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Cultivating an Eschatological Imaginary: A Liturgical Approach to Death

Addison Suzzanne Tenorio, MA

Abstract

Health care is marked by numerous "liturgies"; many are no different whether they occur in secular or Catholic spaces. This article explores how health care's liturgies, namely the practice of cardiopulmonary resuscitation, offers Catholic health care the opportunity to offer care that is uniquely *Catholic*. By living into its theological commitments—including its rich eschatological heritage—Catholic health care can create a social imaginary that supports patients, families, and caregivers in their experience of death.

Keywords

bioethics, Catholicism, health care, cardiopulmonary resuscitation, end-of-life care, pastoral care, theology

> I think earth, if chosen instead of Heaven, will turn out to have been, all along, only a region in Hell: and earth, if put second to Heaven, to have been from the beginning, a part of Heaven itself. (Lewis 2002, 466)

Losing Lucy

This is the story of Lucy.[1] Her death exemplifies death in the hospital in a unique way. Lucy has been a long-time patient of the hospital. Her second birthday is approaching, but she has been getting sicker. Lucy is a child of the hospital, well-beloved by the staff and care team. However, their love for her does not prevent her from entering cardiac arrest, coding, just three days prior to her birthday. Unfortunately, despite the best efforts of all involved, Lucy dies. The staff is in pieces emotionally. Her room is the usual organized disaster that occurs anytime someone codes. After the time of death is declared, one or two of the nurses are in tears—mourning the life that could have been, a life now gone. Many of the staff will cry in their cars on the way home from work. Lucy is a patient that many of the staff will *never* forget. Minutes later, rounds continue, and Lucy's body is swept away to the morgue. Lucy's parents will be notified so they can return to the hospital for a viewing. The room will be customarily cleaned by Environmental

Mercy Hospital Ardmore, Ardmore, OK, USA

Corresponding Author:
Addison Suzzanne Tenorio, Mercy Hospital Ardmore, 1011 14th Avenue, Northwest, Ardmore, OK 73401, USA.
Email: Addison.Tenorio@mercy.net

Services staff members and prepared for another equally sick or sicker child. And perhaps, the cycle will repeat. If not immediately, in that same room, soon enough, on the unit, and undoubtedly in the hospital. Lucy's death was incredibly tragic. It was tragic not only because of it being the loss of a life so young and full of potential, but also because there was no opportunity to acknowledge the gravity of the event that had occurred. Instead, it was seen as an event that was simply *ordinary* in the hospital.

Introduction

In this article, I will argue that Catholic health care ought to cultivate an eschatological imaginary in response to patient death. The Eucharistic life of the Catholic Church ought to compel its health care ministries to face the death of its patients, like Lucy, in a way that is distinct from other non-Catholic health care entities. This response should proceed out of Catholic health care's concern for the pastoral and spiritual care of its patients and as a means of expressing Catholic identity.[2] Hospitals have secular liturgies internal to their structure and operations, some of which communicate beliefs that are internal to the practice of medicine but not consonant with Catholic theology.[3] Throughout this article, I will use cardiopulmonary resuscitation (CPR) as an example of such a liturgy. After outlining some of the metaphysical and eschatological beliefs of health care that are communicated through the performance of CPR, I will discuss how these beliefs differ from a Catholic theological perspective. Revisiting Lucy's case, I suggest that such a liturgy be incorporated into the practice of Catholic health care; I will also address the liturgies that currently exist in the life of the Church and discuss why the need for a liturgy within Catholic hospitals is not wholly met by those existing prayers and liturgies. I will not be able to develop robust content for the liturgy in this article but hope that this can be the work of future scholarship. First, I will begin by elucidating why it is the case that Lucy's death happened the way that it did. This is largely due to the liturgies of medicine, which are shaped by its underlying metaphysics and eschatology.

Communicating Beliefs Through Liturgy

It will be important for the reader to note that throughout this article, I use a broad understanding of what constitutes "a liturgy" (consistent with the work of Johnson (2016; 2019) and Smith (2012; 2013). I do not use this broad understanding to discount the significance of those liturgies that are officially put forth by the Catholic Church, but rather to help the reader to understand how persons are shaped by the practices they participate in and to demonstrate that there are lots of practices that shape people that are not a part of formal religions.[4]

Smith uses an Augustinian philosophical anthropology to identify humankind as *homo liturgicus*, liturgical animals; "Liturgical animals are imaginative animals who live off the stuff of the imagination: stories, pictures, images, and metaphors are the poetry of our embodied existence" (Smith 2012, 165).[5] Liturgies are formative practices that orient one's mind, heart, and body; Smith defines liturgies as "*rituals of ultimate concern*" (Smith 2012, 167). Smith uses "ritual" in a broad way, like Johnson, highlighting the phenomenological nature of these practices.[6] What he means by this is that liturgies—even secular liturgies—can serve to be formative of one's identity and generative of a vision of the "good life" (Smith 2013). Smith specifically points to the embodied experience of participating in a liturgy—whether secular or religious—as being formative and contends that liturgies themselves can teach us about the object of worship.

> Liturgies are formative because—and just to the extent that—they tap into our imaginative core. As compressed narratives and tactile poems, the formative power of liturgies (whether secular or sacred) is bound up with their aesthetic force.

> Such liturgies are pedagogies of desire that shape our love because they *picture* the good life for us in ways that resonate with our imaginative nature. (Smith 2013, 137)

Smith notes that there has been a division between the secular and the religious realms on the basis that religion is a set of intellectually assented to principles, and as such, it is chosen, bidden, or otherwise able to be separated out from the public sphere. However, he says, that to the believer, it is not a matter of intellectually assenting to principles that makes a matter religious. Rather, it is something that draws one's love or affectively attunes a person in a particular direction (Smith 2013, 169).[7] Thus, the "secular"—and its respective liturgies—serve the same kind of function.

Dru Johnson taxonomizes liturgies in one of three ways: day-to-day, rituals of tradition, and rituals of religion (Johnson 2019, 18). The first is rather simple; it could be the mere fact that your weekday morning routine *always* consists of getting up, going to the bathroom, brushing your teeth, taking your medications (perhaps in a particular order), making a cup of tea, getting dressed, and watching *Good Morning America* while you eat breakfast. The second includes singing your school's song during a football game (maybe doing some hand gestures/dance to go with it), saying the Pledge of Allegiance at the start of a school day, or going through security at the airport. The third encompasses rituals, such as the celebration of the Mass, praying of the rosary, Liturgy of the Hours, pilgrimages, meditation, and so on.[8] Johnson also offers a ritual inventory that can be used to assess various rituals (Johnson 2019, 136–7). The questions that one goes through when performing the inventory and assessing a specific ritual are as follows: (1) who prescribes it, (2) to what end, (3) how do I/we safely improvise it, (4) how can this ritual turn dark or flimsy, and (5) what is our response after performing this inventory?[9] James K. A. Smith adds depth to Johnson's definition. In the following sections, I will use Johnson's inventory, and his and Smith's understandings of liturgy, to analyze the practice of performing CPR in the hospital.

Liturgy in the Hospital

Performing CPR on a patient, like Lucy, who is experiencing cardiopulmonary arrest, is one example of a liturgy that one might observe in a hospital. I will assess this liturgy using Johnson's ritual inventory. While many might be inclined to dismiss this as a matter of best practice or standard operating procedure, this is a ritual not just in Johnson's sense, but also in Smith's, that is, a ritual of ultimate concern. This ritual (procedure) aims to stave off death. It is an appropriately violent affair for such a battle. The battle is announced over the intercom system of the hospital ("code blue") to call a special forces team and all available recruits to come to the aid of those on the front lines. The code team army then comes to answer this battle cry, according to a highly coordinated plan aimed to service vitality. This ritual can be improvised to be less violent, in an attempt to show family members that the team "tried" through the use of *slow codes*.[10] Additionally, in an effort to give patients more choices, some hospitals have allowed for the use of *partial codes*, which they can choose when filling out DNRs or advance directives.[11] Although partial codes give patients the sense of more control over the interventions performed on them, they are arguably less efficacious (Sanders, Schepp, and Baird 2011). It is unclear, however, whether this information is well-communicated to patients and their families and if those who elect partial codes understand the potential medical consequences of doing so.

I will not answer each question of Johnson's ritual inventory for the sake of space; however, I hope that the reader can bear this inventory in mind throughout the following discussion. This ritual can—and will—be assessed using Johnson's ritual inventory and in light of Smith's definition of liturgy, that is, "rituals of ultimate concern" (Smith 2012, 167). Further, Smith identifies liturgies as "the most loaded forms of ritual practice because

they are after nothing less than our hearts, our most fundamental motivations. They want to determine what we *love* ultimately" (Smith 2012, 167). These liturgies clearly demonstrate the loves of the hospital, and observation of their performance shows how these liturgies can become misshapen.

CPR is identity-forming for the people who perform it and those who observe it, even those who make decisions regarding its "rubrics." This liturgy "aims to do nothing less than shape our identity by shaping our desire for what we envision as the ideal of human flourishing" (Smith 2012, 167). CPR is not the only liturgy in health care that belies medicine's underlying metaphysics and the eschatology that proceeds therefrom; others, like dissection or the withdrawal of ventilatory support at the end of a patient's life, also communicate these beliefs (Leder 1992). However, an exploration of some of these other practices is the work of future scholarship and not within the purview of this article. CPR demonstrates medicine's ultimate concern for *vitality* by trying to fight in a very violent way against death. This practice communicates that death is something to be avoided, and that even a violent means (potentially breaking a patient's ribs) is acceptable to be used. Medicine assumes that patients would want CPR by making "full code" the default status. In an emergency situation, CPR is assumed to be the default of what a "reasonable patient" would want in the event that they experience cardiac arrest. A discussion around CPR and vitalism would not be complete by peeking into its efficacy (Peberdy et al. 2003). While CPR is fairly successful in its efforts to get return of spontaneous circulation (ROSC),[12] its efficacy at other milestones is less. For example, just because the care team was able to get ROSC for a given patient does not mean that the patient will survive until discharge.[13] And, even if the patient does survive to discharge, it is not guaranteed that they will be without neurological deficits or return to their baseline functional status. CPR's, and ultimately medicine's, concern for vitality can often lead it to disregard larger questions around what constitutes flourishing or the good life, but rather an immediate concern for the existence of bare life (that is to say, life on a most basic level —a beating heart). Without the picture that an understanding of final causation provides, medicine is only able to understand the human person in terms of "the efficient." The practice of performing CPR is a lesson itself in efficient causation: by performing chest compressions and administering the right combination of medicines, health care workers can get a patient's heart to have a return of spontaneous circulation.

As such, medical technology is based upon the body, looking at it only as matter in motion governed by the laws of efficient causation (not beings who are body and soul, destined for the eternal).[14] This kind of efficient thinking paradoxically leads to vitalism, because medical technology both enhances and maintains the efficient causes that act on the human body ("life") (Bishop 2019). The practice of violently staving off death belies medicine's immanentist metaphysics (Leder 1992). Death is seen as *the* last thing. With there being no existence for persons beyond their death, except the remaining corpse (which will eventually decay).

The way in which this, and other, liturgies of secular health care shape the moral imaginations of all of those involved demands second thought as to *how* this type of practice is compatible with the moral imaginary of Catholic health care. While CPR is not *in*compatible with the moral imaginary of Catholic health care, it is important that it (and other liturgies of secular health care) find a proper place within that moral imaginary. For example, if these liturgies take place in a Catholic hospital, then they should be engaged with the knowledge that the patient's continued physical life is good, but not an end in itself. In the following section, I will provide an overview of Catholic eschatology principally articulated by Pope Benedict XVI, further illustrating the difference between it and medicine's eschatology as it can be understood through the liturgy of CPR.

Catholic Eschatology

Theologically, death is seen as the separation of the soul from the body (Pohle 1955, 6).[15,16] At the time of a person's death, their soul does not cease to exist but ceases to animate their body (Aquinas 2017, I.75.1; USCCB 2000, 1007–8). An eschatological framing provides hope that one day a person's soul and body will be reunited, just as Christ's was in his resurrection. This perspective prevents the immanentization of human life and experience and causes those things to be framed ultimately in relationship to God—Creator and Redeemer—for whom humankind is made and to whom it is ultimately called. For the purposes of this article, I will be using a framework derived primarily from Catholic understandings of eschatology, principally articulated by Pope Benedict XVI.[17]

The *eschaton* is the final destiny of creation. For Pope Benedict, to have a proper eschatological imagination, one must have as their starting point the reality of the Incarnation (Ratzinger 1988).[18] Jesus Christ demonstrates —through his dying and rising from the dead —the destiny of all of humankind (and all of creation along with it). He is the "first fruits of those who have fallen asleep" (1 Cor 15:20). Jesus's resurrection serves as a lesson that the same will happen for the faithful. This is all a part of the tension of Christian life; the tension of the "already" and the "not yet." Pope Benedict, when he was Cardinal Ratzinger, in *The Spirit of the Liturgy*, discusses the *exitus-reditus* movement of the liturgy and of creation—the movement of departure and return (Ratzinger 2000, 29). The *exitus* is God's free act of creation (Ratzinger 2000, 32), while *reditus* is the return of the cycle, not one that abolishes this creation, but rather, bestows it to its full and final perfection (Ratzinger 2000, 33). An eschatological imaginary gives one a transcendent perspective. It frames existence—life, death, living, and dying—in relation to God and the ends He has created for humankind; "all human beings are one organism, the destiny of the whole the proper destiny of each" (Kaethler 2016, 93). The Body of Christ is made of all human persons who will be judged individually *and* collectively[19]; "relationality is the very fabric of reality" (Kaethler 2016, 15). Thus, humankind is called to communion with God—both a relational life with him and the partaking in Holy Communion (the latter of the two will be discussed more in-depth later).

Both the eschatology of medicine and the Catholic Church's eschatology are communicated through liturgy. As previously discussed, one example of such a liturgy in medicine is the practice of performing CPR. For the Church, eschatology is communicated through the celebration of the Eucharist within the context of the Mass. The Eucharist, in Johnson's taxonomy, is clearly a "ritual of religion." In the writings of Pope Benedict, "very often by 'liturgy' he clearly means 'Eucharist'" (Biliniewicz 2013, 6).[20] For Catholics, the celebration of the Eucharist within the context of the Mass is "the source and summit of the faith" (Paul VI 1964, 11).[21] Thus, it is the ritual of religion *par excellence*. The Eucharist is the ultimate orientation of one's body and soul on earth. It forms and conforms a person to the life of the Church, the Bride of Christ, in worship: "the goal of worship and the goal of creation as a whole are one and the same—divinization … the historical makes its appearance in the cosmic" (Ratzinger 2000, 28). By participating in the celebration—sitting, standing, kneeling, and praying along—the faithful are acting to orient their bodies in particular ways that submit their wills to the greater logic of the Mass, rather than the actions that they might otherwise like to be performing.

Alexander Schmemann reflects on liturgy's etymology, from the Greek *leitourgia*, "an action by which a group of people become something corporately which they had not been as mere collection of individuals—a whole greater than the sum of its parts. It also meant a function or 'ministry' of a man or of a group on behalf of and in the interest of the whole community" (Schmemann 1973, 25).[22] The liturgy of the Eucharist forms the people of God into the community they are called to be and aims to bring about change in the world

through its very practice. It also effects change in those who celebrate it, preparing them for the Eucharistic feast of heaven.[23] In doing so, the Eucharist also reorients conceptions of space and time.[24] By participating in the celebration—sitting, standing, kneeling, and praying along—the faithful are acting to orient their bodies in particular ways that submit their wills to the greater logic of the Mass, rather than the actions that they might otherwise like to be performing (Schmemann 1973, 25). The liturgy of the Eucharist, Alexander Schmemann says, is not simply a cultic rite, but forms the people of God into the community they are called to be and aims to bring about change in the world through its very practice.

"It's Okay for Patients to Die..."

Because the Eucharist provides the ultimate orientation towards eternal life and union with God and is the "source and summit of the [Catholic] faith," and because Catholic health care derives its practice from the content-full traditions of the Catholic Church, then Catholic hospitals ought to be oriented in such a way that they live with this eschatological vision in mind. Part of that eschatological vision will entail that Catholic hospitals will not be resistant to death at all costs.[25] Now, this statement needs to be *hugely* qualified: (1) it is not okay, under any circumstance, for a patient's death to be directly caused by act or omission of the hospital [staff] (USCCB 2018, no. 20); (2) the staff ought not to perform an act [or omission] by which they intend that the patient in question would die (USCCB 2018, no. 60); and (3) this eschatological framing of the patient's death does not make it any less tragic. It is important to bear in mind that a Catholic hospital's purpose is to cooperate in Christ's healing ministry to restore health (where possible), but always provide care in those instances where restoring health may not be possible (USCCB 2018, 20). The metaphysical commitments of Catholic health care allow for more peace when patients die but demand an appropriate response in regards thereto. The Eucharist should also shape the very way Catholic health care sees the world and the practices that take place inside the walls of its hospitals. A Eucharistic mindset, with its accompanying eschatological vision, should animate the practice of medicine in Catholic hospitals. It may call Catholic health care institutions to look and act differently than their secular counterparts. For this reason, I propose that the death of the patient in a hospital be accompanied by a liturgy.

Set Apart for Sacred Mission

Catholic health care participates in many of the liturgies that are a part of health care, generally, such as CPR, and does not change these liturgies in order to counter the unique way in which they participate in secular medicine's worship.[26] Catholic health care ought to have a distinct character to it, because of the theological tradition that it comes out of, and, ultimately, because of the commitments that tradition compels it to hold (Catholic Health Association of the United States 2016; Gremmels 2019).[27] Pope Benedict XVI, in *Deus Caritas Est* ("God is Love"), describes the difference characterizing the work performed by those in Catholic organizations:

> Those who work for the Church's charitable organizations must be distinguished by the fact that they do not merely meet the needs of the moment, but they dedicate themselves to others with heartfelt concern, enabling them to experience the richness of their humanity. Consequently, in addition to their necessary professional training, these charity workers need a "formation of the heart": they need to be led to that encounter with God in Christ which awakens their love and opens their spirits to others. As a result, love of neighbour will no longer be for them a commandment imposed, so to speak, from without, but a consequence deriving from their faith, a faith which becomes active through love (cf. Gal 5:6). (Benedict XVI 2005, 31.a)

For example, the majority of Catholic health systems have as one of their principal values "dignity," which serves as an institutionally

ensconced reminder that all persons (patients, employees, and visitors alike) are made *imago Dei*.[28]

These theological commitments should compel Catholic health care leaders to ask questions about the kinds of things that occur in their hospitals: *Is what we're doing an expression of Christ's love? Are we extending the healing ministry of Christ when we perform this procedure in this way, or is there something we could do to make it more humane, or better acknowledge the dignity of our patients and clinicians when doing so*? This does not mean that leaders must address *all* medical procedures with a hermeneutic of suspicion; to do so would be counterproductive (to say the least). It may be to the advantage of Catholic health care to be "shepherds living with the smell of sheep,"[29] operating among other health care institutions in a similar manner. However, it may be a call to reimagine spaces within health care where Catholic hospitals are uniquely situated to stand out by ministering in a way that distinctly communicates their beliefs (Bedford 2016).

A Catholic hospital—that is, the physical building—is not only "set apart" in the sense that it performs actions (healing the sick, ministering to the broken, training others in the practice of the faith, etc.) that are proper to the ministry of the Catholic Church, but also in the sense that the physical space is set apart, *consecrated*, for that very ministry.[30] Each new Catholic hospital is (typically) blessed by the bishop of the diocese in which the hospital is located.[31] And all Catholic hospitals, in their chapels, should have the Blessed Sacrament. Thus, Catholic hospitals are both ecclesiologically set apart from secular hospitals, because they are ministries of the Catholic Church, and physically and spiritually set apart through rites of blessing (International Commission on English in the Liturgy 1989, 287–92).

A Liturgical Response for a Death in a Catholic Hospital

The practical import of an eschatological imaginary for Catholic health care is that it would have some sort of liturgical response when people die in its hospitals. This liturgy should come out of a larger Eucharistic orientation, calling the faithful heavenward.[32] This liturgy should be a means of counter-formation against medicine's own liturgies—like CPR—and the metaphysics that those liturgies communicate. The situation should not just be one in which a person dies and there is a quick beat, and then staff go and take care of other patients, because "the patient's not there anymore." Rather, Catholic hospitals should provide physical and structural space for the patient's family members and health care professionals to take time to recognize and grapple with the profoundly significant metaphysical event that has occurred—the separation of the soul from the body. The metaphysics of medicine sees the death of the person concluding with them no longer "being there"; in other words, their mind/brain is no longer governing their body. While this language often also hints at their ceasing to exist, this kind of nihilistic thinking Kornu (2017) precludes the possibility of doing much of anything to acknowledge the significance of the body in the body/soul union. Catholic theology—and its health care ministry, by extension—does not share this metaphysical outlook on death with medicine.

This liturgy would be distinct from current efforts that some Catholic health care systems have, which are memorial services that they host for patients' families after their loved ones have died.[33] For example, the hospital—typically through pastoral and/or palliative care—will send out condolences to the families of patients who have passed away in their hospital and invite those family members to come to some sort of general memorial service for all patients who have died in the hospital during a given period of time (e.g., three to six months). This type of service is generalized to all patients who have died within that particular period of time and is not specific to a given patient.[34] Further work needs to be done to develop the content of such a liturgy. However, that work is outside of the scope of this article.

How Would This Differ from a Funeral or the Church's Other Related Prayers?

Theologically, a funeral is a liturgy that commends the deceased to rest in the peace of Christ. In the Catholic tradition, a funeral liturgy also typically takes place within the sacramental context of the Mass (but a funeral is not a sacrament itself).[35] According to the *General Instruction for the Roman Missal*, "[t]he Church offers the Eucharistic Sacrifice of Christ's Pasch for the dead so that, since all the members of Christ's Body are in communion with one another, what implores spiritual help for some, may bring comforting hope to others" (The Roman Missal 2012, 82). It is significant that a funeral takes place within the context of the Mass because of the transcendent nature of this celebration. Here, those who are left behind, to mourn the deceased, share in the heavenly banquet that awaits their loved one and themselves.

The purpose of proposing a liturgy for the hospital would not be to replace the function of a funeral. Funeral liturgies may be somewhat context-specific (religion, sect, culture, geographic location, etc.). The liturgy's purpose could also not be accomplished by praying the Office of the Dead or the "Prayers Immediately After Death" found in the *Pastoral Care for the Sick and Dying: Rites of Anointing and Viaticum*.[36] While the Office of the Dead or the Prayers Immediately After Death might be appropriate to pray when patients die, the proposed liturgy would be geared toward a wider audience than just faithful Catholics. The purpose of this liturgy within the hospital would be to run counter to the narrative created by the liturgies of the hospital and health care itself and would be aimed to be an expression of the *Catholic identity* of the hospital (Kornu 2022). This liturgy would also serve ecumenical needs that Catholic hospitals have. While the hospital itself is Catholic, oftentimes its patients are not. Within the context of the larger theology of the Catholic Church, this liturgy would not be a sacrament canonically, because it is not one of the seven sacraments instituted by Christ himself, but *could* be a *sacramental*.[37] However, it is outside the scope of this article to determine whether or not the establishment of such a sacramental would be the best way for the Church—through the ministry of Catholic health care—to communicate its eschatological commitments and live out a narrative contrary to that of secular medicine.[38]

Christopher Kiesling says, "The place of the liturgy in the modern world is to preserve sanity, hope, and joy in authentic human existence" (Kiesling 1965, 110). The hope is that crafting a liturgy particular to when patients of Catholic hospitals die, Catholic health care would be able to act in this preservationist role. This liturgy would run counter to health care's prevailing emphasis on efficiency, calling into question both the underlying drive and the toll it takes on patients and their loved ones. Pope Benedict describes liturgy as "play." Liturgy is a form of play because it operates contrary to the ways of the world:

> play takes us out of the world of daily goals and their pressures and into a sphere free of purpose and achievement, releasing us for a time from all the burdens of our daily world of work. Play is a kind of other world, an oasis of freedom, where for a moment we can let life flow freely. We need such moments of retreat from the pressure of daily life if its burden is to be bearable. (Ratzinger 2000, 13)

Play still has its own goals and internal logic, and so too does liturgy. In this case, it is the world of the daily goals of the hospital and medicine that liturgy helps us to escape. This liturgy would point beyond medicine's vitalism and immanentism; rather, it would direct hearts and minds (and bodies) to the transcendent.

Using a liturgy, Catholic health care would be reifying the experiences of family members, friends, and health care professionals who recognize the significance of the metaphysical event that has occurred with the patient's death. Furthermore, on an institutional level, this liturgy would speak to the thick theological

truth that undergirds the tradition of Catholic health care, which recognizes that although the patient has died, this is not the end for the patient and that there is hope for everlasting life with God and resurrection of the body.

Looking Again at Lucy

A liturgy surrounding death grounded in an eschatological imaginary could help the family and health care professionals with their own grieving process.[39] However, this should not be the sole reason for the incorporation of such a liturgy into the life of a Catholic hospital. Health care professionals, and by proxy the institutions that they work for, cannot change the fact that some patients will eventually die under their care—nor should that necessarily be the goal. More robust efforts should be made to honor patients' wishes to die where they would like; the data show that most people would like to die at home, although they nevertheless die in the hospital (Cloud 2000). They can change the experience of dying not only for the patient, but also for family members.

Take a moment to reimagine the opening story: Lucy still codes and dies just three days prior to her second birthday. The staff is in pieces emotionally. Her room is the usual organized disaster that occurs anytime someone codes. After the time of death is declared, one or two of the nurses are in tears—mourning the life that could have been. But, because Lucy died in a Catholic hospital, the staff chaplain is immediately called upon to pray with the team in their distress. His presence could be seen as supplementary (or even complementary) to any debriefing efforts that might be done by other support staff. Instead of everyone merely taking a beat and returning to "work as usual," the chaplain leads the staff in a brief liturgy. This liturgy would allow the staff to pause and not feel the urge to hastily return to work. It could allow them some time to recognize that the event that they have just witnessed is one of profound metaphysical importance (National Conference of Catholic Bishops 1989, 51, 199)—challenging the hospital's conception of its own "busy-ness." It may not always be the case that Catholic health care will be able to operate at the same level of efficiency as its secular counterparts because of theological commitments that compel them to action. A similar or complementary liturgy could also occur when Lucy's parents return to the hospital for a viewing. The hope of this liturgy would be to begin to "get the living where they need to be" spiritually, emotionally, and psychologically without so much focus on the current approach—"getting the dead where they need to go" (which typically just entails the logistics of removing their body from their room and freeing it up for someone else).[40]

Going Forward: An Eschatological Imaginary

Smith notes that religion should be thought of "more on the order of 'mood' than cognition" (Smith 2012, 169–73). Mood is a kind of preconscious cognition; "mood discloses the world for us in a primordial way; it effects a construal of the world before our cognitive, intellectual 'knowledge' of the world comes into play" (Smith 2012, 170). A mood is more akin to the water itself than "what's in the water"—it is the thing that people live and breathe in and contribute to by their being there. In light of the Catholic Church's eschatology, I propose that Catholic health care cultivate an eschatological imaginary. This means that the eschatological dimension of the Eucharist should shape our way of conceiving of the deaths of our patients. A liturgy should be the natural result of these larger theological commitments and should be incorporated into the life of the hospital when patients die.

Currently, Catholic health care engages in many rituals that are similar to those of non-Catholic hospitals. These are often rituals of ultimate concern, having to do with life and death, giving life and leaving it. Catholic health care has a great opportunity to look and act different than its non-Catholic counterparts. These rituals shape our loves and affections—ultimately pointing to what we worship. There are many rituals in health

care that end up pointing to values that are not ordered towards transcendent goods, but finite ones. Catholic health care can continue to cultivate a social imaginary that engages in assessing how to better integrate its robust theological commitments into the everyday practice of providing care. Catholic health care would benefit from giving this matter further attention, cultivating an environment in which such a liturgy would be able to flow forth.

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ORCID iD

Addison Suzzanne Tenorio https://orcid.org/0000-0002-4838-6489

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Notes

1. I would like to thank Paul Riffon for sharing with me an experience of his upon which this story is primarily based. This experience took place at a Catholic hospital.
2. See United States Conference of Catholic Bishops (USCCB), *Ethical and Religious Directives for Catholic Health Care Services* (ERDs), 6th Edition (Washington, DC: USCCB 2018), esp. Parts 3 and 5.
3. Dru Johnson works to define "ritual" as a part of his work discussing "liturgy" in *Human Rites: The Power of Rituals, Habits, and Sacraments*. He notes two different types of rituals: "Rituals that are taught through traditions (to which we'll return). Rituals that emerge from daily practices … In both cases, rituals turn on *who* or *what* is teaching us the rites" (Johnson 2019, 18). He adds religious rituals as a third category. Johnson intends for readers to understand that "ours is a *ritualed world*" and those rituals that occur in our world shape us in significant ways (Johnson 2019, 19). I will define and discuss liturgy shortly.
4. The *Catechism of the Catholic Church* explains what the Catholic Church means by "liturgy" and its purpose in CCC 1069-1075. CCC 1113 notes "the whole liturgical life of the Church revolves around the Eucharistic sacrifice and the sacraments … Baptism, Confirmation or Chrismation, Eucharist, Penance, Anointing of the Sick, Holy Orders, and Matrimony."
5. See also Smith (2013, 126).
6. For more regarding Smith's emphasis on the phenomenological nature of liturgy, see Chapter 3 "'We Tell Ourselves Stories in Order to Live': How Worship Works" in *Imagining the Kingdom: How Worship Works* (Smith 2013).
7. This is also similar to the logic used in *An Essay in Aid of the Grammar of Assent* by Newman (1947).
8. Some of these rituals may be better dubbed "liturgies." This matter will be discussed further later.
9. For Johnson, when a ritual becomes "dark," its purpose is distorted (e.g., the practice becomes unhealthy/addictive) (for more on "dark" rites, see Johnson 2019, 65–76). Similarly, when a ritual becomes "flimsy," it is dressed as a humane practice, but in fact is not, because it does not take into consideration people's ethical lives (for more on "flimsy" rites, see Johnson 2019, 77–87).
10. A "slow code" is a half-hearted resuscitation effort that is made for a number of reasons: because the family might not be able to bring itself to consent or even assent to a DNR, but CPR is likely to be ineffective. There is an extensive debate about the ethical legitimacy

of the use of "slow codes." For example, see, the debate in response to Lantos and Meadow (2011); see also, Bosslet et al. (2015).

11. A "partial code," on the other hand, involves the medical team and the patient/surrogate deciding together in advance of a cardiac even whether or not the patient would like all of the facets of resuscitation to be deployed (e.g., chest compressions, vasopressors, inotropic drugs, defibrillation, endotracheal intubation, and mechanical ventilation). There are a number of critiques of this approach to CPR, as the more selective one is with its various components the less effective it is. However, the seeming intent behind it is that a person could choose whether or not they want to endure some of its more violent features, like chest compressions, and are willing to weigh the possibility of death against survival post-CPR. For more on the challenges associated with "partial codes," see Sanders, Schepp, and Baird (2011), Batten et al. (2021), and Gremmels and Bagchi (2021).
12. Overall, 44% of in-hospital cardiac arrest victims achieved ROSC (Peberdy et al. 2003).
13. Peberdy et al. (2003) reported that 17% of patients survived to discharge.
14. Bishop (2011, 65–66, 125, 183) discusses the effect that the loss of an understanding of final causation has had on medicine and the challenges of focusing exclusively on efficient causation (Harrison 2015).
15. See also Aquinas (2017, I.75.6).
16. Pope John Paul II in his Address to the 18th International Congress of the Transplantation Society, "… it is helpful to recall that the death of the person is a single event, consisting in the total disintegration of that unitary and integrated whole that is the personal self. It results from the separation of the life-principle (or soul) from the corporal reality of the person. The death of the person, understood in this primary sense, is an event which no scientific technique or empirical method can identify directly. Yet human experience shows that once death occurs certain biological signs inevitably follow, which medicine has learnt to recognize with increasing precision. In this sense, the 'criteria' for ascertaining death used by medicine today should not be understood as the technical-scientific determination of the exact moment of a person's death, but as a scientifically secure means of identifying the biological signs that a person has indeed died" (John Paul II 2000, no. 4).
17. For the most part, the writings that I will be drawing on are those that were written before Joseph Ratzinger was appointed to the papacy in April 2005. However, for the sake of simplicity, I will attribute all the writings to Pope Benedict XVI as opposed to trying to delineate between those writings that came before his papacy.
18. For additional reading on cultivating an eschatological imagination, see Rausch (2012).
19. "That is not to say there is no 'I' but that the 'I' is always known and judged in relation to the whole, to the 'we'. Or we could say, there is an 'I' because there is a 'we'" (Kaethler 2016, 93).
20. This is most evident in his writing Ratzinger's *The Spirit of the Liturgy* (examples throughout).
21. See also Jn 12:32; CCC 1324.
22. Schmemann (1988, 241) similarly defines *liturgy* as a "common task," in *The Eucharist: Sacrament of the Kingdom*.
23. See, for instance, Schmemann (1988, 27–48), Ratzinger (2000, 60), O'Connor (2005, 295); cf. Paul VI (1963, 8).
24. "Thus time and space are interconnected in Christian prayer. Space itself has become time, and time has, so to speak, become spatial, has entered into space. And just as time and space intertwine, so, too, do history and cosmos" (Ratzinger 2000, 94).
25. This is consonant with Ethical and Religious Directives: (USCCB 2018) ERDs 56–58, and 60.
26. This is true of other liturgical practices within health care as well. Ventilator withdrawal and CPR are not the only examples.
27. There is not sufficient space to further develop this idea, but I hope to expand on this idea in future work.
28. This seemingly simple foundation can help to foster an eschatological imagination, because it contains the truth of the Incarnation.
29. This is a phrase commonly used by Pope Francis. He first uses it in his first Chrism Mass homily on Holy Thursday in 2013 (Francis 2013).
30. It is common practice in Catholic health care for new buildings or spaces to be blessed, formally consecrating their work. "Any building erected

for the care of the sick may rightly be seen as a sign of the fidelity of Christ's followers to his command, recorded in the gospels, that they heal the sick. The dedication of such a building is an ideal pastoral opportunity for gathering the Christian community, in order that all the faithful may more deeply grasp the meaning of illness and the important place of the medical arts in the working out of God's providence" (International Commission on English in the Liturgy 1989, no. 782). Many Catholic health systems will also be sure to bless new spaces (e.g., clinics, hospital floors, and service areas) as needed. See also, Can.1171 and 1205.

31. The rite says that it may be performed by a "priest or deacon" (International Commission on English in the Liturgy 1989, no. 784). It may not be the case that all new spaces are blessed by a priest or deacon, depending on the location/health care system.
32. The introduction to Part V of the ERDs says, "The Catholic health care ministry faces the reality of death with the confidence of faith. In the face of death—for man, a time when hope seems lost—the Church witnesses to her belief that God has created each person for eternal life" (USCCB 2018, 20).
33. I would like to thank Andrea Thornton for drawing this practice to my attention. However, this practice is not necessarily unique to Catholic health care.
34. Part of the reason for the generic nature of the services are HIPAA regulations surrounding the sharing of patient information in a public forum.
35. Funeral liturgies are sacramentals, which are marked by other signs, such as the sprinkling of holy water to call to mind the waters of Baptism in which the deceased was born into Christ and through which she will be birthed into life eternal (Beal, Coriden, and Green 2000, 1400–01).
36. The full rite, not just the "Prayers Immediately After Death" may be found at https://www.usccb.org/prayers/prayers-death-and-dying.
37. Can. 1166: "Sacramentals are sacred signs by which effects, especially spiritual effects, are signified in some imitation of the sacraments and are obtained through the intercession of the Church" (Beal, Coriden, and Green 2000). If such a sacramental practice were to be introduced in Catholic health care, the Apostolic See would have to introduce it as a *sacramental* proper. Please also see Footnote 38 for more on how this could also be considered a practice of popular piety rather than a formally established sacramental.
38. Other ways that this sacramental/liturgy might come into being—outside of it being established by the Apostolic see—could be as a work of popular piety (see specifically, USCCB 2000, 1674—76). Popular piety is an expression of faith by the faithful of a given time or place. "These expressions of piety extend the liturgical life of the Church, but do not replace it. They 'should be so drawn up that they harmonize with the liturgical seasons, accord with the sacred liturgy, are in some way derived from it and lead the people to it, since in fact the liturgy [Eucharist] by its very nature is far superior to any of them'" (USCCB 2000, 1675; see also Paul VI 1963).
39. One might think of this liturgy as fitting into the spiritual wrestling that many people go through when a loved one dies. This is well exemplified in C. S. Lewis' *A Grief Observed.* However, those who are grieving may find this larger eschatological framing unhelpful or ultimately not spiritually consoling (at certain times, or ever). C. S. Lewis himself laments, laments, "if the dead are not in time, or not in our sort of time, is there any clear difference, when we speak of them, between *was* and *is* and *will be*? Kind people have said to me, 'She is with God'. … But I find that this question, however important it may be in itself, is not after all very important in relation to grief … On any view whatever, to say, 'H. is dead'. Is to say, 'All that is gone'. It is a part of the past. And the past is the past and that is what time means, and time itself is one more name for death, and Heaven itself is a state where 'the former things have passed away'," (Lewis 1961, 24–25).
40. Taken from Thomas Lynch, who says "By getting the dead where they need to go, the living get where they need to be" (Lynch 2020, 327).

References

Aquinas, Thomas. 2017. *Summa Theologiæ.* 2nd rev. ed. Translated by Fathers of the English Dominican Province.