

## Disability and the Future of Catholic Health Care: Bringing an “Unusual Suspect” to the Center

*Editor’s Note: The following two essays were submitted by Alyson Isaksson Capp and Lisa Martinelli to the Graduate Student Essay Contest sponsored by CHA in conjunction with the 2014 Theology and Ethics Colloquium.*

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In 2011, Fr. Tom Nairn of the Catholic Health Association called attention to Howard Brody’s critique of the blind spots in mainstream bioethical literature—areas he believes need more engagement from the bioethics community. Disabilities, along with patient-centered care, community dialogue, and environmental and global issues, made Nairn’s list of “[i]ssues beyond the ‘usual suspects,’”—“the usual suspects” being end-of-life care, *The Ethical and Religious Directives for Catholic Health Care Services (ERDs)*, research ethics, and organizational ethics.<sup>1</sup> Nairn locates disability as an issue bridging right-to-life and social justice concerns of Catholic health care, moving beyond the stalemate that is often perceived between these two perspectives. Citing the United States Conference of Catholic Bishops (USCCB), Nairn points out that a robust ethic of life “implies the defense of other rights which enable the individual with a disability to achieve the fullest measure of personal development of which he or she is capable.”<sup>2</sup> He also recognizes Brody’s assertion concerning social justice: that “for a person with disabilities, quality of

life depends more on the extent to which society is willing to make accommodations than on the severity of the impairment itself.”<sup>3</sup> Nairn suggests that “[i]f in the future Catholic health care ethics incorporates more fully the perspective of persons with disabilities into its purview, it may help build better bridges between pro-life advocates and social justice advocates within the church.”<sup>4</sup>

What will “[incorporating] more fully the perspective of persons with disabilities” entail for Catholic health care ethicists? I propose three ways in which this might occur. First, it will mean reflecting on the history of how the Catholic Church in general and Catholic health care in particular have and have not adequately listened to persons with disabilities and responded in concrete ways. The Catholic Church has a history of advocating for persons with disabilities on both human rights and social justice fronts, especially through institutional commitments from the Vatican, the USCCB, and Catholic health care. However, Nairn is right in pointing out that there has historically been a divide in Catholic discussions between issues seen more as disability rights (or right-to-life) and social justice issues for persons with disabilities. This may be part of the reason that so much of

Catholic theological and ethical engagement with disability is either confined within personhood discussions or concerns practical matters of inclusivity in the Church and society. Health care ethicists ought to draw from the resources of the Catholic tradition to promote a consistent ethic of life that bridges this divide and takes a more holistic approach to understanding disability. Specifically, Catholic teaching on the diversity of human flourishing needs to be brought into conversation with personhood and social justice concerns.

Second, listening to people with disabilities and those who advocate for them can offer poignant critique and insight into how we care not just for their community, but for other socially marginalized and vulnerable groups and our human community as a whole. In health care, we are constantly caring for people who are at their most vulnerable due to disease and illness. Often, it is a combination of individual attitudes and institutional structures that need reform in order to better serve the entirety of our human community. Attention to the experiences of persons with disabilities on the part of Catholic health care ethicists will engender a response to the “medical model” of disability, which projects a narrow, normative body image and locates disability within individual persons whose bodies stray from this norm. The medical model lens can affect social structures and attitudes present in our health care institutions and among our care providers, inadvertently devaluing and dismissing persons with disabilities. Listening to voices from the disability community can

assist Catholic health care ethicists in evaluating and recreating structures and attitudes aimed at inclusivity of diverse bodies while respecting difference. Too often the difference between an archetypal “normative body” (consider the ideal test subject: young, athletic, healthy) and bodies that deviate from this norm is subconsciously translated into a false binary that values a narrow understanding of the human person over embracing a diverse human community.

Third, Catholic health care ethicists need to respond to disability *theologies*. In particular, Eiesland’s “disabled God” and Creamer’s “limits model” of God and humanity need to be evaluated and critiqued. Eiesland’s disability theology takes seriously the resurrection of a savior with an injured body. She states, “In presenting his impaired hands and feet to his startled friends, the resurrected Jesus is revealed as the disabled God.”<sup>5</sup> The image and symbol of the disabled God calls us to question normative ideals of embodiment and power present in our Christian heritage, and recognize the diversity and inclusivity of the body of God. Creamer’s “limits model” reveals a God who lovingly took on human limits through the Incarnation. For Creamer, “Rather than thinking of limits solely in a negative sense (what we, or what God, cannot do), this perspective offers alternatives for thinking about boundaries and possibilities.”<sup>6</sup> While these models of God resonate with some of the experiences of persons with disabilities in the Christian community (both Eiesland and Creamer identify as Christian and as part of the disability community), they also

raise questions about more traditional understandings of God as omnipotent, transcendent, and radically other, as well as questions about the human-divine relationship.

As Brody and Nairn suggest, the future of bioethics necessitates critical engagement and dialogue with the disability community.<sup>7</sup> Catholic health care ethicists have a responsibility to weigh in on important bioethical issues highlighted by disability critique. These include, for instance, navigating discussions of difference versus disability, breaking the pervasiveness of the “medical model” within health care institutions and medical education, and instilling an appreciation of human diversity that has room for all bodies in human community. To help frame this response, this article advances the three discussions mentioned above. First comes a discussion of Christian and specifically Catholic contributions and voids in dialogue with the disability community; second, a call to pay attention to the experiences and voices of persons with disabilities in garnering a more inclusive health care environment that is critical of the medical model; and third, a call to engage deeply and perhaps critically in how we understand “God with us” alongside our patients and our health care providers in light of disability theologies that portray God as disabled and/or limited. As full members of the diverse communities served by Catholic health care, whose ineradicable dignity demands our listening ears, persons with disabilities have much to teach Catholic health care ethicists, and it is time that we hear them and respond.

## Disability in Contemporary Christian and Catholic Contexts

As Nairn points out, Catholic social justice movements and right-to-life activists have had the concerns of disability communities on their radar since at least the 1970s.<sup>8</sup> Catholic institutional statements reaffirm the full and ineradicable dignity of all persons including those with physical and cognitive impairments and disabilities, emphasizing the diversity of the body of Christ and full membership in the Church through baptism. Participation in baptism, the Eucharist, and a vocational call to ministry or other Church service for persons with disabilities are reaffirmed in the face of unwelcoming or inconsistent Church practice. Right-to-life concerns are framed through the lens of social justice:

Defense of the right to life implies the defense of all other rights which enable the individual with the disability to achieve the fullest measure of personal development of which he or she is capable. These include the right to equal opportunity in education, in employment, in housing, and in health care, as well as the right to free access to public accommodations, facilities and services.<sup>9</sup>

Papal statements, both formal and informal, have also addressed the rights and justice issues faced by persons in the

disability community.<sup>10</sup> Addressing a group of persons with disabilities in 1984, Pope John Paul II remarked:

Unquestionably, the quality of a society or civilization is measured by the respect it has for its weakest members... A technically perfect society, where only fully productive members are accepted must be considered totally unworthy of human beings, perverted as it is by a type of discrimination that is no less reprehensible than racial discrimination.

Here John Paul II uses the term “weak” to describe persons with disabilities only in the context of a technocratic society, where “strong” would shallowly equate to being “productive.” He denounces this type of society, calling it dehumanizing, and abhors that citizens would be deemed “weak” or “strong” based on productivity.

Also, consider the commitment, as expressed in the *ERDs*, to service... and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination... In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique

person of incomparable worth, with the same right to life and to adequate healthcare as all other persons.<sup>11</sup>

These are just two examples of a sustained commitment to advocating for and with persons with disabilities. The Catholic Church and Catholic health care have a foundation for attentiveness to people with disabilities and a commitment to growing an increasingly more adequate response to the social marginalization they still face.

With this solid foundation, Catholic health care ethicists have a starting point for moving beyond discussions that narrowly focus on personhood and disability. Different Christian theological communities are already on board with affirming the full humanity and personhood of persons with varying degrees of physical and mental disabilities, even if they do not agree on all points theological. For example, while Hans Reinders dismisses Thomistic insistence on the rational soul for inclusion in the human community and opts rather to understand personhood in terms of received friendship with God, Miguel Romero insists that a rational soul, with the capability (even if hidden, or not realized until the eschaton) to grow in knowledge and love of God is always present within all human-born persons—thus, grounding personhood similarly to Aquinas.<sup>12</sup> Reflecting on these two positions, E. Lawrence remarks:

Reinders’s allergy to rational-capacities

language makes him feel more capable of including people with intellectual disabilities more robustly in an account of what it means to be human, while Romero's inclusion of people with intellectual disabilities in a rational-capacities-based account of what it means to be human allows *him* to feel more successful at articulating an inclusive anthropology... maybe it's just a Protestant/Catholic thing at the end of the day.<sup>13</sup>

While these intellectual engagements with Aquinas are important, I argue that these conversations are no longer the kind being asked for by the disability community. What is remarkable in Lawrence's comparison between Reinder's and Romero's discussions is not their disagreement on how to appropriate Aquinas, but on their shared commitment to advocating for the full humanity of persons with disabilities, especially cognitive impairments. With this shared starting point, what is it that the disability community is asking for from theology, and in particular, Catholic health care ethicists? Echoing the work of Eiesland and Creamer, I suggest that structural analysis of models of disability along with the development of new constructs of disability, informed by persons with disabilities themselves, is what we are presently being called to do. While many Christian theologians are in agreement

about the full personhood of persons with disabilities (perhaps despite their different appropriations of Aquinas), there are significantly fewer involved in confronting structural barriers to this reality. Here I want to highlight how both Eiesland and Creamer critique the "medical model" of disability, and then illustrate how engaging in constructive dialogue based on the experiences of persons with disabilities can advance other models that are more affirming of diversity within the C/church<sup>14</sup> as the body of Christ.

### **Disabled Bodies, Enabled Voices: Listening to the Disability Community**

The disability community is as diverse as any human community that refuses to discriminate based on gender, race, ethnicity, age, or socioeconomic status. It includes people with normative and non-normative bodies alike—persons who identify as disabled as well as persons and institutions who support and advocate for them. Leaders in the Catholic Church and Catholic health care can be included in this community. Indeed, to the extent in which health care providers already serve disabled persons within Catholic health care institutions, to the degree inclusive hiring and employment policies are already in place, and to the level at which health care leadership and providers are already formed by an attentiveness to the shared abilities and limits of all persons and patients, some people working in Catholic health care and some Catholic health care institutions are already disability advocates and part of the disability community. However, this is not always the case. The medical model

of disability unjustly measures all bodies against an unrealistic norm and treats all non-normative bodies as needing to be fixed. This medical model is still functioning, even if subconsciously, in many health care institutions. I want to call attention to normative body bias in the attitudes of health care providers toward patients with disabilities, and suggest how this bias can be broken down. By engaging the voices of persons with disabilities, we can explore how this bias comes to manifest itself within the attitudes of practitioners and the structural practices of health care delivery. Listening to members of the disability community, voiced here by Eiesland and Creamer, also offers corrective insight for how practitioners can reframe their understandings of bodies, limitedness, and the human condition to be more inclusive of the greater human community.

Catholic health care ethicists need to investigate structures within society, and particularly structures within their own turf—hospitals, clinics, and other health care institutions—that maintain barriers to inclusivity for persons with disabilities. Building on Eiesland’s landmark exposition on disability theology, Creamer invites us to reconsider traditional models of disability and their inadequacies. The medical or “functional-limitation” model of disability, all too familiar in health care circles, “is focused around what one can or cannot physically or functionally do” and “is closest to the common sense idea that a disability is what someone has when his or her body or mind does not work properly.”<sup>15</sup> This model is severely scrutinized by the disability community

because of its reliance on a normative body model—a “biological machine that functions to a greater or lesser extent”—from which people with disabilities deviate. In this model, persons with disabilities are therefore in need of “normalization” to fit societal expectations. The medical model also ignores how environmental and social factors respond to bodies that have been constructed as “normal” and do not as often respond to bodies outside this norm (stairs are “normal”; ramps are not). It is not difficult to see where this model is still perpetuated in our health care institutions today. While there are individuals and groups of health care providers who decisively operate outside of this model, the structures of health care institutions themselves, built upon technological efficiency, standardized rubrics and metrics, and success as relative to normative functioning, perpetuate the “functional-limitation” model. For many persons, especially those who identify as disabled, meeting a specific functional capacity is not directly related to human flourishing or “the good life,” and can often times detract from these human spiritual pursuits. The medical model upholds the subconscious mantra of fixing what is broken to restore a normative body, sometimes at the expense of the full human flourishing of those with disabilities in our communities.

To combat this model, some within the disability community have advanced the social or minority group model, which emphasizes “shared experiences of discrimination and oppression.”<sup>16</sup> In contrast to the medical model, this model



focuses on disability as a sociopolitical category where “disability is not so much about what one can or cannot do but rather is about how individuals are treated in their daily lives and by society at large.”<sup>17</sup> The minority group model critiques the ideology of “ableism,” which sets up stereotypes of people with disabilities as either living lives less worthy than “able persons” or as saintly, heroic champions of life amidst adversity. The minority group model unmasks these ableist stereotypes, naming disability as social oppression based on an uninterrogated normative body, and recognizes disability as a human rights issue. Despite the preference for the minority model over the medical model among many disability rights activists, Creamer and others note significant shortcomings. She states:

By emphasizing the social and political nature of disability, the minority model devalues [the physical and emotional reality of impairment.] The minority model suggests that all people with disabilities should accept and even embrace their own disabilities/impairments—after all the impairment is not the (or a) problem.<sup>18</sup>

Creamer advances a new model of disability and embodiment to critique and complement both the medical model and the minority group model. She calls it the “limits model” because it “begins with the notion of limits as a common, indeed

quite unsurprising, aspect of being human.”<sup>19</sup> I will return to considerations of the “limits model” in the next section. What is important here is recognizing that criticisms from within the disability community can give life to newer models that can change dominant structures and attitudes in health care. Catholic health care ethicists need to understand the social marginalization faced by persons with disabilities from their own particular perspectives and experiences. As Mary Jo Iozzio argues, “If the person adequately and integrally considered is the proper subject of theological ethics then both experience and study qualify as sufficient grounds of authority in and for the moral life.”<sup>20</sup> Here I will highlight just two examples of how attention to the experiences of persons with disabilities can shift our moral vision for more inclusive models of disability and humanity.

Eiesland reflects on the life experiences of Diane Devries, a woman born without some of her limbs, to advance an understanding of “bodies of knowledge” that takes seriously the multitude of nonconventional bodies that constitute ordinary existence.<sup>21</sup> Despite negative interpretations of her body suggested by family members and medical professionals, Devries “evaluated her body positively as compact and streamlined,” unique and whole.<sup>22</sup> Devries also challenged normative ideas of beauty, remarking on her resemblance to the *Venus de Milo* and asserting herself as “a woman of rare beauty.”<sup>23</sup> Eiesland narrates how Devries’ self-understanding defies normative models of humanity by exposing the false boundaries between

“natural and unnatural experience,” whole and incomplete bodies, independence and solidarity, and inner and outer beauty.<sup>24</sup> Devries’ critiques are fertile ground for new models of disability and humanity.

Considering “the ethic we need” to cultivate good moral vision, theological ethicist Larry Rasmussen shares the following story of a man with a visible disability while addressing health care professionals about organ transplantation:

The young man spoke matter-of-factly about his condition and went on to say that in many ancient civilizations the disabled were put to death. This had happened in the United States as well and, even now, in certain cases the disabled were not allowed to live.... Several people challenged him from the floor. His reply was a question: If two persons could avoid death, and could anticipate significantly prolonged life from an organ transplant, and if the only difference between them was that one was notably disabled and the other not, who would receive the transplant?... [B]efore long [the transplant surgeons] began to realize the consequences of their train of thought: The young man who had quietly put the question to them

would not, in their considered judgment, be given the transplant that would allow him to live. Quiet moral shock set in as it came clear to them that they had not considered the disabled to be fully persons.<sup>25</sup>

Rasmussen goes on to relay the following reflections from a conference participant: “In the silences between their sentences the participants sensed that they had passed beyond the discussion of ethical, economic, medical, and legal terms to glimpse new horizons of responsibility. Their sense of humanity had expanded.”<sup>26</sup> Rasmussen’s call to “expand our humanity” by considering issues within the wheelhouse of health care ethics from perspectives within the disability community is a step in the direction of fostering a new moral imagination from which to advance new models of disability and humanity.

By listening closely to the experiences of persons from the disability community as an authoritative source, Catholic health care ethicists can begin to critique discriminatory social structures (like the “medical model” of disability) and offer new models that more adequately express the diversity of ordinary life. This will include integrating new sources of experience (interviews, ethnography, and focus groups) with sources present in the Catholic tradition (papal and bishop statements, the *ERDs*, and work by Catholic theologians on diversity and embodiment). It will mean supporting



health care practitioners who resist the dominant “medical model” of disability, along with not being satisfied until the structures that perpetuate the glorification of an abstract normative body are confronted and nuanced. Approaching disability from this perspective makes apparent the limits of focusing narrowly within the personhood discussion, and calls Catholic health care ethicists to ask how the structures and attitudes present within their institutions can invite inclusivity and celebration of diverse bodies within a community. Catholic health care ethicists will also find resources from within a growing group of disability *theologies* from Protestant theologians.

### **Disability Theology: The Disabled God and the Limits Model**

Disability theology grew out of the liberation felt by the disability community with the passing of the 1990 Americans with Disabilities Act (ADA) coupled with the challenges traditional theology and church structures still posed to inclusivity. While the ADA advanced principles of equal access to employment, buildings, transportation, and communication devices, many churches still harbored practices that restricted some persons with disabilities from ordination and partaking in the Eucharist.<sup>27</sup> As Eiesland remarked in 1994, “For many disabled persons, the church has been a “city on a hill”—physically inaccessible and socially inhospitable.<sup>28</sup> Since the 1990s, church bodies have worked “to promote the full participation of persons with disabilities in the life of the church”: for example, in 1995 the U.S. bishops approved *The*

*Guidelines for the Celebration of the Sacraments with Persons with Disabilities*, which clarified and widened access to the sacraments, including ordination and receiving the Eucharist, for persons with disabilities.<sup>29</sup> Though practices within church communities have become more inclusive for persons with disabilities over the past 20 years, especially regarding physical access, normative theological concepts about the body, sin, nature, and grace still project negative images of disability that maintain barriers from full inclusion in the church. As liaisons for an institution of the Catholic Church that serves people with disabilities and advocates for all marginalized persons, Catholic health care ethicists ought to be especially concerned with the effects of these aspects of our Christian heritage that are damaging to the community of disabled persons.

To debunk exclusionary theology and church practices, Eiesland advances the concept of the disabled God. Eiesland explains that the resurrected Jesus Christ, complete with punctured hands and feet and gaping torso, is revealed as God disabled.<sup>30</sup> Her centering upon Christ’s resurrection is key, because it is a foundational mystery of our faith commitment and who we say we are as persons working for ministries of the Catholic Church. Through the resurrection, “the disabled God is also the revealer of a new humanity” and “the revelation of true personhood, underscoring the reality that full personhood is fully compatible with the experience of disability.”<sup>31</sup> If we take the image of the disabled God seriously,

disability cannot be understood as the consequence of sin as it has incorrectly been historically.<sup>32</sup> As Eiesland states, “Our bodies participate in the *imago Dei*, not in spite of our impairments and contingencies, but through them.”<sup>33</sup> Additionally, physical avoidance by able-bodied persons of those who are disabled results in a failure to recognize Christ’s physical impairment as an intersection point of the equality of all limited bodies. Foreshadowing Creamer’s advancement of a limits model of embodiment, Eiesland points out that the limits of our bodies are divinely affirmed, and therefore hope for our eternal and temporal salvation does not rest upon what body we have, as non-conventional as it may be.<sup>34</sup> A final implication of the disabled God is that it affirms the interconnectedness of all of b/Being and the emphasis on right relationships to foster justice.<sup>35</sup> Eiesland argues, “[A] liberation theology of disability is a theology of coalition and struggle in which we identify our unique experiences while also struggling for recognition, inclusion, and acceptance from one another and from the able-bodied society and church.”<sup>36</sup>

The social implications of the image of a disabled God are numerous: it evokes an image of “God with and for us” that fully understands the limitedness and diversity of human embodiment and calls for justice for all who are currently marginalized for traits that actually reflect the divine image. The theological implications of the divine God are more complex, and necessitate critical reflection. For example, the notion of a disabled God may seem contradictory to other

characteristics we normally use to describe God, like omnipotent, omniscient, radically-other, and literally *unlimited*. For Eiesland, these traditional descriptors are not untrue. She notes, “For people with disabilities who have grasped divine healing as the only liberatory image the traditional church has offered, relinquishing belief in an all-powerful God who could heal, if [God] would, is painful.”<sup>37</sup> However, she challenges traditional understandings of omnipotence and power, arguing “the theological implications of the disabled God resist the notion of power as absolute control over human-divine affairs.”<sup>38</sup> For Eiesland, the disabled God is a theological representation of who God is in relationship to us that is authentic of Immanuel—“God with us.”

Bringing Creamer’s description of limitedness to the discussion, we do not have to understand a disabled or limited God in a negative sense. Creamer notes, “When we imagine an unlimited God, there is a subtle implication that the more limits we have, the less we are like God.”<sup>39</sup> Therefore, the idea of a limited God is more reflective of the similarity we share in the *imago Dei*. She points out that in many understandings of God, “God took limits willingly... by creating or allowing free will, or by taking on personhood (and death) through Jesus.”<sup>40</sup> Creamer posits that “limits do not tell us all that God is,” but that recognizing the limits present within the divine allows us to see perseverance, strength, creativity, and a preference for diversity that is more nuanced and like us than “God as radically other” models.<sup>41</sup> In a dialectical

fashion, contemplating a limited God offers insight into what it means to be embodied, either as able-bodied, disabled, or somewhere in between, in relationship with the divine and with each other, in a way that was not before possible.

For those who are skeptical that the image of a disabled God can be complementary with traditional, historical, and especially normative or doctrinal understandings of Christology, I offer one more argument for the place of this image of God within our body of ways of knowing. Eiesland shares an epiphany she had of God, a God that to her “bore little resemblance to the God [she] was expecting or the God of [her] dreams.”<sup>42</sup> She envisioned “God in a sip-puff wheelchair... the chair used mostly by quadriplegics enabling them to maneuver by blowing and sucking on a strawlike device.”<sup>43</sup> Eiesland’s theological imagination calls to mind the Jesuit notion of “finding God in all things”—the spiritual understanding that God desires to make God known to us through creation.<sup>44</sup> Finding God in a sip-puff wheelchair is finding a God who embraces diversity and limitedness, identifies with those who face physical and cognitive impairment, and is present with those who are socially marginalized. Finding God in all things also opens us up to multiple and varying ideas of God and our relationship with God that are not mutually exclusive, but converge toward greater understanding.

For Eiesland, it is not problematic to hold the image of the disabled God in tandem with other images—instead, it is liberatory. She sees the incorporation of

different models of God as the body of God coming alive, and as an invitation to follow these images to a deeper understanding of ourselves in relationship to God. Through the disabled God, we recognize the common yet diversified limitedness of all of humanity and our complicity in creating and maintaining social structures that refuse to acknowledge this diversity. Additionally, by not interrogating how far the medical model of disability reaches, we overlook the particularity and diversity of those who identify as part of the disability community and fail to recognize these persons as full participants in human community.

Eiesland and Creamer’s disability theologies bring up important theological questions that ought to be considered from a Catholic perspective within the context of health care. For example, what does it mean that our resurrected savior is disabled? How does this image of God contextualize more traditional God characteristics like omnipotence? What does it mean to add “disabled God” to our ways of knowing God, not just for people with disabilities, but for all Christians deepening their sense of the divine? Is there room in a Catholic Trinitarian perspective for both a transcendent God and a disabled resurrected Christ? What is the potential role of the Holy Spirit in a Catholic disability theology? The Catholic theological and intellectual tradition is rich with discourses that can address some of these questions. Catholic health care ethicists ought to mine these resources in order to respond to the pervasiveness of the medical model of

disability and to disability theologies. While this section is not attempting to advance a Catholic theology of disability at this point, it does carve out the parameters within which such a theology would need to begin and identify potential partners for the conversation.

### Conclusion: Implications for Catholic Health Care

Catholic health care ethicists must take seriously the commitment to persons with disabilities expressed in the *ERDs*.<sup>45</sup> While the foundation for recognizing and promoting the full participation of the diversity of embodied humanity is present within the Catholic tradition, and many persons and institutions that are part of the Church are considered to be on the side of the disability community, Catholic health care ethicists can do more to critique the medical and minority group models of disability, especially when the structures they reside in continue to marginalize our patients, health care providers, and associates with disabilities. Moreover, Catholic health care ethicists have a responsibility to take seriously the theological contributions of disability theology, including the image of the disabled God and the limits model. While these theologies may require critique and reform in light of Catholic theological commitments, we must acknowledge their consistency with other Christian theologies and the resonance they may have with our non-Catholic patients and associates. Further, the re-centering work these theologies have done to break down the false binary relationship perceived between abled and disabled

bodies, to consider disability and limits as inherently human and divinely experienced, and above all to bring the voices and experiences of the disability community to the center require a response from the largest group of religiously based health care institutions in the country. The future of Catholic health care ethics calls for structural critique of disability models informed by voices from the disability community, as well as a response to disability theologies. The trajectory for such endeavors ought to be toward embracing a fuller and more diverse human community through advancing a creative and renewed moral imagination of humanity.

<sup>1</sup> Thomas Nairn, OFM, "Issues Beyond the 'Usual Suspects,'" *Health Progress* 92, no.9, 72.

<sup>2</sup> Ibid., 72. Quoting USCCB, *Pastoral Statement of the US Catholic Bishops on Persons with Disabilities* (Washington DC: USCCB Publications, 2001).

<sup>3</sup> Ibid., 72-73. Citing Howard Brody, *The Future of Bioethics* (New York: Oxford University Press, 2009), 162.

<sup>4</sup> Ibid., 72.

<sup>5</sup> Nancy Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability*, (Nashville, TN: Abingdon Press, 1994), 100.

<sup>6</sup> Deborah Beth Creamer, *Disability and Christian Theology: Embodied Limits and Constructive Possibilities*, (New York: Oxford University Press, 2009), 113.

<sup>7</sup> This is especially necessary when considering issues such as pre-implantation and prenatal genetic testing, organ transplantation, enhancement versus therapy, structural justice in health care delivery, inclusive social responsibility and public policy, and social attitudes concerning a/the "normative body."

<sup>8</sup>. The United States Conference of Catholic Bishops has published a *Pastoral Statement of the U.S. Catholic Bishops on Persons with Disabilities, Guidelines for the Celebration of the Sacraments with Persons with Disabilities*, and *Welcome and Justice for Persons with Disabilities: A Framework of Access and Inclusion* in 1978, 1995, and 1998 respectively.

<sup>9</sup>. U.S.C.C.B., *Welcome and Justice for Persons with Disabilities*, paragraph 4.

<sup>10</sup>. Vatican documents specifically addressing disability include *Conclusions of a Vatican Conference on the Family and Integration of the Disabled* (1999) and *The Person with Disabilities: The Duties of the Civil and Ecclesial Community* (2000). These are in addition to numerous others that mention disability in another context, as well as speeches and shorter statements.

<sup>11</sup>. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5<sup>th</sup> ed., 11-12.

<sup>12</sup>. Hans Reinders, *Receiving the Gift of Friendship: Profound Disability, Theological Anthropology, and Ethics*,” (Grand Rapids, MI: Eerdmans, 2008); Miguel Romero, “Aquinas on the *corpus infirmitas*: Broken Flesh,” in *Disability in the Christian Tradition*, ed. Brian Brock and John Swinton (Grand Rapids, MI: Eerdmans, 2012), 101-151.

<sup>13</sup>. E. Lawrence, “How Are We All Human? Intellectual Disability and Appeals to Aquinas,” *Women in Theology Blog*, March 27, 2013, <http://womenintheology.org/2013/03/27/how-are-we-all-human-intellectual-disability-and-appeals-to-aquinas/>.

<sup>14</sup>. My use of the construct C/church is to reflect both Catholic and Protestant understandings of the body of Christ.

<sup>15</sup>. Deborah Beth Creamer, *Disability and Christian Theology: Embodied Limits and Constructive Possibilities*, (New York: Oxford University Press, 2009), 22.

<sup>16</sup>. *Ibid.*, 25.

<sup>17</sup>. *Ibid.*

<sup>18</sup>. *Ibid.*, 27.

<sup>19</sup>. *Ibid.*, 31.

<sup>20</sup>. Mary Jo Iozzio, “The Authority of Experience and Study: Persons with Disabilities Adequately and Integrally Considered,” in *Lowain Studies* 35, no.1-2 (2011):162.

<sup>21</sup>. Eiesland, “The Disabled God,” 32-33.

<sup>22</sup>. *Ibid.*, 34.

<sup>23</sup>. *Ibid.*, 39.

<sup>24</sup>. *Ibid.*, 32.

<sup>25</sup>. Larry Rasmussen, *Earth-honoring Faith: Religious Ethics in a New Key* (Oxford: Oxford University Press, 2013), 143-144. From an unpublished paper by Roy Branson, “Apocalyptic and the Moral Imagination,” proceedings from a conference on “Bioethics: Old Models and New,” held at Loma Linda University, November 1986, 1-2.

<sup>26</sup>. *Ibid.* This participant is Roy Bronson.

<sup>27</sup>. Eiesland, *The Disabled God*, 20.

<sup>28</sup>. *Ibid.*

<sup>29</sup>. United States Catholic Conference, *The Guidelines for Celebration of the Sacraments with Persons with Disabilities*, Washington, DC: 1995, p. 19-21, 30-33.

<sup>30</sup>. Eiesland, *The Disabled God*, 100.

<sup>31</sup>. *Ibid.*

<sup>32</sup>. *Ibid.*, 101.

<sup>33</sup>. *Ibid.*

<sup>34</sup>. *Ibid.*, 103.

<sup>35</sup>. *Ibid.*

<sup>36</sup>. *Ibid.*, 26.

<sup>37</sup>. *Ibid.*, 105.

<sup>38</sup>. *Ibid.*, 104.

<sup>39</sup>. Creamer, *Disability and Christian Theology*, 112.

<sup>40</sup>. *Ibid.*

<sup>41</sup>. *Ibid.*, 112-113.

<sup>42</sup>. *Ibid.*, 89.

<sup>43</sup>. *Ibid.*

<sup>44</sup>. I am grateful to Dr. Sandra Sullivan-Dunbar and my classmates for this insight

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<sup>45</sup> U.S.C.C.B., *ERDs*, 11-12.

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