prohibition on intentionally ending the life of another person can be overridden only in cases where one can correctly judge that their life is not or is no longer worth living.

When someone requests MAiD, they are effectively saying, “It would be better if I no longer existed.” A moral agent who acts on such a request, then, must agree that it would indeed be better for the person requesting MAiD not to exist any longer. One could object that the MAiD provider need not judge or agree that the life of the person seeking MAiD is not worth living because all that is needed to warrant provision of MAiD is the person’s own judgment that their own life is not worth living. Accordingly, the MAiD provider need only determine whether the person requesting MAiD has competently and without undue pressure judged their own life not to be worth living in light of the intolerable suffering resulting from their grievous and irremediable illness. But if MAiD is to be understood as a medical practice along with other end-of-life care practices, then the practising physician must be able to determine when it is medically indicated. Again, the

eligibility requirements show that MAiD is not medically indicated simply when a person judges that their own life is not worth living. There must also be objective indicators: the patient must have an irremediable illness that causes intolerable suffering. The point of these objective indicators is precisely to enable the physicians involved to determine when it really would be better for a person not to exist than to continue to exist. And if the physician is involved in such a determination, then they must themselves judge that the patient's life is not worth living.

A second line of objection would attempt to break the connection between MAiD's legitimacy and *any* judgment about whether the life of the person requesting MAiD is worth living. Accordingly, no one (neither the person requesting MAiD nor the MAiD provider) needs to judge that the person's life is not worth living; the only requirement is to judge (a) that the person is in fact suffering from a grievous and irremediable illness, and (b) that the resulting suffering is intolerable to them. Would a person's meeting conditions (a) and (b) in itself justify aiding them to end their life by providing them with MAiD, by contrast to the case of anyone who fails to meet either or both of (a) and (b), for whom the provision of MAiD would constitute a criminal act? No. To see why, consider that there might be means available for addressing the symptoms of their illness—even if it cannot be fundamentally cured—which the patient has not yet tried. In fact, if we believe the testimony of many palliative care professionals, there normally are ways to address an individual's suffering without ending their life by means of a lethal dose of drugs. In such a situation, a physician with the duty to uphold the sanctity of the life of their patient would at least need to make it very clear that these means exist and—in their opinion—ought to be tried. If the patient continued to insist on receiving MAiD without availing themselves of these means, would the physician be warranted in acting to end their life? Only if the patient and the physician were to agree that the life remaining to the patient is not worth living. This is the reason for the additional clause in the MAiD eligibility criteria that the individual's enduring and intolerable suffering “cannot be alleviated *under conditions the person considers acceptable*.” Presumably, the patient's reason for finding the available means of addressing the suffering would have to be sufficiently weighty.¹⁸ What other reason, besides the judgment that continued life in their condition is not worth living, would fit the bill?

I take the above to show that providing MAiD, and thereby violating the principle of the sanctity of life, can only be justified if the patient and the MAiD provider both agree that the patient's remaining life is not worth living. Without the additional judgment that the individual's life is not worth living, it would not be legitimate to end someone's life by providing MAiD. To reach

my conclusion that MAiD is (almost always) morally indefensible, I must also show that it is (almost always) morally indefensible to agree that another person's life is not worth living.

Is it ever morally okay to agree that a person's life is not worth living?

It is entirely understandable that, in the face of intolerable suffering, a person would question whether their life is worth living. And it is an important part of a physician's task, in caring for people facing such suffering, to listen, try to understand, and empathize with the patient. As Fredrik Svenaeus puts it, “Clinical empathy and medical hermeneutics demand an attempt to understand the whole life situation and identity of the patient, especially in cases of severe, chronic, and terminal suffering. What does the patient's life look like and what makes it worth or not worth living?”¹⁹ Surely, there are many situations where a person's core values, identity, and sense of attributed dignity are so damaged by illness that only an unfeeling and hard-hearted person would fail to appreciate the urgency and seriousness of their request for assistance in ending their life. In light of this, one might ask, “So what if MAiD involves agreeing with a patient that their life is no longer worth living?” If it is true that their life is no longer worth living, what is wrong with acknowledging that fact and acting accordingly by providing MAiD?

An initial problem with such a stance is that there is no universally agreed upon standard for judging when a person's life is or is not worth living. But some standards are arguably ones we ought to oppose, and judgments arrived at using those standards should likewise be opposed. Svenaeus warns that

the question if a person's life is worth living may very well become strongly influenced by the utility-productivity paradigm. If you do not feel much pleasure but rather pain, if you are no longer able to do things that make your life meaningful, and even less contribute to the flourishing of others, your life may quickly look like a useless productivity drain, stealing time and resources from others.²⁰

The point is that people might reach the conclusion that their life is no longer worth living on the basis of a mistaken or harmful standard. If so, it would be better to resist agreement with their judgment rather than simply giving in to their request for help to die. A further problem, also raised by Svenaeus, is that a person's sense of their worth or value is typically relationally constructed. In particular, “a person's dignity and wish to live is dependent on how her life appears in the eyes of others when vulnerable and desperately in need of solidary assistance and support from fellow

human beings.”²¹ If so, then the judgment of others that one’s life is not worth living could be a key factor in leading one to believe that their life is not worth living. Psychiatrist Herbert Hendin, along with many experienced palliative care professionals, states that “persons who ask for assisted suicide are often merely testing the waters, looking to see whether others will confirm one of their own deepest fears – that they truly have become worthless.”²² In such circumstances, to adopt a stance of agreement with the patient’s judgment would be to provide evidence for the judgment itself and thereby to participate in causing the patient’s sense of worthlessness.

A third problem with judging that a person’s life is not worth living (that it would be better for them to be dead than to continue to live) is that to do so entails the further false judgment that the person no longer bears intrinsic value, worth, or dignity. This is because if one recognizes the intrinsic value or worth of a person, one cannot act to destroy that person. The link between the intrinsic value or worth of a person and the impermissibility of destroying a person is the intuition captured in the principle of the sanctity of life.

This line of argument is hypothetical: If human persons normally bear intrinsic dignity, and if the intrinsic dignity of persons entails the impermissibility of destroying them, then to judge that a person’s life is not worth living, one must judge that their life no longer bears intrinsic dignity.²³ I assume that human life does normally have intrinsic dignity, and that part of what it means for x to have intrinsic dignity is that it is wrong to destroy x. And so, I conclude that to judge a person’s life not to be worth living involves judging their life to have lost its intrinsic dignity. But a judgment that a person’s life has lost its intrinsic value will be mistaken unless that person has already ceased to exist. This is because, given what it means for something to have intrinsic value, it is not possible for a person to lose intrinsic value while still remaining a person. Intrinsic value is distinct from instrumental value. But whenever the judgment that a person has lost their intrinsic value is mistaken, the further judgment that their life is no longer worth living will also be mistaken. Since acts of euthanasia imply agreement that the recipient’s life is not worth living, acts of euthanasia are necessarily based on mistaken judgments.²⁴

Conclusion

I have offered an account of the way in which acting to end the life of a patient (via MAiD) violates the sanctity of life and the intrinsic dignity of the human person that complements Sulmasy’s Kantian account. Except perhaps in extreme cases, like the case of the fictional dying car explosion burn victim I mentioned earlier, MAiD involves undermining a person’s intrinsic

dignity (by destroying it). Arguing that MAiD is necessary to preserve the person’s dignity, then, involves one in a contradiction of practical reason, as Sulmasy suggests. But the point can be made more compellingly by explicating the relational dynamics involved in ending someone’s life via MAiD. Acting in this way involves the MAiD provider to agree with the patient that the patient’s life is not, or is no longer, worth living. Adopting this stance toward a patient is morally problematic for at least three reasons: (1) it may endorse and reinforce false standards of assessing the value of human life; (2) it may contribute to the patient’s sense of their own worthlessness; and (3) it entails the false judgment that the patient no longer possesses intrinsic dignity. I leave the question open whether in certain truly extreme cases a person might (paradoxically) determine that the only way to respect a person’s intrinsic dignity is to help in destroying it: that is, by assisting the person to end their life. But most of the cases of MAiD currently taking place in Canada and other jurisdictions that permit it would not fall under the classification of extreme cases. These non-extreme cases are morally indefensible from a moral point of view that takes sanctity of life and intrinsic dignity seriously.

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1 In Canada, MAiD includes both physician-assisted suicide and euthanasia, but since euthanasia is the form of MAiD practised almost exclusively, in this article I will use “MAiD” and “euthanasia” interchangeably. Furthermore, I use “euthanasia” to refer only to voluntary active euthanasia.

2 See especially Daniel P. Sulmasy, “Death with Dignity: What Does It Mean?” *Josephinum Journal of Theology* 4 (1997), 13–23, and, by the same author, “More than Sparrows, Less than the Angels: The Christian Meaning of Death with Dignity,” in *Living Well and Dying Faithfully: Christian Practices for End-of-Life Care*, ed. John Swinton and Richard Payne (Grand Rapids, MI: Eerdmans, 2009); “Dignity, Rights, Health Care, and Human Flourishing,” in *Human Rights and Health Care*, ed. G. Diaz Pintos and David N. Weisstub (Dordrecht: Springer, 2007); “Death, Dignity, and the Theory of Value,” *Ethical Perspectives* 9 (2002), 103–18; “Dignity and Bioethics: History, Theory, and Selected Applications,” in *Human Dignity and Bioethics*, ed. E.D. Pellegrino (Washington, DC: The President’s Council on Bioethics, 2007).

3 Here is a particularly clear formulation of the idea in Kant: “Whatever has reference to general human inclinations and needs has a market price ... but that which constitutes the condition under which alone something can be an end in itself, has not merely a relative worth, i.e., a price, but an intrinsic worth, i.e., dignity.... Hence morality and humanity, insofar as it is capable of morality, alone have dignity” (*Grounding for the Metaphysics of Morals*, Ak 435, trans. J. W. Ellington [Indianapolis, IN: Hackett, 1981], 40–41). Sulmasy has shown how Italian theologian Antonio Rosmini brought the Kantian notion of dignity into Catholic theology by fusing it with the Judeo-Christian notion of the *imago Dei* (Sulmasy, “Death with Dignity”).

4 Sulmasy, “More than Sparrows, Less than the Angels,” 229. Although commonly associated with the Judeo-Christian notion that human beings are created in the image of God (*imago Dei*), the idea that human life is sacred appears in various religious faiths as well as in

secular accounts. See Steve Clarke, "The Sanctity of Life as a Sacred Value," *Bioethics* 37 (2023), 33.

5 This kind, Sulmasy writes, has the following features: "capable of language, rationality, love, free will, moral agency, creativity, humor, aesthetic sensibility, and a capacity to grasp the finite and the infinite" (Sulmasy, "More than Sparrows, Less than the Angels," 233).

6 Sulmasy, "More than Sparrows, Less than the Angels," 235–36. Plausibly, dignity in this sense is what the Universal Declaration of Human Rights (1948) intends in stating in its preamble that "[R]ecognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world..." and in article 1 that "All human beings are born free and equal in dignity and rights" (<https://www.un.org/en/about-us/universal-declaration-of-human-rights>).

7 Clarke, "The Sanctity of Life as a Sacred Value," 32–33.

8 For an account of the conditions that must be met for the rule of double effect to apply to a situation, see Ana S. Itlis, "Euthanasia in Catholic Healthcare," *Christian Bioethics* 12 (2006), 281–90.

9 A simple test to determine whether one intends the patient's death in carrying out a particular intervention involves asking whether, if the intervention failed to lead to death, one would seek to use some other means to bring about death. In the case of MAiD, the answer would necessarily be "yes," but in withdrawing life-sustaining treatment or administering palliative sedation, the answer could be "no."

10 Hannah Faris, Brian Dewar, Claire Dyason, David G. Dick, Ainsley Matthewson, Susan Lamb, and Michel C. F. Shamy, "Goods, Causes and Intentions: Problems with Applying the Doctrine of Double Effect to Palliative Sedation," *BMC Medical Ethics* 22 (2021), 141.

11 Under current Canadian MAiD legislation, the illness causing the suffering cannot be (solely) a mental illness. In March of 2021, Bill C-7 was passed into law, including a two-year period to prepare for the inclusion of individuals suffering solely from mental illness within the eligibility criteria for MAiD. In February 2023, this two-year period was extended to March 2024. I have discussed elsewhere ways in which actual occurrences of MAiD in Canada can differ from the idealized conditions of a competent patient giving fully voluntary consent (see my 2023 article in *The Conversation*, "As Eligibility for MAiD Expands, the Ethical Implications of Broad Access to Medically Assisted Death Need a Long, Hard Look"). Among the other impacts of Bill C-7, patients whose death is reasonably foreseeable no longer need to give final consent. Moreover, the extent to which patients are fully informed of and provided access to alternative ways of addressing their suffering can be quite limited; Canadian legislation only requires that they be informed of such alternatives, not that the alternatives be tried.

12 I say that it would suffice, *all other things being equal*, because the patient, while being the agent whose interests are most directly affected, is not the only agent affected by the outcome. For purposes of argument, I am bracketing off a broader consequentialist analysis that would factor in the interests of others who are affected.

13 Sulmasy, "More than Sparrows, Less than the Angels," 242.

14 Harvey Chochinov, *Dignity Therapy: Final Words for Final Days* (Oxford: Oxford University Press, 2012).

15 Sulmasy, "Death, Dignity, and the Theory of Value," 110.

16 *Ibid.*, 113.

17 *Ibid.*, 113–14.

18 In addition to awareness of alternative means to address suffering, a physician might also believe that the individual requesting MAiD has good reasons to continue living despite their suffering. If so, they would only be warranted in providing MAiD if they became convinced that these reasons are outweighed by the burdens of continued life. But to judge that the burdens of continued life outweigh the positive reasons for living just is to judge that the remaining life is not worth living.

19 Fredrik Svenaeus, "To Die Well: The Phenomenology of Suffering and End of Life Ethics," *Medicine, Health Care and Philosophy* 23 (2020), 335–42, at 339.

20 *Ibid.*, 341. To see the implications that can be drawn from using a standard like this, see D. Benatar, *Better Never to Have Been: The Harm of Coming to Existence* (Oxford: Oxford University Press, 2006). Svenaeus notes that Benatar holds that most or all human lives are not worth living.

21 Svenaeus, "To Die Well," 341.

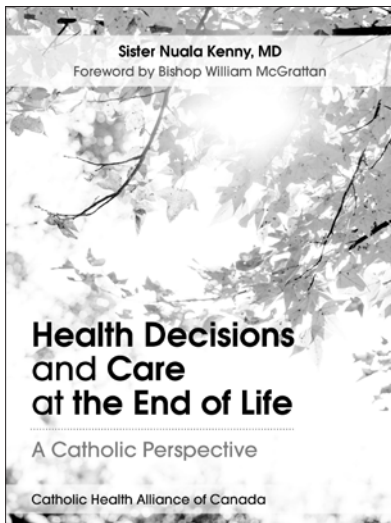
22 Herbert Hendin, *Seduced by Death* (New York: W.W. Norton, 1996), 156; cited by Sulmasy, "More than Sparrows, Less than the Angels," 243.

23 Of course, one could simply deny that human persons ever possess intrinsic dignity. But that denial comes at a great moral cost.

24 Recall that by "euthanasia" I am referring only to voluntary active euthanasia. Since such acts assume a recipient who has voluntarily requested that their life be ended, such acts assume a recipient who remains a person. I do not have time to consider here the issue of when a human being ceases to be a person. But on any criterion for personhood-cessation of which I am aware, a competent human being who is capable of expressing their wishes to have their life ended must be a person.

Health Decisions and Care at the End of Life

A Catholic Perspective



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also offers the light of Christian faith, which can illuminate how we might approach this important event in our life by trusting in God.” —*Bishop William McGrattan, from the Foreword*

Sister Nuala Kenny, OC, MD, FRCPC, is a member of the Sisters of Charity of Halifax. She received her MD degree from Dalhousie University in 1972, then specialized in pediatrics. She is the author of *What Good Is Health Care?* and *Lost Virtue: Professional Character Development in Medical Education*, as well as *Healing the Church* (Novalis).

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Jewish and Catholic Bioethics: My Experience

By Yoelit Lipinsky
Toronto, Canada

The call to Ethics Services came in around 2:00 that afternoon. The caller wanted to have a consultation with me about whether we, as a Catholic hospital, would ethically permit a patient to undergo an exorcism as an alternative treatment for her diagnosis. This was a call that could only come through to the Jewish bioethicist, at the Catholic hospital, trained in both religious traditions. Religion—and its tensions with secular medicine—has always been interesting to me. Indeed, the prism of religion is what some believers use to make medical decisions. While some may find religious structures too restrictive, I find that religion can promote creativity and innovation. This nexus between religion and intellectual imagination is where my mind thrives.

How, then, does a Jewish scholar become a Catholic bioethicist? The journey was as winding as a Talmudic argument and was blessed with mentorships and happy coincidences along the way. I was privileged to have studied under superb scholars for my MA at the University of Toronto in religion, Jewish studies, and bioethics. My thesis focused on Jewish reproductive technologies. While exploring bioethics as a career path, it became utterly apparent to me that I needed to pursue a doctorate degree to follow my intellectual passions. I found myself at Duquesne University, a Jesuit institution that has a PhD program in bioethics—that is, Catholic bioethics.

I recall having trouble with grasping the ethics concept of double effect. My struggles lay in my trying to draw comparisons within Judaism's legal-religious structures. Once I learned to compartmentalize my mind into three boxes—Jewish, Catholic, and secular—I found that I could easily turn my mind to each box in turn when analyzing a case. This compartmentalization forced me to master Catholic concepts and their nuances. It also forced me to hone my knowledge in Jewish medical ethics to ensure that my analysis of both religious traditions was timely and accurate. Once I demonstrated authority over both religious (and secular) bioethics foundations, I allowed the boxes to “leak” into each other to expose beautiful ways that each religious tradition could “teach” the other—and to inform otherwise secular thinking that dominates the medical field. My expertise allowed me to criticize

each religion and, at the same time, find each religion's strengths. I also took (and continue to take) small pleasure in pushing the envelope in terms of theological logic.

During my course work at Duquesne, students were encouraged to take at least one rotation in clinical ethics, which happened to be at our local Catholic hospital. I recall one Ethics and Lunch meeting there where the head chaplain asked us to bow our heads to pray. As the sole Jewish student in the group, I just sat quietly. The priest walked up to me. “My dear,” he said, “I hate to pry, but what is your relationship with Jesus?” I was a little dumbfounded since my relationship with Jesus was very much a platonic one. I told him that I am Jewish. Now was the priest's turn to be dumbfounded. I saw him try not to struggle openly. “Well then,” he continued, clearly struggling. “My dear, will you please bless us with a Hebraic prayer during next Lunch meeting?” We both walked away probably equally confused.

I also recall one rotation on the geriatrics ward. I was working with a fellow student, and we both went to the room of a particular patient who was supposed to be making a rather difficult care decision. She was joyful. She looked at both of us and said, “Can you kids both pray for me?” I told her that I am Jewish, but I would be happy to do so. My colleague said he was Christian and would do the same. “Well, damn,” she said, “I want both of you to pray 'cause at least one of you is right!”

Being a practising Jewish woman in a Catholic environment has not always been humorous. There were times when the ethics of one religious tradition clashed with another. In my experience, the one issue that most exposed the difference in ethical traditions was reproductive options. Perhaps because of political movements in the United States, people often lump Catholic and Jewish ethics together. This is a mistake, especially for beginning-of-life issues. At an ethics round during my university days, my colleagues and I were presented with a case of a young woman who, at 19, was pregnant for the second time. Her first pregnancy was the result of rape; she then proceeded to have a traumatizing vaginal birth. She wanted a

planned C-section this time around to avoid birth trauma, hence the ethics consult. The team also noted that her mental health was declining, which led us to become worried about her health were she to get pregnant again. We were also aware that she was not keen on having protected sex. I asked whether we could prescribe birth control for mental health purposes since it could prevent further trauma until her therapist felt she was in a place to go off it. Heads turned to look at me. After all, I opined, couldn't the principle of double effect be used here? I was asked to leave the room. My supervisor later came to find me and said, "Yoelit, I'm so sorry. You cannot offer contraception at a Catholic hospital." I argued gently that I know this but in terms of mental health, couldn't the principle be applied here? "No, Yoelit," said my supervisor, sadly, "not in this case, no. You are being too ... too ... Talmudic!" I am happy to report that I have since become far better at separating both religious traditions. But I still think the principle of double effect applies in this case.

My time as a clinical ethicist in a Catholic hospital overlapped with the overturning of *Roe v. Wade*, which was a difficult time for me. Jewish ethics considers why a woman would want an abortion—there is no ethical prohibition against it in Judaism, and Jewish law allows for it. It has been trying, at times, to reconcile my personal beliefs, my religious beliefs, and the religious beliefs of my Catholic employer.

There have been times when Jewish friends or community members look askance about how I came to work in Catholic ethics. They are sometimes confused and sometimes concerned. Am I *really* Jewish? What is going on here? They have also wondered how I can work in an environment that has crosses everywhere. I have often joked that I don't feel comfortable without at least one on the wall—it's a response that doesn't always come across very well. Among my Catholic friends and colleagues, I have often been asked to give lectures and classes on Jewish bioethics. Those opportunities kept my skills up in Jewish ethics and served as a break from Catholic ethics.

In early 2023, I made the difficult decision to leave Catholic health care for a new position at a private company as a data ethicist. I loved the pace, dilemmas, and challenges of working within Catholic health care. I also, however, love data ethics, which I was exposed to as a postdoctoral fellow. I have been extremely lucky to be trusted with being a data ethicist, which is a bit of a Wild West compared to the structures and frameworks of the bioethics world!

Yoelit Lipinsky holds an MA in Religion, Jewish Studies and Bioethics from the University of Toronto, a Master of Public Administration from Queen's University, and a PhD in Healthcare Ethics from Duquesne University. Currently, she is an ethicist at Telus focusing on data ethics and artificial intelligence ethics.

The Way of the Samaritan in Health Care

By Scott Kline

St. Jerome's University, Waterloo

"I have no idea what's awaiting me, or what will happen when this all ends. For the moment I know this: there are sick people and they need curing."

While these could easily be the words of an emergency room doctor attending to patients suffering from the deadly effects of the coronavirus, they actually belong to Dr. Bernard Rieux, the fictional character in Albert Camus' 1947 novel *The Plague*, a story about what happens in the North African city of Oran as people there come to terms with a mysterious epidemic.¹ I have taught *The Plague* for many years in an ethics class for university students preparing to embark on a four-month international service-learning term. I ask my students to consider why Dr. Rieux does what he does. He sees so much suffering, so much death. He knows that he will relieve the suffering of a small number of people and that he will save even fewer lives. He is also fully aware that he is risking his own life doing all of this.

As the plague settles over Oran, Dr. Rieux encounters various characters who engage him in meaningful conversations about life. Included in this cast of characters is a bombastic Catholic priest who initially sees the plague as a punishment for Oran's sins. He later acknowledges that his view was wrong when he adopts a pastoral message of caring for the sick, suffering, and dying. Rieux also encounters a foreigner named Tarrou, who is trapped in Oran. A pacifist and an atheist, Tarrou questions the doctor about his lack of belief in God and whether he is concerned about his soul. Rieux tells Tarrou over the course of several conversations that while he has contemplated the existence of God, the possibility of an afterlife, and even whether this current life has a purpose, it is not fear over "what's awaiting" that motivates him. He just knows that people are sick and they need help—and helping the sick is the right thing for a doctor to do.

Tragically, the COVID-19 virus has generated countless real pandemic stories. Since late 2019, hundreds of millions of people around the world have been infected by the deadly virus. Estimates show that more than six million people have died from COVID-related causes. We've experienced so much suffering, so much death. We've lost family members, friends, colleagues, and neighbours. We grieve their passing even as we celebrate their lives.

Throughout this pandemic, we supported one another with hope-filled stories. We told stories about how important health care workers are to our communities. We called them "heroes" as they head off to hospitals, long-term care facilities, and emergency health clinics overwhelmed with the sick. Many of our health care workers continue to suffer from physical exhaustion and mental fatigue. The virus has stretched our health care system to a breaking point. And yet, in spite of their already heavy loads, the sheer commitment of nurses, doctors, health care practitioners, and personal support workers, as well as operational staff such as cleaners, food service personnel, and hospital attendants, has kept the system from utterly collapsing. There are sick people—and they need our help.

Moreover, we've come to recognize in stories too numerous to name that we do, in fact, rely on essential workers to keep our essential services running. These are not only health care workers but also grocery store clerks, meat packers, agricultural workers, truck drivers, schoolteachers, and daycare workers, to name just a few.

Through many of these same stories, we've also heard stories of injustice. For example, we've learned that personal support workers may be working full-time to care for our most vulnerable community members, but many do not earn a living wage. We've heard stories about shockingly unsafe conditions in our long-term care facilities, distribution warehouses, and even in some of our schools. Many who live and work in these environments have been putting their health at risk for years—COVID has only highlighted the unsafe, unjust conditions.

The pandemic has also highlighted, once again, the socio-economic disparities in health care access and outcomes. For instance, in the United States, Black and African American communities were disproportionately affected by COVID-19 in the first 18 months of the pandemic, with higher case rates, more deaths, and more severe economic effects than other racial and ethnic communities. Why was this happening? Surveys tell us that it was due to lack of access and vaccine hesitancy fuelled by stories about morally reprehensible studies carried out on Black men in the 1930s. Behind all of this is the dehumanizing, structural evil of racism: the historical injustices suffered by Black people at the hands of political, educational, and

medical institutions continue to have harmful effects on the health of Black people today.

I have been teaching courses in ethics for almost three decades. One of the lessons I've learned during this time is that teaching ethics is best done by introducing students to stories that speak to them, challenge them, and invite them to contemplate their meaning. My hunch is that this approach to teaching ethics works well because our ethical reasoning is naturally developed through the stories we encounter around the kitchen table, in our schools, in our clubs, over coffees or beers with friends, in our youth groups, and so on. We share stories about our families, friends, and communities. Stories are how we remember and memorialize. They have the capacity to shape, reshape, and explain our experiences. They help us make sense of the world and our place in it. They can inspire us, teach us, challenge us, and call us to action. Stories can upset the status quo. They can communicate something core about what we, as human persons, value or ought to value in life. Our stories connect us to a past and provide direction for the future. They help us answer fundamental ethical questions such as "How shall we live?" and "Who do we hope to become?"

Figuring out what stories mean can be a bit tricky. Stories must be interpreted and reinterpreted if they are to mean something to us. The meaning a story holds for us today may change later as our horizons expand and we grow in knowledge and wisdom. We may come to recognize that stories, even the simplest ones, can have several layers of meaning. Hannah Arendt, one of the most provocative and insightful philosophers of the 20th century, observes, "Storytelling reveals meaning without committing the error of defining it."² In other words, the storyteller must not succumb to the temptation of simply telling us what the story means or what the storyteller thinks it means. Rather, it is up to us, the interpreters, to reconcile the reality of the ways things are now with the possibilities that confront us in the stories we read and hear.

The Parable of the Good Samaritan

One of the stories we Christians like to tell when we consider the gospel imperative to "heal the sick" (Matthew 10:8) is the parable of the Good Samaritan, which we find in the Gospel of Luke (10:25-37). In fact, The Catholic Health Alliance of Canada uses the parable of the Good Samaritan as a way to frame the most recent edition of the *Health Ethics Guide* (2012). The *Health Ethics Guide* is important because it "outlines the moral obligations for the sponsors/owners, boards, members of ethics committees, and personnel of Catholic health and social service organizations."³

The Samaritan story is one that Jesus tells a Jewish legal scholar in response to the question "Teacher, what must I do to inherit eternal life?" Jesus prompts the scholar to give the correct answer, in accord with Jewish law: "Love your neighbour as yourself." But the legal scholar isn't fully satisfied with the answer, so he asks Jesus another question: "And who is my neighbour?" Jesus then tells the story of a man left along the road, "half dead," the victim of an assault. A priest, no doubt heading to his home in Jericho from the temple in Jerusalem, doesn't just pass by the injured man without helping him, he actually crosses to the other side of the road to avoid him. And then a Levite—whose vocation is to help priests carry out religious rituals in the Jerusalem temple—walks by; he, too, decides to cross the road to avoid the "half-dead" man. Finally, a Samaritan, who belongs to a group that Jews consider to be heretics, sees the injured man, is moved by compassion, and comes to the aid of the victim. Not only does the despised Samaritan provide immediate care, but he also ensures that the man is cared for in the longer term. The Samaritan leaves the injured man with an innkeeper and gives the innkeeper money to be used to nurse the man back to health. The story ends with Jesus asking a question of the legal scholar: "Which of these three, do you think, was a neighbour to the man who fell into the hands of the robbers?" The scholar says, "The one who showed him mercy." Jesus replies, "Go and do likewise."

Let me make a few general observations about this parable. First, the parable's style is consistent with other parables recorded in Matthew, Mark, and Luke—the synoptic gospels. While Jesus' parables contain echoes of traditional rabbinical parables, they were different. Joachim Jeremias, the author of the classic book *The Parables of Jesus*, which was first published in 1954, observes that, in comparison to other parables from the same period and cultural context, Jesus' parables have a unique "clarity and simplicity." In them, "Hearers find themselves in a familiar scene," Jeremias writes, "where everything is so simple and clear that a child can understand, so plain that those who hear can say, 'Yes, that's how it is.'"⁴

Second, in telling the Samaritan story, Jesus did not need to tell his followers what to think about the priest, the Levite, or the Samaritan. They already had well-formed opinions about these characters. They had shared stories about them. They knew how each character was *supposed* to act. They knew the script. So, as the story of these characters went off script, with the hated Samaritan coming to the aid of a critically injured victim, it would have prompted further conversation, more debate, and a new ethical problem to be figured out, which was precisely the objective of the parable.⁵

And third, like any good storyteller, Jesus did not tell his followers what the story meant. He left it up to them to figure it out. But what did the story actually mean then? And what does it mean now? These are complex questions that require complex answers. But let me try to simplify things a bit without offending (too many) New Testament scholars.

To begin, there is a consensus among current parable scholars that all of the parables had one overriding message: *the kingdom of God*. In the decades following Jesus' death, it had become popular to interpret the parables as allegories that concealed the mystery of the kingdom of God from outsiders. Surely, Jesus had to be talking about something else, something far more profound, when he tells stories about crooks, dysfunctional families, ungrateful children, sacrilegious separatists, despised tax collectors, incompetent farmers, persistent women, unfruitful fig trees, and a whole slew of this-worldly conundrums that would have undoubtedly made followers' ears perk up with interest.

Indeed, by the fourth century, St. Augustine had developed an allegorical interpretation of this parable that identified Jesus as the Samaritan, Adam as the victim, and the thieves as the devil and his fallen angels.⁶ By the 20th century, the long tradition of allegorical interpretations had given way to historical-critical approaches. Today, New Testament scholars use historical, sociological, and literary analyses to illuminate the meaning of scripture to help us better understand the meaning of the parable in its original context.

While historical-critical approaches to the parables remain popular among scholars of early Christian literature, a decidedly ahistorical approach continues to hold sway among many pastors, homilists, and even moral theologians. The Catholic New Testament scholar Gerhard Lohfink observes that it is quite common these days to regard Jesus' parables as "autonomous aesthetic constructions" that communicate universal wisdom which can be applied to a wide range of contemporary situations that call for action amid moral uncertainty.⁷ This is Lohfink's fancy way of saying that we *should not*—indeed, *must not*—treat Jesus' parables as saccharine stories designed to elicit sentimental meaning solely for the individual consumer. They're not the stuff you should find in the self-help section of the bookstore. Nor are they isolated nuggets of ethical wisdom to be used indiscriminately in the odd Hallmark card, sermon, homily, or public lecture.

For Lohfink, parables foretell the kingdom of God. He writes,

If we regard Jesus' parables as "autonomous aesthetic constructions" that stand by themselves ... we will too easily miss what they have

to say. Then we will see them only as general ethical admonitions, acute precepts of wisdom, or the uncovering of the realities of human existence ... But Jesus' parables were decidedly more than that: they spoke of the urgent advent of the [kingdom] of God and about the "here and now" of the rule of God in Israel. Jesus' parables must never be isolated from the one who spoke them and the situation into which they were uttered.⁸

Today, the parable of the Good Samaritan is often used as a metaphor to encourage us to engage in some virtuous or humanitarian act. And rightfully so. As we will soon see, I, too, want to read the parable as a motivating narrative, especially when it comes to contemporary health care. But in doing so, we *must always remember* that the story of the Samaritan was politically dangerous. It was subversive because it challenged the power of the Jewish authorities in Jerusalem and the authority of the Roman empire. Those with power and privilege in the Samaritan story—that is, the priest and the Levite—are not the heroes. They are the foils. It is, rather, the marginalized and hated Samaritan who acts in accord with the Law, exemplifies the virtue of neighbourly love, and cares for the injured victim.

One subversive subtext of the parable is that unchallenged power and privilege can lead to complacency, indifference, and utter disregard of those who are less powerful and in need. The legal scholar undoubtedly comes to this same conclusion once he realizes that the priest and the Levite, models of Jewish orthodoxy, are not following the law to "love your neighbour as yourself." The hypocrisy of the priest and Levite, who are charged with keeping the Law but end up violating it, breeds suspicion and cynicism. This is why we must, at times, pose questions to those in authority. It is also why we must continually question our own power, our own privilege, our own way of *being* Christian. As Pope Francis says as he reflects on the parable, "This simple and inspiring story [of the Samaritan], indicates a way of life, which has as its main point not ourselves, but others, with their difficulties, whom we encounter on our journey and who challenge us. Others challenge us. And when others do not challenge us, something is not right; something in the heart is not Christian."⁹

While it is true that the parable of the Good Samaritan is not about first-century health care, the story does revolve around a question of health care justice: Who is responsible for caring for the victim left for dead alongside the road? As the Catholic philosopher and social critic Ivan Illich rightly observed, the Samaritan had no ethical duty to care for the injured victim because the man, presumably a Jew, did not belong to the Samaritan's people, nation, or tribe. In the context of first-century Palestine, one's ethical duty

was only to one's neighbour. There was no sense of a "common humanity" or what we would today call a "cosmopolitan ethic of universal humanity." Going to the victim meant actually challenging cultural norms, violating moral decency. As a result, the parable of the Good Samaritan invites us to ask difficult, perhaps even subversive questions about how our political decisions, social structures, cultural practices, religious authorities, our concept of the common good, and our responses to vulnerable and underserved populations affect the way we care for our sick neighbour.

The Samaritan Story as a Motivating Narrative in Health Care

On June 9, 2018, an emergency call came into the 911 dispatcher.

Dispatch: Ambulance: What is your emergency?

Caller: I need an ambulance at [gives address]. My husband. He's 51 ... I think he's having a heart attack. He's grey. He's not responding.

Dispatch: ... Is he breathing normally?

Caller: No, no he's not. Not at all. It's laboured. Sounds bad. Oh my God. Please help me. [Crying]

Dispatch: Hey, ma'am. Please calm down. Ambulance is on the way. Please stay on the phone. Are you near him?

Caller: No, he's in the other room. My phone won't reach that far. How long will it be before the ambulance gets here?

Dispatch: Soon. Please just stay calm and listen to me ...

Indeed, that 51-year-old man is having a heart attack, and he has gone into cardiac arrest. His heart has stopped beating—he is clinically dead. Every year, in Canada, some 35,000 people will become the victim of a sudden cardiac arrest. Only 10 percent will survive. And only 8 percent will survive without any loss of brain function. Without someone's help—without someone doing cardiopulmonary resuscitation (CPR) or using an automated external defibrillator (AED)—his heart will not restart. Luckily, his wife is there to call 911. The ambulance is eight to 10 minutes away. The fire truck is closer—it's six to eight minutes away. He has already been down, without a pulse, for three or four minutes. In this case, time does not heal wounds.

Research has shown that early and effective CPR is crucial to increasing the chance of surviving a sudden cardiac arrest. For every minute a cardiac arrest victim is without CPR, their chances of survival decrease by 10 percent. While emergency response times have been creeping downward across Canada generally,

there are still areas where response times can be quite long. For instance, in rural areas of Southwestern Ontario, where I live, an ambulance might be 15 to 20 minutes away, at best. And even in high-density urban centres such as Toronto or Vancouver, actual response times can also be quite lengthy, especially when emergency responders need to reach the upper floors of high-rise condos. Delays created by tight security systems, slower elevators, and just the fact that it takes time to travel up 25 or more floors in an elevator can mean multiple minutes lost. To put it bluntly, a penthouse is not the place you want to be if you go into cardiac arrest—that is, unless you have neighbours nearby who can respond with CPR and, ideally, with an AED.

Surviving sudden cardiac arrest depends on a series of events, beginning with someone calling 911. Sometimes referred to as "The Chain of Survival," the next link in the chain, after calling for help, is CPR.¹⁰ Traditionally, this link has meant high-quality CPR done by professionally trained emergency responders. In practical terms, though, we know that survival most often depends on a community bystander, often a family member, starting CPR as soon as possible and using an AED.

Here is where I would like to pose a question to you. What can we—and by "we," I mean all of us—do to increase the chance of survival by *decreasing* the time between an individual collapsing with a sudden cardiac arrest and having someone else providing CPR and using an AED?

To help answer that question, I would like to introduce Neighbours Saving Neighbours, a community-first response program that has been launched in Frontenac County (Kingston), Ontario, and is being organized in Perth County (Stratford), Ontario. It is an approach that empowers lay (that is, non-medically trained) community members to respond to a sudden out-of-hospital cardiac arrest first, while emergency medical services (EMS), fire fighters, and other emergency responders are on their way.

Neighbours Saving Neighbours begins by recruiting volunteers in the community who are willing to be trained in basic CPR—these days, just simple "hands only" CPR. These volunteers are also trained on how to use an AED. Typically, there are enough trained volunteers to "saturate" an area when a cardiac arrest call comes in. In some cases, AEDs are assigned to individuals; in other cases, AEDs can be strategically placed in neighbourhoods and properly registered. A key component of Neighbours Saving Neighbours is the use of technology, such as a mobile phone app, to dispatch community responders to the scene. One of the apps is appropriately named "Good Sam." This

use of technology to dispatch community responders is important because it can even further reduce the time between collapse and life-saving resuscitation measures.

In the gospel story, it was fate, chance, luck, or a miracle that the Samaritan happened to be walking down the road and found himself in a position to respond to the victim. What the Neighbours Saving Neighbours program does is try to reduce our reliance on chance, luck, and even the miraculous. Instead, it equips our neighbours with the knowledge, skills, and means to help save someone's life.

The community-first response approach is a simple concept. But there are significant barriers facing community-first response programs.

One barrier is cultural. Generally, we Canadians consider CPR and the use of an AED as too technical and too medical to be trained to use them. Part of the problem is that we've developed the idea that health care is a specialized field and requires specialized knowledge, skills, and language. As a result, part of the recruiting process involves reassuring the public that the training isn't onerous. This means that, in recruiting and in training volunteers, Neighbours Saving Neighbours must use plain language and stories that speak to the community and its culture. Let me give you an example. The Canadian Heart and Stroke Foundation has been promoting the idea that a lay bystander can save a life by using "hands only" CPR, compressing at around 100 to 120 beats per minute, keeping the beat of the Bee Gee's disco tune *Stayin' Alive* in their heads. This approach uses playful pop-culture references, which not only demystifies CPR but also subtly invites us to respond with potentially life-saving action.

Second, we need to support members of our community who are hesitant to start CPR because they're afraid they might do it wrong and might hurt somebody. We have a tendency to leave the response to the professionals. To use the Samaritan story, we may see the victim, but we cross to the other side of the street, hoping that someone more qualified will help the victim. This is especially true for family members who, in that moment of crisis, may be struggling with a wide range of emotions. In fact, they may not be able assess the reality of a family member who is having a cardiac arrest. Surely, they may think, it must be something else. While we need to be sensitive to these very real concerns, the reality is that if the person has no pulse, they will die without CPR and someone restarting their heart, likely with an AED.

Third, we also need to do a better job of allaying persistent fears that performing CPR on a person may expose them to legal liability. Here we need better

education on our "Good Samaritan" laws: these are in place to protect bystanders from legal liability (e.g., British Columbia's Good Samaritan Act, 1996¹¹). In short (and I'm not pretending to be a lawyer giving out legal advice), you are legally protected if you step in and perform CPR.

And fourth, perhaps the most complex challenge is to identify larger motivating narratives that help community members frame their role in responding positively to victims of sudden cardiac arrest. Because these motivating narratives often belong to larger cultural, national, or religious stories, they can help members of the community ascribe meaning to their action and overcome any fear, lack of confidence, or hesitation members may have in responding to someone in need of life-saving help.

Here is where the story of the Samaritan can play a vital role. Indeed, the parable of the Good Samaritan is an apt motivating narrative because it speaks to the hopes and challenges we face in community responder programs. On the one hand, the parable is a story about a lay bystander, the Samaritan, who goes out of his way—apparently not crossing the road but certainly crossing cultural and religious convention—to come to the aid of the half-dead victim. Without the Samaritan's helping hand, the victim would presumably have died. In this respect, the parable is about doing—doing the right and virtuous thing, recognizing the dignity of the victim, responding with mercy and compassion, and acting on the moral imperative to "love your neighbour."

Let me return to our 911 call. That caller was actually my wife. I was the victim of a sudden cardiac arrest, which was brought on by a heart attack (the culprit being a 99-percent blockage of the right coronary artery). Just a few minutes prior to her calling 911, I told my wife, "I don't feel well." She was about to leave for the afternoon. I was going to be home with our two young boys, who were six and four years old at the time. Before leaving, she peeked into the living room, where I had sat down. I was slumped over and not responding. She leapt into action. She tried to hail our next-door neighbours, who are physicians. They weren't home. However, a construction worker we know who happened to be at their house finishing a job heard my wife say, "Scott's having heart attack!" He rushed into the house to help. Another neighbour heard the commotion and came to see what he could do. My wife called 911. As one of the neighbours was coming into the house, he saw the physician neighbour driving up the street. He flagged her down and told her I was in trouble. She rushed in and checked for a pulse. There was none. My neighbours got me down on the floor and, within about four or five minutes of my collapse, the physician began "hands only" chest

compressions. She continued for the next 15 minutes, until the fire department showed up with an AED and then the ambulance. I was shocked three times by the AED—to no avail. Declaring a “scoop and run,” they loaded me into the ambulance, now with a mechanical chest compression device known as a LUCAS strapped to my chest. On the way to the hospital, my heart started to beat again. My neighbours had saved my life.

Samaritan Story Extended

Having been a victim whose life was saved by my neighbours, the story of the Samaritan has taken on new meaning for me. In particular, I’ve come to realize that our focus on the scandalous act of neighbourly compassion in the parable has perhaps prevented us from considering more fully how the crisis affected the actors in the story. This, of course, is asking more of the parable than it could ever deliver. But still, even in the parable itself, the fact that the Samaritan gives money to the innkeeper and promises to give more if needed is a clear indication that the Samaritan’s care for the victim entailed an ongoing relationship, a new way of being with the victim/neighbour, and thus an ongoing ethical commitment to the other.

I would like us to focus on the innkeeper. In the Christian tradition, we’ve honoured the actions of the Good Samaritan by naming hospitals, rehabilitation centres, and hospice care facilities after him. But in doing so, perhaps we’ve missed an opportunity to honour the innkeeper as well, for it is the innkeeper who cares for the victim in the longer term. It is the innkeeper who will journey with the victim as he goes through a difficult recovery. By focusing our attention on the innkeeper, we realize that today’s innkeepers are the doctors, nurses, and other health care workers who have dedicated their lives to caring for others. Many of them talk about their work in terms that sound much like a religious calling or vocation, even if they’re not religious. They are like Dr. Rieux from *The Plague*—there are sick people, and they need care.

As those of us who’ve been around the Church have too often witnessed, it can be easy to take advantage of people who give themselves to others out of a larger sense of calling. The Samaritan’s commitment to pay the innkeeper is a good reminder that health care workers must be justly compensated. They must also have safe working conditions and leisure time to be with families, friends, and loved ones.

Perhaps most importantly, neighbours within the community—that is, all of us—must ensure that our “inns” (our health care institutions and social services providers) are adequately funded to meet the needs of those who are sick. While underfunding public health

adversely affects all of us, it is most acutely felt by the marginalized in our communities—the poor, people experiencing homelessness, and Indigenous populations. As Catholics, we understand the public funding of health as part of our commitment to the common good. It is a matter of social justice. Drawing once again on the Samaritan story, Pope Francis puts it this way:

Let us turn at last to the injured man. There are times when we feel like him, badly hurt and left on [the] side of the road. We can also feel helpless because our institutions are neglected and lack resources, or simply serve the interests of a few, without and within. Indeed, “globalized society often has an elegant way of shifting its gaze. Under the guise of being politically correct or ideologically fashionable, we look at those who suffer without touching them. We televise live pictures of them, even speaking about them with euphemisms and with apparent tolerance.”¹²

Our primary goal should not be to stumble upon a victim who is chronically underserved by our institutions but rather to ensure that our institutions are equipped to serve all who are unwell in our communities.

I also would like us to return to the Samaritan, the bystander who chose to care for the wounded man along the road. If we read the story too quickly, we might easily assume that the Samaritan went away largely unaffected by the events of that fateful day. But we know this is likely not the case, because he has already implied to the innkeeper that he has chosen to establish a new relationship with his neighbour. What’s missing in the parable—and frankly, what’s often missing in stories of bystanders heroically coming to the aid of a victim—is how do the Samaritan’s actions affect him or her emotionally and spiritually?

I ask this question because we know from stories shared with the Bystander Support Network that bystanders often have difficulty making sense of their experiences.¹³ Indeed, research tells us that bystanders can experience trauma, in some cases leading to diagnoses of post-traumatic stress disorder. Those of us who work with bystanders often call them “the forgotten patients.”

On a personal note, this is certainly the reality for the neighbour-bystanders who saved my life. As the victim-patient, I encountered world-class medical professionals and extraordinarily high institutional standards. My physical healing has been stellar. I suffered no emotional or spiritual trauma, in part because I don’t remember anything from that event. But the story of my heart stopping also includes my wife, Megan, my two young boys, my next-door neighbours,

and those who love and care for me—in other words, my community. Regrettably, my two boys saw a lot: they saw their dad lifeless in their living room, then being put in an ambulance with a machine pounding on my chest. *You don't unsee these things*. Megan experienced so much; her world was completely shaken. Even my doctor neighbours, people who are trained, experienced emotional trauma because of their actions saving my life.

It is now more than five years since “The Thing,” as my boys call it, and our family continues to struggle. I survived a cardiac arrest—so did my family. I survived my heart stopping for 20 minutes—so did my family. The formal supports I needed to survive and flourish have been numerous and incredibly helpful. I cannot, however, say the same for my family survivors. We are on a journey together, but they need more support.

In short, being a bystander, being a “good neighbour,” can come at a cost. But in community, we recognize that we may at times need our neighbour to come to us in a time of need. Pope Francis puts it this way:

Each day we have to decide whether to be Good Samaritans or indifferent bystanders. And if we extend our gaze to the history of our own lives and that of the entire world, all of us are, or have been, like each of the characters in the parable. All of us have in ourselves something of the wounded man, something of the robber, something of the passers-by, and something of the Good Samaritan.¹⁴

My hope is that we choose the way of the Samaritan.

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1 Albert Camus, *The Plague* trans. Stuart Gilbert (Harmondsworth: Penguin, 1947); quote above on p. 105.

2 Hannah Arendt, *Men in Dark Times* (New York: Harcourt Brace Jovanovich, 1968), 105.

3 *Health Ethics Guide*, 3rd ed. (Ottawa: Catholic Health Alliance of Canada), x.

4 Joachim Jeremias, *The Parables of Jesus*, 2nd ed. (London: SCM Press, 1972), 12–13.

5 Ernest van Eck, *The Parable of Jesus the Galilean: Stories of a Social Prophet* (Eugene, OR: Cascade Books, 2016), 15.

6 Augustine, *Quaestiones Evangeliorum*, II, 19; cited in C.H. Dodd, *The Parables of the Kingdom* (New York: Scribners, 1961), 1–2.

7 Gerhard Lohfink, *The Forty Parables of Jesus* (Collegeville, MN: Liturgical Press, 2021), 6. The term “autonomous aesthetic construction” recalls philosophical debates regarding the ability of an individual to assess the aesthetic value of piece of literature or art without an outside source. In this case, Lohfink argues that such a construct means that an interpreter does not need to inquire about the historical context or Jesus' intended meaning, an interpretive approach that Lohfink rejects.

8 *Ibid.*, 6. The term Lohfink prefers instead of “kingdom of God” is “reign of God,” since the latter emphasizes the ongoing action of God in the world. He acknowledges that the terms may be used synonymously. I have chosen to use “kingdom of God” because it is more common in English.

9 Pope Francis, “Angelus,” July 10, 2016, https://www.vatican.va/content/francesco/en/angelus/2016/documents/papa-francesco_angelus_20160710.html.

10 For example, see Heart and Stroke Canada, *Addressing Cardiac Arrest in Canada* (Toronto: Heart and Stroke, 2019), 3, <https://www.heartandstroke.ca>.

11 Government of British Columbia, Good Samaritan Act [RSBC 1996], https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96172_01.

12 Pope Francis, *Fratelli tutti* (2020), no. 76; Francis quotes a talk he gave to the Meeting of Popular Movements in February 2017 in Modesto, California.

13 See the Bystander Support Network website: <https://www.bystandernetwork.org>

14 Pope Francis, *Fratelli tutti*, no. 69.

Book Excerpt

“I Call Myself Riscylla, Child of God, Métis Citizen”

Indigenous Realities

Excerpted from *Faith as Protest: Answering the Call to Mend the World*, compiled and edited by Karen A. Hamilton: Chapter 8, With Bishop Riscylla Shaw, Anglican Church of Canada, pp. 81–91) (Novalis, 2023 – used with permission).

It is important to self-identify. I call myself Métis, a person of mixed European and Indigenous ancestry. (Along with First Nations and Inuit, Métis are one of the three Indigenous Peoples in what is now Canada.) This means I walk between worlds. I walk between the settler world, the colonial world and the Indigenous world, and I come from a long line of people who do and have done that. We are the people in between. We are the bridge between “them and us” and “us and them.” First Nations, Inuit and Métis can call ourselves what we need to call ourselves. For a long time, the term “Aboriginal” was used because it is in the Canadian Constitution and some of the historical Canadian documents. And of course, at one time the term used was Indians, as in cowboys and Indians, because some of the first colonial explorers thought they had landed in India. (They had not.)

In current discussions of Indigenous realities, the terms “colonist” and “settler” are used for those of European ancestry whose families came and settled/colonized North America in the past few centuries. They are helpful terms because people understand them. They can still be somewhat controversial, because some people see them as pejorative, but they are becoming more commonly used in ways that are descriptive. At the same time, there are new challenges with the use of such language: we now have many refugees and immigrants in Canada who have arrived and settled in a very different context from those of the original, mostly European, settlers and colonists. Although every Canadian, of longer or shorter roots in this land, is written into the documents and the Calls to Action of the Truth and Reconciliation Commission of Canada (TRC), not every Canadian has the same understanding of what that means.

The TRC was created as a response to our history of residential schools. Residential schools were legally mandated by the government and implemented by four Christian denominations: Roman Catholic,

Anglican, United Church and Presbyterian. We churches collaborated to administer the schools, which were funded by the federal government. The attendance of Indigenous children at the schools was compulsory from 1894 to 1947, with the last school closing in 1996. The residential school system was created to intentionally remove Indigenous children from their families, languages, cultures and traditional ways for the purposes of both assimilating them into Euro-Canadian society and, especially, removing the peoples from the land to give settlers free access to the abundant resources and wealth of the “New World.” As is now well documented, many of the schools perpetrated and perpetuated deprivation, disease and suffering on multiple levels, including long-term physical and sexual abuse. Although many, many reports were brought forward over the years highlighting and pointing clearly to the failure of the residential schools system as a whole and the poisonous and cruel nature of the treatment of these children, they were ignored. After all, the purpose was not ultimately the education of children but the clearing of Indigenous Peoples from the land so others could have access to its wealth.

My grandfather and his sisters were sent to a residential school as very young children, so for me it is also a family story. It was a personal pilgrimage for me, therefore, walking between worlds as Métis, granddaughter of a residential school survivor and an Anglican priest to witness the TRC’s work. I attended all of the TRC’s national events – seven events from 2010 to 2014, in seven cities from sea to sea to sea – with the closing event being held in Ottawa in 2015. I knew I had to be present to listen and to hear what was being said. One of the things that I heard being said over and over again as a sort of refrain that resonated through the proceedings was “Where are the children?” It was being asked as a direct question about both the locations of the graves and the lost little ones, and it flowed through the proceedings as a theme. Since May 2021, we can now say that we know where some of them

are – not all of them yet, but some of them, since it was then that the discovery, rediscovery, revelation of unmarked graves at the former residential school in Kamloops, British Columbia, happened. More unmarked graves have been identified on the grounds of other former residential schools since.

We need to ask ourselves why those who are non-Indigenous, and Canadian society generally, have let injustices to Indigenous Peoples of this land go on for so long – and it is not only the residential schools and the unmarked graves. Why has the fact that so many reserves have undrinkable water been accepted or ignored? Or the fact that so many Indigenous children are in foster care? Or that a very high proportion of Indigenous people are incarcerated? Why have the horror and long-term damage of the residential schools run by the government and the churches been so dramatically underestimated? The answer is that these realities have persisted for such a long time because it has served the privileged in Canadian society to accept and ignore them. The cost of restitution, restoration and recompense is very high, whether it is a psychological, spiritual or emotional cost, let alone a financial one. It can be hard to explain and understand that restitution, restoration and recompense are not only about justice but are also about healing and reconciliation for all peoples – and, indeed, the whole country.

Many are using the term “genocide” to refer to the way that Indigenous Peoples have been treated in this country. It is hard for citizens and the government to use that term because it means having to acknowledge complicity and benefit from the ongoing unjust treatment of Indigenous siblings. For the Canadian government, the churches and society to use the term “genocide” means admitting complicity in colonizing Indigenous Peoples and actively suppressing their culture as well as taking responsibility for these actions and attitudes. Some people do not want to do that because it will cost, yet so it should! Reconciliation needs to have personal buy-in from the majority of individuals as well as collectively. That’s how we change a culture. People are willing to mine in the north and extract resources but are not willing to put the benefits of those resources back into the communities from which they have come. Indigenous Peoples have been removed from the land to make it easier to access resources from the earth. Even the term “resources” is a challenge. From an Indigenous perspective, the earth is our Mother; money is being made from exploiting her so that more resources can be taken. It is a vicious cycle.

It can help to think of the notion of “all my relations.” It is a way of speaking, thinking and being which reflects the Indigenous worldview of interconnectedness. It

is a prayer of oneness and harmony with all forms of life: other people, animals, birds, insects, trees, plants – even rocks, rivers, mountains and valleys. When we drill down into what that means, we can start to relate to the web of interconnectedness and the notion that everyone’s well-being is connected. If I am doing something that is harmful to myself or to the environment or to the community around me, that harm affects everyone and everything. We have often done everything we can to differentiate ourselves, to separate mind, body, spirit and soul and to intellectualize, to separate our collective into individuals. But reconciliation on all levels is better for us because the well-being of all of God’s creatures will bring a badly needed balance to our planet. It is related to how we treat each other and prioritize our relationships. We can still prioritize our families, for instance, because families are very important in Indigenous teachings, but more than immediate circles, it is about remembering that everything and everyone is interconnected. We are related to creation as well as to each other. It is about all my relations, not just some of my relations. There is value in the individual, of course, because it is individuals who come together to make the family or community. Indigenous teachings also emphasize the truth that we operate together in community and relationship with one another. Reconciliation makes us better because we come to be more fully human. We are taught by our Christian scriptures that we are more fully human when we are in the community of God. God speaks of God’s self as being in a community of love – the Trinity.

At the TRC hearings, I talked with Elders who spoke with conviction about how they wanted to put up a monument to the children of the residential schools. I asked one of them, Julia, what children she was referring to – those like herself who went to residential school? Her response was “Well, we are important. The survivors are important. The ones who did not survive are important, the ones who vanished while they were at school.” To those with ears to hear, these children are now our teachers: they are speaking to us, their voices are being heard in a way that they have never been heard before. They were buried without ceremony, without honour, without family or friends, and without community present to mourn. The goal of the residential schools was met by suppressing Indigenous languages, cultures and peoples, by very effectively burying our voices.

Now there is what I call the revelation of the unmarked graves. If we believe, which I do, in the continuing revelation of the Good News of Christ incarnate in the world, then these unmarked graves are revelation. The voices of the vanished children are now speaking to us and calling us to recognize where we have gone so far astray – as a Church, as a government and as a

society. The children are calling us back to repentance, which the Bible defines as turning in a new direction, and we will need to keep listening to hear exactly what new direction we are being called to and how we get there.

So, what is the Good News? The news of the graves is mixed; it is both terrible and good, in that it is also a relief, a grace, a kairos moment to have them revealed, to find them, to learn from them. We need to discern what is being revealed to us, what the silenced voices of the children are saying to us and how we are being called forward in a new direction. If we truly believe in the prophetic revelation of the Gospel of Matthew (25:45) – “Then he will answer them, ‘Truly I tell you, just as you did not do it to one of the least of these, you did not do it to me’” – can we see that it is the Infant Jesus whom we starved, abused and buried out behind the school? We have to wrestle with this massacre of the innocents. What is the path we need to be called back to or turned toward? What is the story telling us, and how does it point to liberation in Christ? We do not know all the answers yet, but we need to be asking: What does metanoia / repentance look like?

I was at the meeting of Indigenous Peoples with the Archbishop of Canterbury in April 2022. Just as I went with intention to all the national TRC meetings to hear people share their truths, it felt important to be at Archbishop Justin Welby’s apology to the Indigenous Peoples. I witnessed with my own eyes the experience of the Archbishop receiving the news, the information, the truths and stories of the people. I felt that he was completely changed by the meeting and experience, and I think that is essential. Discipleship happens one person at a time. Evangelism, sharing the story, sharing the truth can happen when one person receives it. It can be a powerful experience when many people receive the revelation at once, but in this reality, the one person who we really needed to receive it was the Archbishop of Canterbury, and to my eyes he clearly did. There was a seeing eye to eye.

His heart has been converted, and he can share that with others in an authentic way. He also has experienced the revelation. He physically went out from Prince Albert, down the long gravel road with us to the James Smith Reserve, where he listened to the people: he watched and heard, he saw and witnessed. Witnessing such a reality makes a huge difference. In recent days, I have spoken with a Catholic Indigenous person about the visit of Pope Francis to Canada and several Indigenous communities in July 2022. She was so pleased that the Pope was coming and believed that it would make a huge difference to future reconciliation. I heard that broadly. It was the first visit of the Archbishop of Canterbury to Canada for this purpose, and it will be the first visit of a Pope for truth and recon-

ciliation. Some have said and will say that neither visit was enough, but I believe that both are very important. Reconciliation is nowhere near done, so both visits are a significant and called-for beginning in the building of right relationships. The Church as a body needs educating and a space for reconciliation to happen.

A part of that educating and space for reconciliation is good news that the Anglican Indigenous Church is persisting. It is declaring by voice and by presence that we are still here. In fact, the Anglican Indigenous Church was formally recognized and affirmed at our Anglican General Synod in 2019 as the self-determining Indigenous Church within The Anglican Church of Canada. We insist that we are still here by valuing our ministry and our relationships. We value ourselves as created by God. We have a call and a mission to work together for reconciliation. That persistence which is a sign of hope is very biblical. It brings to mind the story of the woman in Matthew’s Gospel (15:22-28) who persists in asking Jesus to heal her daughter even when he resists; finally, he declares that she is right. What does that persistence look like in this time and place for the Indigenous Church, for Indigenous realities and for reconciliation for all? One response to that question was given by an Indigenous bishop, who said that some people think reconciliation means that non-Indigenous people will have to give back the lands that were taken from Indigenous Peoples over the centuries, many of which include the lands where some of Canada’s largest cities are found. Her incisive response to that perspective was that Indigenous people would not do to others what was done to them.

And a sign of what might be called progress or hope in Indigenous realities in Canada could be seen in the shift of mood in the national TRC events. The first, which took place in Winnipeg in 2010, was an intense gathering. People were really hurting. Talking about truth and reconciliation felt like exposing raw, open wounds. It was the truth part of the process and a powerful and painful one to witness. A tornado swept through the site during the event, with tents pitched into the air and people running for cover; as is often presented in biblical and Shakespearean narratives, the weather seemed intimately connected with the events and matched the mood.

By the time of the Edmonton TRC event in 2014, the last of the national events, the mood had shifted. The questions being asked were how reconciliation would be achieved, how we were all going to walk forward together, how everyone could get engaged with it, how we were going to get to reconciliation through justice, because reconciliation always comes through justice. Some of the answers, at the time and since, include the sharing of our assets, the giving of money and lending a hand where it is needed and requested.

It could be offering financial support where needed, advocating with government and implementing or changing policies. A concrete answer can be sending necessary supplies. A community in Port Hope, Ontario, got in touch with an Indigenous community in the north and asked how they could help with the reconciliation process. The Indigenous community requested a container of various food and art supplies, but particularly peanut butter. So, peanut butter it was! It was not about sending the extra stuff that had accumulated in church basements but about asking and sending what was needed and wanted. It was about listening and then responding to what was heard.

Marie Wilson, one of the three commissioners on the TRC, said that reconciliation through justice also looks like using one's sphere of influence. It is crucial not to misuse one's privilege, something that has often been done both by those who have worked for that privilege and those who have been given it because of their skin colour, gender, education or economic reality. It is also crucial to use our spheres of influence to advocate for change and justice for other people and communities – for the benefit of all peoples and all creation.

An avenue for possible change – reconciliation through justice and the use of spheres of influence, alongside but very relevant to church realities – can be found in two Canadian educational systems. Some newcomers to Canada are being thoroughly introduced to Indigenous realities through the Canadian citizenship exam, which now has an extensive section on the history of, context for and terminology for Indigenous Peoples. There are also some good courses in the high school system, but there exists a big generation gap in education about Indigenous realities. Many people who were already citizens – born here or having become citizens decades ago – did not have courses or studies in Indigenous realities when they were in school and are not learning about it from their children and grandchildren. Education is a process, and we are still in that process as nation and nations together. Further reflection on what that education looks like is needed, but one way of bridging the gap is for older people to ask children, grandchildren, nieces, nephews, neighbours' kids, and so on what they are learning about Indigenous realities in school. Or ask a new Canadian citizen! As Métis and as an Anglican bishop, I see that this has the added benefit of making everyone more community minded and oriented and more intergenerational in teaching and learning about Indigenous issues.

The younger generation and new citizens who are learning about Indigenous history and current reality can use their sphere of influence to teach the older generations. The older generations might use their spheres of influence to call meetings, host gatherings

and offer educational sessions. It is not about positions of hierarchy or dominance but about learning from each other – and not just for the sake of the future, though it is about that. It is very much about our present as well. All generations are needed to learn together for both the future and the present.

The conversation that resulted in this chapter took place during National Indigenous History Month. Having a specially designated month brings the realities before people for an extended time. A day is not enough. Such designations invite people into dialogue with neighbours, the community and, hopefully, Indigenous neighbours and communities who are holding events such as pow-wows and cultural gatherings. It is an expansive model of education, and that is a good thing. It is good to encourage and commit to reading Indigenous authors and listening to Indigenous music. What is crucial, however, is to stop talking and thinking about such things as something foreign. We need to integrate and inhabit these realities as part of our understanding of the texture of who we are as a people in this land. National Indigenous History Month is an invitation to deepen our identity and it is connected to Canada Day on July 1. I usually wear my Louis Riel T-shirt on Canada Day; last year, we were all wearing orange shirts to honour the children of the unmarked graves.¹

Reconciliation through justice is complicated. It is about recognizing Indigenous authors and music as a deep part of our reality. It is about celebrating and being present at the Indigenous events like pow-wows near us. It is also about the revelations of the unmarked graves and the knowledge that there will be many more. It is about working for drinkable water up north and in all Indigenous communities. It is about the TRC Calls to Action. In the Anglican tradition, it is about the Church – finding ways to supplement and finance a self-determining Church. How do we walk together and recognize each other's identity? How do we educate, equip, enable, support, honour and continue to be related to one another?

Some things are happening that might be called progress in reconciliation through justice. Professional and political relationships are developing, and there is an expanded understanding around representation on committees. Indigenous people are lawyers, advocates and priests, and Canada has its first Indigenous Governor General. There are new ways of including Indigenous Peoples that are less about tokenism and more about mutual learning. This is a positive interpretation of what is happening, though I wish to acknowledge that not everyone would agree that Indigenous realities in Canada are all that positive yet. I also believe that social and educational gatherings,

pow-wows and cultural days put on and participated in by all communities are helpful.

Common conversations are opening up. In the era before COVID-19, the City of Toronto had a huge National Indigenous Weekend event. Many people experienced it; Indigenous realities and experiences started to become part of common conversation, a kind of table talk. It is important for all people to talk about Indigenous realities together – as a family, as a community, as friends. Such engagements need to become part of our everyday reality, part of the regular understanding we have in relationship to one another as people inhabiting this land together. Some conversations will be uncomfortable, even painful, but we need to have them in regular and ongoing ways.

A concrete part of and response to the reality that energy and awareness is spreading is the growth and prevalence of land acknowledgements at the beginning of many public events and gatherings. They are an important step, but what is critical is how we expand forward. We need to deepen our understandings of the richness of relationship with each other as well as call to mind the fact that Indigenous realities are not just a thing of the past. Many Indigenous Peoples are living vibrantly in all parts of Canada. We have gifted and skilled Indigenous leaders in all professions, occupations and realities. This is our identity as a country of many peoples. There is still a lot of anxiety, and there is still a lot of injustice, much of it perpetrated and perpetuated because of racism. However, there are new directions, with a lot happening that is promising, hope-filled and good. We can look for the good and build momentum, moving us forward through truth, justice and reconciliation, for the purpose of rehumanization, seeing each and all as created in the image of God.

Links

Truth and Reconciliation Commission of Canada:

<http://www.trc.ca/about-us/trc-findings.html>

United Nations Declaration on the Rights of Indigenous Peoples:

https://www.un.org/development/desa/indigenous-peoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

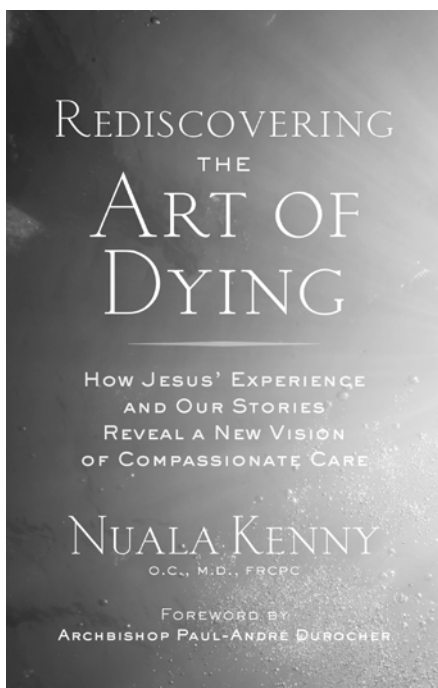
United Nations definition of “genocide”:

<https://www.un.org/en/genocideprevention/genocide.shtml>

Bishop Riscylla Shaw serves in the Anglican Diocese of Toronto, Canada. With Métis family roots, she grew up on a small farm, a child of the soil, learning from the land. Ordained a priest in 2001 and a bishop in 2017, her ministry has been inspired by Desmond Tutu and the South African Truth and Reconciliation Commission. Riscylla is connected into justice work and community building and is actively involved in working with the National Indigenous Anglican Church in reconciliation with the colonial Church. She is married and has two teenagers. She loves fresh air and the northern lights.

¹ Orange Shirt Day was established in 2013 as part of an effort to promote awareness of and education about the residential school system and its impact on Indigenous communities for over a century. This impact, which has been recognized as cultural genocide, continues to this day. The use of an orange shirt as a symbol was inspired by the accounts of Phyllis Jack Webstad, whose personal clothing – including a new orange shirt – was taken from her during her first day of residential school and was never returned. The orange shirt is thus used as a symbol of the forced assimilation of Indigenous children. The day was elevated to a statutory holiday, called National Day for Truth and Reconciliation, by the Canadian government in 2021, in light of the revelations of over 1,000 unmarked graves near former residential school sites. (Wikipedia)

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Subscriptions: Canada: \$16 • International: \$33 (postage and taxes included).

To order: Periodicals Dept., Novalis, 1 Eglinton Avenue East, Suite 800, Toronto, ON M4P 3A1

Tel: 1-800-387-7164 Fax: 1-800-204-4140

ISSN: 2562-0347

Please send submissions and correspondence to criticaltheology@novalis.ca.

Printed in Canada

