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Stabat Mater

*Near the cross of Jesus stood his mother and his mother's sister,
Mary the wife of Clopas, and Mary of Magdala. (John 19:25)*

*Stabat mater Dolorosa
Juxta crucem lacrimosa
Dum pendebat filius.*

*Cujus animam gementem
Contristatam et dolentem
Per transiit gladius.*

*At the cross her station keeping
Stood the mournful mother weeping
Close to Jesus to the last.*

*Through her soul of joy bereaved
Bowed in anguish deeply grieved
Now at length the sword had passed.*

Jacobo Benedetti
from *Stabat Mater*

Fourteenth-century hymn for the
feast of Our Lady of Sorrows

In the care of the dying, as in many other fields of endeavour, there comes a time when the carer's hands are empty, when all the treatment manoeuvres have been explored, all the words of comfort said. It is then that one is left standing at the foot of the bed, useless, impotent, wanting more than anything else to run away.

The first lines of Stabat Mater, etched in my memory from twenty years of pre-Vatican II liturgies, capture better than any photograph the agony of the death-bed vigil. In seven years of caring for the dying, I have stood at over a thousand

bedsides and shared in the impotence of families and friends as they watch the life ebb away from someone they love. This powerlessness to prevent impending death is one of the hardest things for carers to come to terms with, especially when the dying person is young. It produces all sorts of emotions which are often unexpected and hard to handle and may lead to patterns of behaviour which, misunderstood, can cause considerable distress, both to the person experiencing the emotion and those around him. The hospice movement, with its philosophy of openness, is producing a marvellous healing of the medical and nursing profession's wounded attitude towards death and dying, a recapturing of the ancient acceptance of death as part of life.

It is here that we must learn the spirituality of the foot of the cross, the stance of the impotent bystander. Of all the vigils that come to mind the one that I recall with greatest heartache is that of a young woman called Ros who died in our hospice on Christmas day. Ros was only twenty-eight when she died. She had a brain tumour which recurred a year after treatment and, in its final stages, caused her terrible headaches and bizarre hallucinations. Her last days at the hospice have remained fresh in my memory because of the singular poignancy of the circumstances. Ros was a doctor and, knowing that the tumour had recurred, faced death with a particular courage and charm. Absurdly, of course, she thought she was a coward; as the brave always do. She mistook fear for cowardice, and wept for her frailty, angry that she was not coping as well as she had hoped. At a loss as to know what to say, I remembered the preface of Martyrs, copied it out and gave it to her, shyly, because what helps one person may be useless to another:

Her death reveals your power
shining through our human weakness.
You choose the weak and make them strong
in bearing witness to you . . .

I like to think it helped. Anyway, she gathered strength and went home for a week, and then when things became bad came back. Together we faced the last lap. As it happens it was the week before Christmas, and Ros's mother kept vigil at her bedside amid the decoration of the house and all the preparations for the coming feast. Ros was unconscious now,

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her pale face tranquil and her dark hair, lovingly brushed by the nurses, silhouetted against the pillow. Fit young people with brain tumours often take a long time to die and Ros was no exception. It must have been three or four days, perhaps longer that her mother sat – a quiet composed woman, apparently asking nothing more of us than we gave her by instinct and by profession. Surely, I thought, this is the stuff of Holy Week, not Christmas, of the woman at the foot of the cross, not the Madonna.

When a dying person is unconscious the carers' focus shifts instinctively to whoever is the principal mourner. They must be cherished, accompanied, supported, in whatever way seems right for them. There is no blueprint for the care of the grieving – some wish to keep constant vigil, sitting or sleeping at the bedside until the moment of death and beyond. Others find themselves unbearably distressed or even revolted and need permission to go home. More than anything they need to know that, however they feel, that is OK. If they want to stay they will not be a burden, and if they cannot bear to come in, we will not think badly of them. We give this kind of support instinctively now, but from time to time we too fall into the trap of judging people as being selfish or uncaring when really they are possessed by a grief too great to bear. It can be particularly difficult when families are divided among themselves; for instance when parents, divorced and remarried come together again at the bedside of an only child. Sometimes there is real unpleasantness as people fight for the right to be at the bedside and we have to be very firm in order to protect the child from the burden of jealousy and possessiveness.

Another very difficult scenario is the conflict between a young wife or husband and the parents of their dying spouse. It happens commonly when a young wife is dying and her husband has to cope with looking after the children while holding down his job. The girl's mother, distraught at the loss of her daughter, is often blind to the need of the husband and wife to be alone together. Sometimes the hospice provides a sort of neutral ground in which all those grieving can find space to be with the person who is dying without usurping the role of the other.

And in the midst of all this grief and tension, what of the professional carers? What do they feel? It has long been

assumed in medical nursing circles that it is wrong for the carers to become 'involved' and I have struggled with this issue in Chapter 3. The fact remains that however professionally correct they are, carers are inevitably caught up in the tragedy of untimely death. One of the key factors in my experience is to identify with the patient or close relatives. Many of the nurses with whom I work are in their mid-forties and they are particularly vulnerable to identification with the young married women who are desolate at leaving their children. I, as a single person, am most vulnerable to the rather off-beat professional people or the very young and find myself taking their pain home with me.

For all of us, however, there is some respite from pain when we can *do* something. In a way the nurses are luckier than the doctors, for there is always *something* they can do: washing, tidying, massaging pressure points. These loving actions somehow soak up the pain. On the other hand, however, the nurses are 'at the coal face', inescapably exposed to the reality of pain and physical and psychic disintegration.

The doctors' burden is a different one. They too are happiest when they can *do* something: adjust medication; drain off fluids; give injections. The hardest thing is to keep on visiting when all the physical manoeuvres have been exhausted.

The illustrations that follow are designed to show how many of us cope with ministering to the dying. The first drawing shows the doctor, armed with his competence and his instruments and protected by his aide.



It is the same for the priest performing his sacramental ministry. Here we see him in his stole and dog collar protected by having a role to play and a ritual to perform.

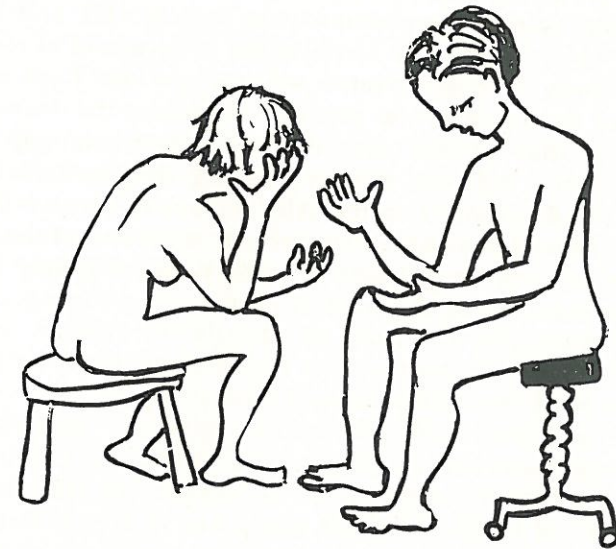


In the next drawing we see the patient meeting with either doctor or clergyman when he has exhausted the physical aspects of his ministry. He is left with his hands empty – but with his resources of counselling still available.



Much of my work is done like this. I work with my hands physically empty but with a wealth of experience in listening and advising the dying. It is taxing work, for one is always searching for the right word for that particular person. At its best this kind of work is tailored to the needs of the individual. It requires much sensitivity and intuitive skills, for what may be marvellously healing for one person may be disastrously wounding for another. One does not always get it right: I once tried to help a very religious elderly lady by giving her one of our hand crosses – a plain wooden cross which fits into the palm of the hand and can be gripped when someone is afraid or in pain. To my chagrin, she shied violently away from me, repeating desperately, 'No, no thank you, I'd rather not.' What I had not realised was that this woman was a member of the Plymouth Brethren and objects like the cross were anathema to her.

The last drawing shows both patient and carer stripped of their resources, present to each other, naked and empty handed, as two human beings.



There is a terrible pain in this impotence, in admitting that one has nothing more to give. It happened to me a little while ago when a young woman lecturer was dying from a slow asphyxiation. Her lungs were filling up with tumour and she

sat in her room surrounded by flowers, classical music playing on a tape recorder – and gasping for breath. There are many things one can do for breathlessness, but when the lungs are taken over by tumour there comes a point when there is nothing one can do and people die of lack of oxygen. I sat on the bed with my arm lightly round her heaving shoulders as she asked in despair, ‘Can’t you *do* something?’ Gently I said, ‘I’m sorry – there’s nothing I can do.’ (I could have sedated her, but we had already discussed this and she wanted to remain alert.) She gasped out, ‘Oh, *don’t* say that!’ The pain of moments like that is hard to bear. It would have been easier to have said, ‘yes, of course’, and given her a useless injection or a powerful sedative. Either of these courses would have been professionally correct, but quite wrong for her. Gasping for breath, and blue as she was, she had a magnificent dignity, sitting imperiously with her husband and lover, friends flying in from abroad to bid her farewell. Hers was a death I would be glad to die – a hard bitter agony, but in control to the last.

Slowly, as the years go by, I learn about the importance of powerlessness. I experience it in my own life and I live with it in my work. The secret is not to be afraid of it – not to run away. The dying know we are not God. They accept that we cannot halt the process of cancer, the inexorable march of that terrible army that takes over a human body like an occupying force, pillaging, raping, desecrating without respect and without quarter. All they ask is that we do not desert them: that we stand our ground at the foot of the cross. At this stage of the journey, of being there, of simply being: it is, in many ways, the hardest part.

Why Me?

*Since I have lost all taste for life,
I will give free rein to my complaints;
I shall let my embittered soul speak out.
I shall say to God, Do not condemn me,
but tell me the reason for your assault.*

Job 10:1–2

One of the effects of the constant exposure to pain and death involved in the care of the dying is that one is forced to grapple not only with the ‘problem of evil’, but with God himself. I believe that our spiritual attitude to suffering is crucial because it not only determines the way we relate to those for whom we care but our very survival as carers. If our attitude is illogical because of ignorance or a flawed theology, we run the risk of being so overwhelmed by pain that we ‘burnout’. If, however, we are able to maintain a paschal overview, keeping the resurrection in the same perspective as the cross, then our inevitable human sadness will be tempered by the joy we experience in our faith in the loving purposes of God.

The prophet Micah tells us that, not only must we act justly and love tenderly but we must *walk humbly* with God. What does it mean to walk humbly with God? Does it mean genuflecting properly in church? Not swearing? Being respectful to the clergy? Not arguing the toss about contraception and fish on Fridays? If that is what it means then I am guilty of even more arrogance and pride than I had thought, and may the Lord have mercy upon me. No, I see humility more in terms of stance before God, a way of being rather than a code behaviour.

For those involved in caring, Micah’s counsel of humility makes particular demands. It asks that we bow down before

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