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THEOLOGY AND SPIRITUAL CARE IN PALLIATIVE CARE

Teología y cuidados espirituales en cuidados paliativos

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Abstract

The recognition that spiritual aspects are involved in health and that sick people can benefit from spiritual care as part of their healthcare justifies this study. Furthermore, it is important to consider people who are enjoying longevity but are simultaneously facing chronic degenerative diseases and their consequences, and who also need to find meaning and significance in their suffering at this stage of life. Therefore, spiritual care as part of Palliative Care is necessary. For this assistance to constitute ethical, comprehensive, and pluralistic care, it must be based on spirituality and religiosity rather than being limited exclusively to voluntary or pastoral-religious practices. Otherwise, the risk of proselytizing arises, and amateurism can become harmful. Thus, it is crucial for practitioners to be adequately trained to act professionally as spiritual assistants. This qualitative, theoretically exploratory, and explanatorily deductive study aims to ascertain whether individuals with formal theological training are equipped to work in healthcare, particularly in palliative care. To support this hypothesis, the study drew on contributions from the literature, with an emphasis on Public Theology; the review was guided by critical reflection. The research results show that theological knowledge can contribute to helping patients and their families transcend, give meaning to, and reframe their suffering in the face of vulnerability, which is exacerbated by life-limiting illnesses and finitude. In conclusion, it is highly relevant and pertinent for theologians to serve as spiritual care professionals within multidisciplinary palliative care teams, and theological education must adequately prepare them for this specialized role.

Keywords

Theology; public theology; theological knowledge; spirituality; religiosity; finitude; spiritual assistance; theologians; spiritual assistant; palliative care.

Resumen

El reconocimiento de que los aspectos espirituales están involucrados en la salud y de que las personas enfermas pueden beneficiarse de la atención espiritual como parte de su atención sanitaria justifica este estudio. Asimismo, es importante considerar a las personas que alcanzan una edad avanzada y que, al mismo tiempo, enfrentan enfermedades crónicas degenerativas y sus consecuencias, y que también necesitan encontrar sentido y significado a su sufrimiento en esta etapa de la vida. Por lo tanto, la atención espiritual como parte de los cuidados paliativos es necesaria. Para que esta asistencia constituya una atención ética, integral y pluralista, debe fundamentarse en la espiritualidad y la religiosidad, en lugar de limitarse exclusivamente a prácticas voluntarias o pastorales-religiosas. De lo contrario, surge el riesgo de proselitismo y el amateurismo puede resultar perjudicial. Así, es fundamental que los profesionales estén adecuadamente preparados para desempeñarse como asistentes espirituales. Este estudio, de carácter cualitativo, teórico-exploratorio y explicativo-deductivo, tiene como objetivo determinar si las personas con formación teológica formal están capacitadas para desempeñarse en el ámbito de la atención sanitaria, particularmente en los cuidados paliativos. Para sustentar esta hipótesis, se recurrió a aportes de la literatura, con especial énfasis en la Teología Pública; la revisión estuvo guiada por una reflexión crítica. Los resultados de la investigación muestran que el conocimiento teológico puede contribuir a ayudar a los pacientes y sus familias a trascender, encontrar sentido y resignificar su sufrimiento ante una

situación de vulnerabilidad exacerbada por enfermedades limitantes de la vida y por la finitud. Se concluye que es altamente relevante y pertinente que los teólogos se desempeñen como profesionales de la atención espiritual en equipos multidisciplinarios de cuidados paliativos y que la formación teológica los prepare adecuadamente para este papel especializado.

Palabras clave
Teología; teología pública; conocimiento teológico; espiritualidad; religiosidad; finitud; asistencia espiritual; teólogos; asistente espiritual; cuidados paliativos.

Introduction

The secular nature of democratic states has allowed religions to flourish and be recognized, legitimizing religious pluralism and acceptance built upon respect and openness (Domingos, 2010). As a result, the space for theological contributions has expanded, and "frontier" issues have become a place for theological practice, which requires interdisciplinarity.

Theology is the study of the divine that is believed in. Thinking about the God that is believed in, whether one or several, or seeking understanding for faith in something that transcends the human, is no longer the sole priority of theology (Moraes, 2019). Theorizing beliefs, re-reading the facts and events of the time through the lens of one doctrine or another, and improving intramural hermeneutics constitutes only part of its mission. Another part concerns the good, the transcendent, which is revealed in time and history and is not restricted but is recognized in the most diverse situations and places.

In its public dimension, theology reaches out to society with its plurality and diversity, the academy, where it has yet to regain or reoccupy its own space and to the church in its many tents and paths (Tracy, 2006). The people who make up churches are simultaneously a constituent part of society and those who sustain the academy and its perpetually developing wealth of knowledge. Furthermore, they emerge from society and may or may not congregate in churches (Tracy, 2006).

All these publics have to do with beliefs, religiosity, and spirituality. Whether they know it or not, they live with their expressions of spirituality and those of others (Puchalski & Romer, 2000; Puchalski, Vitillo, Hull & Reller, 2014). Even those who claim to be agnostic or atheist position themselves in the face of a god who is believed in by many others (Puchalski, Dorff & Hendi, 2004). When seriously ill and facing the imminent possibility of death, most individuals suffer and search for a meaning to living and suffering (Pessini & Bertachini, 2011) and they can find it through spirituality and religiosity.

Although there is no doubt about the benefits of offering spiritual care as part of healthcare, this is still not happening. In Brazil, there is no professionalized and/or specialized spiritual care service, and consequently, spiritual care is not actually integrated into healthcare, not even in palliative care (Salvador & Esperandio, 2023). Considering this situation a significant gap, especially in light of finitude, it is believed that there is a need to professionalize spiritual care in healthcare.

In view of the above, the possibility arises for the professional integration of theologians as spiritual care assistants within healthcare systems. Such a role is not unprecedented, for example, North American chaplains are certified professionals, both generalist training in religions and a postgraduate degree in theology are requirements by The Board of Chaplaincy Certification Inc. (2016). Another example is that of Belgium where "the need for professional chaplaincy can also be seen as a patient's right", so in order to fulfill this right, "a typical Belgian Catholic chaplain, [...] would have a master's degree in Theology and Religious Studies [...]. He or she would also have a second master's degree in Theology, specializing in Chaplaincy" (Vandenhoeck, 2013, pp. 552-553).

This study explores this theological perspective, specifically the contribution of public theology. It focuses particularly on David Tracy's understanding of theological practice within the context of human experiences. It also sought texts that discuss public theology as understood by authors from the context of the Global South, as well as others that address the interdisciplinary interface between health and spirituality. Through critical and reflective reading, the aim is to build a rationale and offer sufficient arguments so that theology, as academic knowledge, recognizes that spiritual assistance can be a form of extramural public action and a viable professional field for theologians.

Initially, the relevant concepts and necessary distinctions are presented. Subsequently, the theoretical framework resulting from the research is introduced, along with reflections on the relationship between theology and society, public theology, and public theology in the context of suffering and finitude –specifically, its potential contribution to palliative care from a bioethical perspective. Finally, the conclusions are presented.

Concepts: differences and meanings

There are conceptual differences between spirituality, religiosity and religion. Recognizing that they are not identical is essential in spiritual assistance practices as part of healthcare. Spirituality is a fundamental human characteristic that refers to the search for “meaning, purpose, transcendence and experience of the relationship with oneself, with one’s family, with others, with community, with society, with nature and with the meaningful or sacred” (Puchalski, Vitillo, Hull, & Reller, 2014, p. 646).

That is, spirituality "is expressed through beliefs, values, traditions and practices" (Puchalski, Vitillo, Hull, & Reller, 2014, p. 646) therefore, may or may not be linked to religiosity and religion. The latter refers to the "expression of the individual's involvement with religious practices [...] beliefs, […] and ethical-moral values linked to an established religion" (Esperandio, 2014, p. 808). Religion is "a social phenomenon defined by particular limits, expressed in a body of doctrines assumed by the community of faith that shares the same beliefs" (Esperandio, 2014, p. 808).

The distinction between concepts is important. On the one hand, in Brazil, the population has the right to religious assistance in hospital settings, which is assigned as a function to religious leaders of any denomination (Brazil, 2000). On the other hand, there are few hospital chaplaincy services, most of which are faith-based and un-professional. At the same time, nurses are expected to make "diagnoses" about spiritual issues (Herdman & Kamitsuru, 2018). However, nurses report a lack of knowledge, insufficient training, and even omission because they do not know how to resolve these issues (Castelo-Branco, Brito & Fernandes-Sousa, 2014; Simão, Chaves; & Iunes, 2015). In other words, there is a need for a professional/specialized spiritual care service that is broader and more inclusive than religious care, composed of professionals specifically educated and trained for this work.

It should be noted that the plural and broad nature of spiritual assistance understanding remains the focus, while the aim is to urge that theological knowledge is integrated into the core competencies present in the specialized practices of palliative care. This care seeks relief or control of "pain and other distressing symptoms", which implies "integrating psychological and spiritual aspects into the care" of the seriously and fatally ill person and their family (World Health Organization, 2002).

Regarding theology, although it seems to belong to the Christian universe– and in Brazil, it mostly does– theology is not exclusively Christian. When approaching the public side of theology, the option in this text was to consider Christian theology as a backdrop, as it corresponds to the desire to respect that most of the Brazilian population claim to be Christian (Brazilian Institute of Geography and Statistics, 2025). It is also based on the truth expressed in the words of Christ himself when he sent his disciples out: "Go into all the world, [...] to every creature" (Mark 16:15).

Theology and Society

In 2011, Soares and Passos wrote about the relationship between theology and society. They highlighted the role and recognition of theology as an area of knowledge and a profession. Passos (2011, pp. 68-69) argues that ceasing to be a "church thing" can become a reality if theology is recognized as "knowledge offered to society". Given that official opinions exist in Brazil dealing

with the admission of theology to its place of historical belonging, the university. Since these opinions establish recognition and guidelines for undergraduate and postgraduate programs, it is worth considering whether this knowledge should also be offered in the field of healthcare.

Passos (2011) and Fabri dos Anjos (2011) realize that changes demand a renewed position over time: there are spaces for public action amid the plural society of the twenty-first century. Kuzma (2011) looks to the structural foundations of faith and reason for the validation of theology opening up and placing itself publicly within the world. Nevertheless, how will theology respond to the current questions of a plural society that welcomes diversity? The answer is propositional: a public theology that is co-responsible for the world and presents itself as an option for promoting relationships of otherness.

Theology contributes by bringing "two essential anthropological dimensions" to bioethical reflection: "awareness of vulnerability" and "awareness of alterity" (Souza, 2016, p. 128). The former, which "leads to accepting vulnerability and transubstantiating personal limitations", serves, according to the author, as "the basis for the constitution of subjectivity and the corresponding autonomy" (Souza, 2016, p. 128). This statement leads us to think about whether the patient's autonomy is truly respected as they undergo the process of subjectivation and live out their spirituality. The second dimension similarly "leads to recognizing the other as different" so that it constitutes the "basis for intersubjective relationships and corresponding responsibility" (Souza, 2016, p. 128), which to directly addresses the clinical attentiveness that healthcare professionals extend to those suffering under their care.

Several distinct dimensions can be identified when establishing a relationship between Christian theology and health. It can be assumed that health is part of divine pedagogy (Alvarez, 2013) and that the divine self-communication can occur during suffering and pain, for patients, their families, and their healthcare providers alike. Another dimension reveals that human beings always carry their broader existential circumstances –including their spirituality– wherever they go. When a person is hospitalized, they naturally remain embedded within the surrounding local culture, regardless of their personal belief system. Given that Brazil features a predominantly religious population, a characteristic shared by countries such as Poland, India, South Africa, and Turkey (Ipsos Global Advisor, 2023).

In this sense, Pessini (2013) points out that it is a mistake to value the binomial paradigm of illness-suffering to the detriment of an equally crucial paradigm: health-salvation. Indeed, popular misconceptions, fostered by the "theological silence" surrounding health, frequently overvalue suffering under the false assumption that it facilitates salvation (Pessini, 2013, p. 9). Correspondingly, Clavel (2007) offers a clear perspective on pain and suffering, asserting that "a healthy theology

never idolizes pain or condones the cult of suffering" (p. 191). Ultimately, existential wholeness must be sought; being healthy –even while enduring a physical illness– grants the individual the interior freedom necessary to pursue salvation.

Establishing an ethic of solidarity based on theology, religiosity, and, more broadly, spirituality provides a pathway for theology to engage and break away from disciplinary isolation (Cavalcante, 2011). This opportunity manifests through public discourse and a readiness to act, functioning not merely as a "speech about God" but also by recognizing that God speaks in the world and its historical circumstances (Cavalcante, 2011).

It is impossible to select only individuals in perfect health from among the members of the various publics conceptualized by Tracy (2006). Furthermore, it is ethically indefensible to leave a seriously ill person spiritually unattended, regardless of their beliefs, unless one assumes a framework of arbitrary divine favoritism, a concept that is empirically unverifiable and would fundamentally compromises the Christian God, "who does not show favoritism" (Romans 2:11).

The Gospel narrative in Luke 10 has at least three facets that should be highlighted as a theological foundation for spiritual care in healthcare. They are *diakonia*, *martyria*, and *koinonia*, which refer to establishing contact and bringing peace, offering hospitality, and making oneself available. There is an explicit directive regarding this self-disposition: "Do not carry a purse, saddlebags or sandals [...]. In whatever city you enter and are welcomed, eat whatever they serve you" (Luke 10:4-8); in other words, what matters is what one encounters wherever one goes, rather than what one brings along. Clinical care is part of the mission ("heal the sick", Luke 10:9), directly reflecting the proclamation of God's proximity –the very relationship that offers salvation.

Within this framework*, diakonia* stands out: the Greek term assimilated by Christians meant "service". Originally, it had no connection with religious functions. However, in the early days of Christianity, some individuals were assigned to the "task [...] of looking after the physical well-being of their fellow Christians, especially those most in need" (Bock, 2022, p. 85). Bock (2022, p. 85) revisits the term, proposing an update, because he believes that, more than a tradition, "it is a permanent challenge". In this case, if "the Christian faith proclaims God's love for all human beings" and is a "way of demonstrating God's love in people's concrete reality", then "knowledge of this love has implications for human life… From a subjective point of view, it is a fundamental mark of new dignity and identity" (Bock, 2022, pp. 85-87).

Although he did not explicitly attempt to relate *diakonia* to clinical spiritual care, Bock (2022) gives reasons for interpreting it in this way when he states that "it can be said that every diaconal practice has a preventive and a curative dimension. One is more concerned with treating the manifest symptoms of suffering and pain, while the other aims to identify and combat the causes

of that suffering" (p. 87). On the other hand, the same author argues that diaconal practice "looks to the social sciences [...] and theology for theoretical tools for its work", which can be inferred as recognizing a public role for theology, because "in the permanent dialogue between practice and theory there is a mutual fertilization" (Bock, 2022, p. 87). The author maintains without disagreement, that "practice divorced from theory can lead to activism devoid of content. Theory detached from practice, in turn, can lead to an academicism uncommitted to social reality" (Bock, 2022, p. 87).

Of the action models reported by Bock (2022), one stands out: the "ecumenical *diakonia*: diaconal action sees the human being as a child of God, regardless of creed, race, gender, social and economic condition" (p. 87). Therefore, as well as being ecumenical, it exhibits an inter-religious and plural character. Why not envision an additional conceptual update that proposes a contemporary *diakonia* focused on healthcare delivery –particularly in palliative care (PC)– anchored in spirituality and religiosity?

This *diakonia* is explicitly related to public theology. The public Gospel *per se* is, therefore, accessible to everyone. Each individual assimilates what the Word transmits, resignifying what is lived in their subjectivity, and realizing that God is permanently communicating through concrete realities. Theology can gather knowledge from experiences, understanding what is lived right where life happens. At the same time, it can adopt a discourse of welcoming human needs and seeking equity in addressing them across different spaces and audiences.

One may not be able to prove the effectiveness of theology, but one cannot deny it. One cannot prove the existence of God, but one cannot prove the contrary either. It is convenient to separate religion from the state, but it is not possible to silence religions. Nothing prevents some people from disregarding the spiritual beliefs and values of others. However, beliefs and values do not disappear; they are present in the public space subliminally because they govern decisions on almost everything, including critical clinical decision-making on health issues.

Public Theology

Among the questions that can arise when explaining what public theology is, one concerns the meaning of the word "public" as a concept, the character of what is public, or the operational limits of theology. To answer this, we should first consider that "[...] the first Christian theology was public, [...]. It explained the Christ event and the Christian reality to others, to the world". It was interactive because it relied on "[...] the other partner in the dialogue also expressing their conviction or their doubts, in an equal way" (Albuquerque, 2012, p. 7).

This "genuinely theological dialogue, however, is not limited to the proclamation of Jesus but involves all aspects of human life, reflected on together with non-Christians as well" (Albuquerque, 2012, p. 7), so it was public and if not pluralistic, at least inter-religious. Over time, what was Christian became the general rule (Christendom). However, with modernity and secularization, there were changes to the point of reducing theology to "themes for the teaching of the clergy and by the clergy, while the people were left in the lay environment, with a theology reduced to a plate made of dogma and morals, served by some hierarchical body" (Albuquerque, 2012, p. 7).

The primal theological discussion has lost its public and dialogical character and has become the preserve of a chosen few, following strict magisterial norms and ecclesial theology. Theology still risks being confused with the magisterium and the doctrine of a particular religion in the twenty-first century. Perhaps this is because, for example, until the Second Vatican Council (1962-1965), Metogo (2012, p. 12) points out, "Catholic theology was a largely closed discipline, taught by priest-teachers in seminaries controlled by male religious orders or dioceses". Furthermore, the author notes that "theologians were trained at pontifical universities and were part of the same clerical communities as their bishops" (Metogo, 2012, p. 12).

As one of the results of the Council, theology returned to the academy, where it began to compete for scientific *statu*s. In this case, if people, in general, can take this degree and its *stricto sensu* postgraduate programs, it should no longer be a private theology at the service of one religion or another. In Brazil, most theology degree courses are housed in private, confessional universities or higher education institutions (HEIs), and lately via distance learning, meaning that theology has not returned to the public academy. As Junges (2006) states, little has changed since the seminaries; in undergraduate theology courses, there is a "formation of seminarians and people from the church" (p. 5); it seems that the seminaries have been taken to the HEIs.

After all, if the course is housed alongside other human sciences and claims to be a science, yet presents itself "as 'knowledge,' and, ultimately, revealed 'knowledge'" (Ribeiro, 2009, p. 201), how can theological knowledge be included in the desired interdisciplinarity between academic knowledge? On this point, Junges (2006) contributes by distinguishing ecclesiastical theology from public theology, which, in his view, "[...] allows itself to be challenged by the current sciences and, on the other hand, also critically challenges the sciences in their presuppositions. In this sense, theology is public because it wants to be present in the public space [...]" (p. 6).

The difficulty lies in understanding the public space because it does not seem obvious where theology can speak. At most, it alludes to questions about religious education and the secularity of the state, demonstrating how little public theological action there still is. Now, "social ethical theology cannot be confined to an intra-church discourse, because what it says applies to society as such. The same should be recognized in other fields of ethics [...]" (Albuquerque, 2012, p. 9).

Finally, "the specificity of public theology is not in its subject matter [...], but in its mode and, above all, in its forum [...]" (Albuquerque, 2012, p. 9), so in the face of an audience that is also made up of "gentiles", care must be taken to be self-critical and to maintain a purpose of open dialogue. This means that "in the forum of public theology, the theologian is not right beforehand, like someone who arrives with a selection of texts from the Bible or the magisterium tucked under their arm" (Albuquerque, 2012, p. 9). Theological action will lead to reflection on different subjects where divine self-communication can be envisaged –particularly when such reflection addresses practical actions prompted by the motivation behind this self-communication. So "a theological discourse for the world is not enough; a theological dialogue with the world is necessary" (Albuquerque, 2012, p. 8).

Based on these reflections, it is evident that the academy's search for an institutional locus for theology is underway; if this is a public arena is to facilitate meaningful contributions, theology must remain entirely receptive to external discourse. Theology may not want to discuss or question itself, but if it argues from its presuppositions of faith, wouldn't it be abandoning the Kingdom?

If theology offers an academic education with the clear objective of contributing to society rather than exclusively to those who accept divine revelation, then perhaps there will be gains. It seems counterintuitive for an undergraduate program, open to the general public, to fail to provide knowledge, tools, and preparation for a professionalized service beyond the ministerial/ecclesial, which is restricted.

It is precisely at this point that I would argue that theology brings with it an ethical proposal: offering care to individuals facing vulnerabilities that carry a distinctly public dimension, thereby contributing to these contexts of need. The quest to know the God we believe in allows us to see how faith sustains resistance and how the space of spirituality can be a refuge, encouragement, and strength; this theological action can be reflective, but at the same time, it must be a source of solidarity and cooperative support.

The logical grouping undertaken by Jacobsen (2011) to provide a foundation for public theology shows that it is God who drives action: He reveals himself in different ways to different actors who subsequently bear witness through words and actions (dissemination). The aim is to be able to "answer" the existential questions common to human beings (universal) who are not exempt or separate; on the contrary, they live between their ethical-moral-religious convictions and the conflicts present in everyday life (factual).

The issue is the publicization of theology, which is directly implicated in the publicization of theological practice. Tracy (2006, p. 19) maintains that "all theology is public discourse", while simultaneously addressing critiques that construct the "social portrait of the theologian", wherein the academic is often mischaracterized either as a sectarian spokesperson or as a merely "useful generalist".

Tracy (2006) argues that theological performance in the public space correlates to the audience: people who enjoy the discourse start from an original scenario; if they are in academy, they are also part of society and may be in the churches. Even for those who are not believers, do not belong to churches, or are not in academia. In that case, theology can still reach them as a society by affirming ethical values that are naturally, at least in the West, mixed with religious values.

In addition to distinguishing between the public that listens and the public that listens and obeys, it is necessary to argue in such a way as to make the message even more accessible (apologetic dialogue) without forgetting that God speaks to all people and to each one in a particular way. The scope of action is wide-ranging: public theology is called to plurality.

The context of the twenty-first century is no longer that of most Christians in the world; human mobility, for one reason or another, is intense and disregards borders, and techno-scientific development is impressive. Some consequences involve living longer. The rapid acceleration of population aging requires preparation to deal with the reality that demands and will increasingly demand an unprecedented type of spiritual care: individuals can be supported in preparing for death by addressing existential questions while living with incurable, fatal, and chronic illnesses.

This reality prompts critical questions: Should healthcare professionals assume sole responsibility for spiritual care, or should individuals trained in public theology occupy this space by organizing professional chaplaincies within long-term care institutions and PC services? What other field of knowledge can clarify to society that there are no "foreigners"? Who, for instance, will say that the Catholicism professed by Haitian migrants possesses distinct cultural expressions compared to Brazilian traditions, and that this pluralism is completely valid?

Referring to Tracy (2012), "if there is a rich experience of an event [...]", which may be what happens in the spiritual therapeutic space in PC where the sick person faces finitude, "the call for a new way of thinking is 'reasonable' [...]" (p. 49). The author has argued that "being reasonable does not include the need to be logical" (Tracy, 2012, p. 30). So "the experience of what different thinkers have apophatically labeled the Insurmountable, the Impossible, the Incomprehensible, the Ineffable, the Infinite can happen 'suddenly'" (Tracy, 2012, p. 49). This was not the experience Tracy was initially referring to. However, this way of thinking seems reasonable for the public actions of people who know theology and have a degree in theology.

Spiritual Assistance in PC can be one perspective for doing public theology. This is because the space of PC, where there is pain and suffering, can be understood as an *ad extra* theological *locus*, wherein the Divine is also manifested and communicated for believers (Ribeiro Jr., 2012, p.180), and for non-believers, it is a moment of existential meaning. This possibility of theology graduates from the academy working this way is seen here as independent of a religious ministry.

It is reasonable to align this work with Anjos (2011), who emphasizes that "among the great services of theology to humanity is the interpretation of the horizon of fundamental meanings that permeate life and death, and the discussion about the attitudes and actions that correspond to them" (p. 130). In the context of PC, in its most active phase, it seems appropriate for theology to contribute its knowledge to take care of the spiritual dimension of the sick person who, after all, can be helped to resignify the reality that affects them in light of transcendence.

Westphal and Fontana (2012) think that public theology can contribute to bioethical issues during decision-making processes, but they do not go so far as to address spiritual care. Streck (2012) points out the importance of religious aspects in dealing with HIV/AIDS, which has been linked to moral judgments for a long time. The author believes that caring holistically for sick people is a challenge for public theology, but his focus remains confined to pastoral counseling rather than clinical spiritual assistance (Streck, 2012).

However, if theology can "create metaphors and meanings, new ways of conceiving social problems, of overcoming impasses and critical real-world situations" (Buttelli, 2012, p. 57), then its application must extend beyond socio-economic and political issues. After all, Sinner (2011), when talking about how theology can be present in public life, agrees with Tracy (2006) that there may be other demands and other audiences beyond the academy and institutional churches, reaching into the wider society wherein they operate and by which they are shaped. It does not seem unreasonable to think that spiritual assistance in healthcare is a real need and a space for theology to act publicly.

As Tracy (2006) contends, public theology encompasses a broad audience, ideally, humanity as a whole. Tracy emphasizes that individuals must be engaged within their specific contexts because there are existential questions, even before religious ones, that are common to all people.

Suffering in the Face of Death and the Contribution of Public Theology

Faced with pluralism, the interpretive key can be hopelessness because it seems chaotic and aligned with pervasive relativism in which all truth claims are deemed equally valid. It can also be a positive perspective, in which case, as Tracy argues (2006, p. 11), re-reading the public role of theology is a responsibility.

Returning to Tracy's (2006) framework, theology addresses three distinct publics: society, the academy, and the church, each of which has its peculiarities. Academia encompasses the scientific and academic discipline; the church operates as both a sociological and theological reality; and society comprises different overlapping domains, namely the cultural, the political, and the techno-economic. Consequently, theology must articulate its public discourse as an essential mission, discussing fundamental existential questions and reflecting on the reality of God with a discourse that reaches public understanding.

Tracy (2006) proposes using an "analogical imagination" so that theologians and communities need not surrender internal criteria of meaning and truth amid contemporary pluralism. The author presents a re-reading of Jesus Christ as a religious event from the New Testament and from a contemporary interpretation to arrive at the discourse required for today's pluralistic times (Tracy, 2006, pp. 11-13).

The issue of spiritual care at the end of life must be recognized as a particular occasion, an institutional space, and an opportunity, an authentic *locus* that requires a contemporary discourse updated by theology. The clinical demand is already manifest, repeating daily in its uniqueness; it is projected to expand significantly as global life expectancy rises, making death via chronic physical or neurological illness a normative trajectory. The time between a diagnosis of an incurable and grave illness and the moment of death has increased. This extension introduces a prolonged pause, an interval that provides an opportunity to prepare, to deal with oneself, to experience care, including spiritual care.

How does the Christian message reach the most vulnerable people and help them make sense of their suffering and find meaning in life now? Furthermore, how can spiritual care shield patients and their family from being mistreated and vulnerable? These are legitimate concerns since their values are not considered, and their dignity is belittled to the detriment of the disproportionate use of medical technology, leading to a painful prolongation of death, no longer of life.

A significant theological function manifests within healthcare environments, especially in PC, as spiritual, ecumenical care, but more than that, in inter-religious dialogue and beyond in the plurality of religions. Caring for the spirituality of human beings involves paying attention to the expression of their vital energy, their wisdom expressed in their ability to reconfigure themselves in the face of obstacles and events that cause suffering and stress and from which they draw meaning (Frankl, 2006). Unlike the resilience of materials, which withstand pressure and return to their original state without changing, the same is impossible with human "material", which withstands pressure but changes, and indeed should change.

To answer the questions that permeate existence, whether about its ultimate meaning or about a truth that all people can trust, "religions raise and give answers"; theology credits religious traditions with the "authentic answers" (Tracy, 2006, p. 21). However, these questions do not just target an audience within the churches. The corresponding answers concern each human being –in other words, everyone– who is not a single, ready-made model because they have different readings of themselves. Tracy (2006) speaks of the "various internalized audiences" that also constitute the "various external audiences" (p. 23).

Among the social realities that the theology graduate addresses, one will be primary, according to the circumstances and contexts that will "affect the self-understanding" of this person and their reading of theology. The theology graduate is an individual, one and plural, and the public addressee of these reflections –situated within a deeply woven social fabric– demands a "genuine" theological discourse, yet "authentic" as "a common commitment" to those who have theological knowledge. Whether it is addressed to the church, to society in general, or the academy, "it demands a commitment to the authentic public dimension, the attempt to speak from a particular social *locus* in such a way that this speaking crosses all three publics" (Tracy, 2006, p. 24). No speech is restricted to a specific sector; it spreads whether intended or not.

Pluralism, devoid of its meaning, is "relaxed", as Tracy (2006) puts it, and runs the risk of leading the individual astray because one must have some conviction and foundation to have confidence. To do this, someone must have committed, reasoned answers: "A person with a degree in theology cannot shy away from public discourse" (Tracy, 2006, p. 25).

Does theology have to be restricted to the academy to become a science? Who will account for God's self-communication? Methods and verifiable data would certainly study and measure the relationship with a Supreme, a Divine, a Numinous, a Sacred, a God, contained and classifiable, a God returned to the temple, sometimes in need of interlocutors and unrecognized in historical time. However, it would be insufficient.

Theology will find itself in the *praxis* of healthcare *vis-à-vis* the Supreme and not only as understood by Christians; for example, for Buddhism, the "Supreme" is not separate, has no form, and is expressed more in the emptying of oneself in search of the self and openness to the whole. Consequently, Buddhism leaves this mystery in silence so as not to be mistaken (Teixeira, 2009). In another example, one encounters the Islamic Divine, who is the same, omnipotent, and omniscient: a creator, maintainer, forgiving, compassionate, and possessing many names. Always Allah, who sent Muhammad, the most perfect of God's messengers, Adam, Abraham, Moses, and Jesus preceded him, but not in perfection (Maçaneiro, 2014; Schlesinger & Porto, 1995).

Furthermore, theology will deal with the reality of Olorum (also called Olodumaré or Zambi), the creative principle in constant movement, the source of everything that is and can be perceived; the Supreme Being in Candomblé is one, but there are several divinities worshipped as "psychological representations, [...] within the individual lives a divinity", an orixá that governs him and impels him to transformations (Carmo, 2006, pp. 22-23). It will also deal with the Jewish Divine, the Primordial Being, the One Cause of existence whose Kingdom was revealed to Moses, YHWH, who freed the Hebrew people. Revealed through the prophets and not materialized, the messianic hope does not necessarily refer to the coming of a savior or intermediary.

Thus, it is possible to reconcile not only Christian patients with their Christian Divine, the one and trinitarian God who communicates and speaks to His own in His own time and is compassionate and merciful. Faith for a time of plurality and interculturality is strengthened when the Divine is the one who makes Himself known in the experience of otherness that takes place in care at the end, in particular. Be it Allah, God, HaShem, Buddha, Ultimate Truth, Higher Power, manifestations of Brahman, or Dao –this spiritual entity can be present in the space of care where there is pain and suffering of patients in PC.

In a bed, where a person with an incurable illness is suffering, whose process of death, under the aegis of technoscience, is prolonged and made chronic, there too is a *locus ad extra*. The search for the ultimate meaning, so that while alive, they can accept death, occupies the sufferer, and only a few times is their anguish relieved by adequate and diligent spiritual care.

Public Theology and Palliative Care

To make oneself available to the person with an indication for PC when the disease-modifying therapy is exhausted would be to experience a moment of authentic dialogue. To experience moments like this, which is crucial, Tracy (2006) explains, is to be present when the "question takes hold", when "we are taken, and sometimes snatched, by the subject itself into the rare event or happening called 'thinking' and 'understanding'" (p. 138). Understanding, the author points out, takes place within the perspective and expression of language according to the experiences of origin and assimilating the event that is taking place. It requires a hermeneutic that mediates the understanding that has already been translated beforehand for the occasion and is transformed by being open to what is happening (Tracy, 2006).

Since it is a widely accepted reality that sick people do spiritual coping (Pargament, 1997), whether or not they are religious; since medicine has carried out countless studies proving the interference of spiritual resources during healthcare; since healthcare professionals are unable to

take on spiritual care as expertise without running the risk of failing to meet even the minimum spiritual needs of these individuals, someone must step in. It is argued that this is not a function of the biomedical field, nor of religions, nor of the sciences of religion, since this is not exactly a phenomenon to be studied. It is believed to be a practical issue for theology in its public outreach bias.

Even though spiritual care is not automatically religious, theology can find a proper theological place and an opportunity for *ad extra* service to the community beyond the academy, houses of worship, and their communities of faith. As there are no religious boundaries in hospital settings, all sick people constitute a population to be cared for spiritually.

The framework of PC includes spiritual care as a core component of holistic patient attention. It recognizes the limitations of integrating the spiritual dimension of the human being into clinical tasks. Identifying spiritual suffering requires training, appropriation of tools for spiritual anamnesis, and interdisciplinary refinement of actions. Assuming that spiritual needs are beyond the reach of technoscience and biomedical research is a first step.

Therefore, a specialized spiritual assistance service in healthcare urgently needs to be implemented, either as an enhancement of the hospital chaplaincy –which must broaden its religious horizons– or as a new discipline. Ultimately, this service must be professionalized and specialized to welcome all people without distinction. Church pastoral workers, social volunteers, and individuals driven by solidarity must be trained and diligently prepared for this clinical role, strictly avoiding any form of proselytism.

Jacobs, Damen, Suransky & Kate (2021) point out the concern that people receive spiritual care, even in a secular society; in the context of PC, chaplains should articulate "specialized knowledge and experience in spiritual care more broadly [...] to provide person-centered care" (p. 85). MacLaren (2021, p. 27) also proposes adequate education for chaplains in view of the "demands of a professional spiritual care service that must guarantee equal access to all people".

Visser, Vähäkangas, Baig & Thomsen (2025, p. 245) contend that this pedagogical framework must cultivate "interreligious knowledge", stimulate the capacity for "critical social analysis", and foster "interprofessional collaboration skills"; while navigating the fundamental challenge of sustaining the "depth of spiritual care". Together with Bradford (2023), these authors underscore the necessity of balancing generic spiritual competencies with the highly specific dimensions of distinct religious traditions.

Specifically, in PC teams, those who take on spiritual care must have a sufficient understanding of this approach. Consequently, active listening and dialogue between the spiritual assistant and the sufferer manifest as a liberating and uncoerced engagement. However, clinicians and practitioners

must guard against premature interpretations that fit with those already brought to the conversation. These would limit the profound experience that is revealed when you are in front of someone who knows they are going to die and who, thanks to technology, has time for this dialogue. The point is that the patient has time that they would not have had before, that they know they have, and that they have the right to use it as they see fit, including the right to decline spiritual assistance entirely. This provision exists precisely because health is multidimensional, and human beings have integrated dimensions. Even if the person does not recognize religious expressions for their spirituality or does not even recognize themselves as spiritual, they are entitled to assistance.

In a PC environment and service, in the antechamber of death, there is someone who is living while slowly and naturally dying, who is left with the comfort of not feeling pain or at least having as much pain relief as possible. As far as suffering is concerned, the most potent painkiller can be the qualified and professional presence of a professional dedicated to the existential and spiritual domain, who addresses both the suffering of the patient and those they recognize as family.

If the death of the "other" is an event of such magnitude that it presents itself to those who witness it as something that produces reflection (incessantly referring to one's self), it is no different for the person who dies. The event of death has a hermeneutic character of "unraveling" in search of understanding, permeated by the total uncertainty surrounding it. Death impacts and imposes a reflection that Tracy (2006, p. 140) qualifies as "authentic" because the subject provokes questions.

Nowadays, in most cases, when deaths from trauma do not occur, it takes longer to die. Suppose there has been a gain with the possibility of prolonging life, even when navigating a reflective yet terminal illness. In that case, it has been that of time, chronological time that allows an event like death to be thought about while it is happening. If to provide spiritual care to an individual who is actively dying but remains fully alive, ready-made interpretations and classic speeches are used, then this interlocution with free and generous silence for open listening is not happening. If the Divine can manifest itself there, something new can happen. After all, the experiences will be singular, unique, and unrepeatable, with the weight of being conversations that will not necessarily have conclusions and closures.

Thus, to be in front of the "other" is to experience being stripped like someone in front of a work of art: "We find ourselves 'captivated' by their world, we are shocked, surprised, challenged by their striking beauty and recognizable truth, their essential instinct" (Tracy, 2006, p. 155). Therein lies the incalculable: what will not fit into data or statistics, nor will it be on the achievements chart. What is realized transcends material concreteness; paradoxically, it manifests precisely as it dissolves into ash and dust.

In a methodological exercise of first-person imagination, when I have the experience of observing the death of the other person in my care, again in analogy with the experience of being impacted by art, "I recognize the truth that I know in a certain way, but that I do not know, except through the experience of recognizing the essential to which I am instigated [...]" (Tracy, 2006, p. 158). I cannot shy away from the consequences; such is the grandeur of what is happening, "I am transformed by its truth when I return to everyday life, to the totality of what I ordinarily call reality, and discover new affinities, new sensitivities [...]" (Tracy, 2006, p. 158).

However, when remembering and bereaving, those around the person who is suffering can experience the effects of consistent spiritual care: a pathway that imparts meaning to the suffering, and a journey towards peace and acceptance. All beings, without exception, are "insufficient" and "precarious" (Birman, 2000, p. 180). We will never be sure of having reached the dimension of either the suffering or the encounter with peace that each sufferer experiences. However, the balance and maturity with which the care team and the bereaved family deal with the continuity of their days will be the answer to minimally sufficient spiritual care.

Interdisciplinarity and the Bioethical Perspective in Palliative Care as a Context for Public Theology

Interdisciplinarity and the bioethical perspective can motivate thinking about PC as a context for public theology. Clavel (2007) provocatively questions whether bioethics constitutes a transient trend, and whether technological development inherently equates to human progress? His reasoning addresses the emergence of the necessary bioethical reflection from the point of view of the manipulation of life by the sciences and technologies, as well as the consequences and impacts on people's lives. The author sees the integration of the traditions of spirituality with the sciences as an "unfinished task: to become more interreligious or, better still, more intercosmovisional" (Clavel, 2007, p. 54). This task, given to Bioethics, is also called theology in this text, in an interdisciplinary mission.

The ethical paradigm proposed by Clavel (2007, p. 55) aims to "translate" and listen clearly to arrive at an interpretation of facts and values to be a mediator concerned with communicating more and better, widely and in an inclusive way. In contemporary times, there are increasing ethical efforts to respect diversity, which, when translating human differences, does not only refer to visible physical aspects but also reveals itself in practices, declared beliefs, and organized behavior.

The humanization of healthcare is the task of human beings in a relationship; it does not depend on technique or apparatus; it is a daily challenge. While the depersonalization of care constitutes the core of clinical diagnosis, the corresponding therapeutic approach demands compassionate and empathetic attitudes and an understanding of the human being as a being of and in a relationship. The expression of alterity refers to someone who leaves their sameness behind to encounter and welcome the "other". In this reciprocal space of mutual recognition, each subject reveals the other to themselves, culminating in an ethic of responsibility (Lévinas, 1993). This establishes a "principle of fraternity [which] is precisely the principle of difference and not that of equality. At the heart of this difference, the principle of responsibility for the other who is different arises" (Duque, 2015, p. 76).

Although the autonomy of the sick individual progressively diminishes, and leaves very little trace as they that their remaining temporal window will be characterized by profound respect within the PC model. Crucially, "the new state of dependence they are entering will be marked by fraternal affection and solicitude" (Martin, 1996, p. 205). The appreciation of fraternity among members of the same human family is revealed in the search for quality of life (for the entire life, which includes going through the terminal phase of an illness), which interests believers and non-believers alike.

This converse demonstrates that "there is fertile ground for dialogue between a secular humanism and a religious humanism [...] both value a common brotherhood that calls for a transformative solidarity that lights the way" (Martin, 1996, p. 205). The beliefs that may differ do not determine personal practices in themselves. A person who is religiously confessed may at some point no longer use religious rules and guidelines, just as it can happen that even someone who has never followed them, from a particular moment or occasion, begins to follow them. Precisely in pursuit of an existential “salvation”, subjects make approximations. So, when considering the human dimension in terms of the meaning and significance of living, spirituality seems more appropriate, as it encompasses any manifestation of identity (Silveira Filho, 2012, pp. 64-66).

Grounded in the dialogical en ethical framework of Buber (2001), Lévinas (1988), and Vidal (1981), an "I" contemplates the "other" as an entity fundamentally distinct from the self –unique, irreplaceable, and entirely different– which constitutes the foundational ethical criterion. The "I", also unique and different, is at the same time "myself" and an "other" for to the counterpart. Once the essential relational care ethic has been established, differences are celebrated as opportunities and inequalities give rise to equity.

Theology is profoundly integrated into this ethical care project, and its public action in relation to the rights and special needs of suffering people is essential. Welcoming each person's convictions about their spirituality is increasingly an opportunity to serve others who are more vulnerable due to a fatal illness and need shelter, attention, and care.

The seriously ill person, in addition to the pain, conditions, and consequences of the illness they are suffering, is often treated as the subject upon whom every technological intervention must be deployed, frequently jeopardizing the essential criteria of respect for dignity and the right to die in the natural course of the illness. It has gotten to the point where the phrase "Where is God when human beings suffer?" needs to be rephrased to: "Where is the human being when he imposes disproportionate, futile treatment on other human beings at the cost of aggravated suffering? Professional spiritual assistance for patients and professional and specialized care teams can effectively curb these inappropriate and useless maneuvers since their activity, attitude, and presence become enlightening during ethical conflicts.

This intersection marks the moment where bioethical reflections interrogates the boundaries of medicine when there is no longer any prospect of a cure, and the course of the illness can no longer be changed. This is the time when efforts are intensified to achieve maximum pain control, care is focused on the sick individual, their family, and their surroundings, and anticipatory mourning is at its peak. How the patient and their family reach this moment also depends on their spiritual experience, how well the relationship between spirituality and health has been understood, and what knowledge, instruments, and tools have been at the disposal of the individual whose life is fading, as well as to those who must say goodbye.

The psychological phases experienced by individuals navigating the trajectory of terminal illness and mortality range from denial to acceptance, with anger, bargaining, and depression frequently coexisting or fluctuating non-linearly (Kübler-Ross, 2017). If the spiritual aspects that matter to these people are also cared for, their acceptance of the unavoidable will be more mature, perhaps with fewer conflicts.

Those who assist can only presume because "the only possible (viable) knowledge of suffering is that which suffering has of itself" (Ribeiro Jr., 2012, p. 184). The meaning of suffering, the non-physical pain of the other person, is unimaginable; it is impossible to frame it without making a mistake. However, the person spiritually assisting them can offer a listening ear, become sensitized to the patient's suffering, and put their expertise into compassionate action.

As a field where the Divine manifests itself and the relationship with the Sacred is laid bare, the specialized domain of PC called "end-of-life care" demands recognizing theology as an activity area. Theology must no longer function as a moralizing discourse or an abstract investigation into the nature of evil, but rather as a pastoral practice of mercy available to believers and non-believers alike. Does death merely violate life, or does it value the days already lived and produce a "theology of hope that sees death as the entry into definitive life?" (Clavel, 2007, p. 197). Clavel (2007, p. 198) replies that it is "the role of the Church: instead of being a soldier of morality, to be a proclaimer of hope".

For Cord Neto (2012), "suffering provides material for exercising freedom of action and the fulfillment of life, even when we suffer" (p. 220). Rather than finality, there is meaning in suffering if it is understood as a movement towards a better place. While the medical establishment may occasionally ignore this reality, it cannot afford to do so. Should theology ignore the fact that a person who dies in a chronic and slow process is on a journey and requires care in search of spiritual health? It should not. The person diagnosed with a fatal illness confronts an existential vulnerability that has transcended to theoretical abstraction and will not be consummated quickly and abruptly. The person who is suffering knows that their time is numbered while, unlike others, they can prepare for the event of their death.

From a theological perspective, suffering possesses a pedagogical dimension, precisely because the person who suffers and the person who assists and accompanies them can access ways to overcome the "absurdity of pain and suffering" (Cord Neto, 2012, p. 223), whether through a relationship with their Sacred, with divine Grace, or with what leads them to transcend. Once the "fatalistic perception of suffering" (punishment or injustice) has been overcome, Cord Neto (2012, p. 223-224) understands that a "loving experience" can be achieved because there is no indifference of the Divine to suffering.

A dynamic is revealed between human suffering and divine compassion: those who open themselves up to the possibility of divine, compassionate love and that of the people who accompany them receive encouragement otherwise, "those who allow themselves to be captured by suffering despair, succumb, waste away in pain, wear themselves out in revolt and lose the vitality to connect" (Cord Neto, 2012, p. 224). The experience of people who accompany someone else's suffering is no different, and extends naturally to professional clinicians. Within this shared clinical arena, the pain of the "other" resonates and calls for awareness of one's vulnerability, which, added to the feeling of powerlessness, can lead to an obstinacy "to do everything" and even sometimes to abandonment. Rigorous, careful spiritual assistance can offer a substantial contribution to this crisis by providing a balanced reading and "internal mobilization through faith (in life, in God, in people), trust, hope and love" (Cord Neto, 2012, p. 225). Ultimately, the guiding paradigm must be that "dealing with suffering is part of the human way of existing, preferable to the illusion of eliminating it (moral, spiritual and even economic and techno-scientific illusion)" (Cord Neto, 2012, p. 225).

Conclusions

Spiritual suffering is related to existential issues, meaning, significance, and the sense of life, which are more abstract and subjective. For this reason, it also includes religious suffering, linked to uncertainties about death that lead to the fear of being at fault with the divine entity; dying

without forgiveness generates anguish, as many people feel that they have sinned and fear the fate that awaits them.

Spiritual care in health is considered an issue related to theology because the importance of caring reflects the ethical appreciation of human life across its entire development and existential continuum. From this perspective, a new way of looking at the frail human being can be directed at the unique and moment of death. It should be emphasized that every human has the right to quality of life, even at the end of life. Consequently, the care that surrounds this person should make the act of dying less painful, with less suffering. The concept of PC also includes the spiritual dimension of the sick person, which refers to compassion, mercy, and a supportive presence.

Furthermore, as a field of knowledge that goes beyond confessionalism and denominations, theology can make its position known in the public arena, so claiming a professional position in healthcare could be an option. Therefore, since the need for spiritual care in healthcare is clear and existing training is insufficient, it is argued that it is essential to have formal training in theology to work in healthcare. To be part of the PC team, it is necessary to specialize, just as people with other degrees do. It has been shown that it is coherent for theology to present itself in this interdisciplinary work that has not yet been done.

There is certainly a lot to be explored regarding this subject to bring health services and care ever closer to the point of excellence. From the above, promoting the specialized professional integration of people trained in theology in multi-professional PC teams constitutes a compelling institutional imperative. Through this innovative perspective, theology fulfills its public vocation, extending its reach to address the unique vulnerabilities of every individual in need.

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