

The *Proistamenoï* Paradigm: Reimagining Theology and Missiology in Light of COVID-19
HT-503: Church, Humanity, and Christian Life in the Church's Theological Reflection
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Introduction

As I write the work at hand, even now self-quarantined, the entire world is preoccupied with the three-month old COVID-19 pandemic, more commonly known as Coronavirus. Church leaders are not immune to this fixation, and we are making tough choices regarding whether to gather, how to cooperate with civil and public health authorities, and how to be the Church during this crisis in world history. Grateful for myriad articles written recently that reflect the plethora of wisdom from our Christian forebears, to whom disease was no stranger, I am also mindful that, soon enough, the pandemic will have abated, and the Church will be left questioning where to go from here.

The thesis of the work at hand is that, although unwelcome, global health crises serve as defining moments for the Church, affording believers an opportunity to realign their theology and missiology to the context of the world around them. This paper will demonstrate instances in which this has occurred through an abridged study of Christianity's relationship with healing. After considering scriptural, pastoral, and missiological principles involved, the paper will reflect on the modern nature of healthcare, aiming to apply a new paradigm the Church might use to envision her relationship to healthcare. While development of this paradigm in full is beyond the scope of this paper, special attention will be given to one aspect: the possibility of understanding the role of a Christian medical practitioner as a formally recognized office in the Church.

Caring for the Sick as a Christian Principle

When the Pharisees and scribes complained about the company Jesus kept, His response was straightforward. "Those who are well have no need of a physician, but those who are sick; I

have come to call not the righteous but sinners to repentance.”¹ The metaphor betrays a first century Palestinian worldview in which sin and sickness are intertwined.² For the gospel writers, illness and disability were, at best, signs of darker spiritual forces at work, and at worst, punishments for sins.³ This worldview can be traced back at least as far as Job, whose friend Eliphaz acknowledges the former’s righteousness, yet assumes Job must have sinned given his malfortune.⁴ It is also at work when Jesus’ disciples question Him about the blindness of the man He cures in John 9, whether his sins or those of his parents caused his disability.

Here, Jesus’ response points to a new paradigm of caring for the sick, centered on the arrival of the Kingdom of God: “Neither this man nor his parents sinned; he was born blind so that God’s works might be revealed in him.”⁵ In other words, what the enemy intended for evil in Eden, God will now use for good.⁶ Perhaps more than most other aspects of God’s Kingdom, save for proclamation and calling to repentance, caring for the sick is one of the most longstanding manners by which the Church has imagined herself to be the Church. This certainly is rooted in the instructions Jesus gives to His followers through His forceful, prophetic stance against those who will seek to enter eternal reward without having ministered to the hungry, thirsty, naked, sick, and imprisoned. “Then He will answer them, saying, ‘Assuredly, I say to you, inasmuch as you did not do *it* to one of the least of these, you did not do *it* to Me.’ And these will go away into everlasting punishment, but the righteous into eternal life.”⁷

¹ Luke 5:31-32, NRSV. Unless otherwise stated, all scripture quotes are taken from the NRSV.

² Amanda Porterfield, *Healing in the History of Christianity*, (Oxford: Oxford University Press: 2005), p. 34.

³ Porterfield, *Healing*, p. 22.

⁴ Job 4.

⁵ John 9:3.

⁶ See Gen. 3 and 50:20.

⁷ Matthew 25:45-46.

How the Church Has Cared

The pertinent question is what is meant by ministry to the sick. In the Apostolic Era, the Apostles continued in miraculous signs and wonders on the scale of Christ's miracles. Later, caring manifested in efforts ranging from deacons moving from dwelling to dwelling, to established care houses for the needy. Care has been both active and palliative; in the early Byzantine Empire, Christian tenets joined with traditional Near Eastern welfare concepts and led to the creation of segregated guests houses where the needy could receive shelter, rest, food, and medical attention.⁸ Clerics oversaw these outposts of mercy, where admission rituals emphasized that care would be primarily directed toward the soul.⁹

The extent to which medical practitioners constituted a significant contribution to such houses' efforts varied. Church fathers differed in their attitudes toward the medical class. Generally speaking, for the first 500 years of Christianity, professional physicians were better regarded in the East than West. There, physician-clerics were popular, and leading Eastern bishops deemed the work of lay physicians necessary and appropriate.¹⁰

Care houses, combined with Roman infrastructure, contributed to greater access to healthcare – and a growing church. The ability to belong to a family in which philanthropy was institutionalized and protected orphans, widows, and provided medical services during epidemics, was a membership boon.¹¹ More recently, Western medicine has similarly affected growth through medical missions in Africa, Asia, and Latin America. Where there are people,

⁸ Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals*, (New York: Oxford University Press: 1999), p. 87.

⁹ Risse, *Mending Bodies, Saving Souls*, p. 85.

¹⁰ Risse, *Mending Bodies, Saving Souls*, p. 83.

¹¹ Risse, *Mending Bodies, Saving Souls*, p. 73.

there are medical needs, and when medical needs are present, there are opportunities for gospel proclamation.¹²

In addition to immediate physical care, the Church also contributed, indirectly, to medical advancements. The prevailing Hellenistic medical theory was the Humoral Theory,¹³ aided by pagan deities who might speak directly to the sick regarding their own bloodletting needs.¹⁴ The Church, still mindful of sin as the cause of sickness and placing emphasis on divine healing, did not contribute an alternative biological theory that might underly treatment. Humoral Theory gave way to Galenic medicine, equally flawed in its understanding of the human body.¹⁵ Ultimately, the Roman Catholic Church of the Middle Ages made a significant contribution by giving its tacit approval to human dissection for the purposes of teaching new physicians, something previously unthinkable to all three monotheistic religions which had exercised influence in the West. The practice, initially intended for pedagogic purposes, eventually led to more accurate understandings of human biology.¹⁶

In the 16th and 17th centuries, scriptural interpretation continued to contributed to responses to epidemic, now through public responses. The response of the laity was public penance, while the cornerstone of public policy became the quarantine (all too familiar at the time of this writing). Interestingly, the quarantine was not based on a medicinal understanding of incubatory periods or transmission windows. Rather, it comes from the Italian word *quaranta*

¹² Porterfield, *Healing*, pp. 144-54. Depending on time and place, however, medicine and missiology have enjoyed a symbiotic, if not tranquil, relationship, as they have mutually raised the reputation of the other across the globe.

¹³ Frank M. Snowden, *Epidemics and Society: From the Black Death to the Present*, (New Haven: Yale University Press: 2019), p. 17.

¹⁴ Risse, *Mending Bodies Saving Souls*, pp. 24-38. The author conveys historical records regarding an ancient orator named Aristides and his efforts to be healed through such cultic practices and devotion to Asclepius.

¹⁵ James Hannam, *The Genesis of Science: How the Christian Middle Ages Launched the Scientific Revolution*, (Washington, D.C.: Regnery, 2011), p. 252.

¹⁶ Hannam, *Genesis of Science*, p. 255.

(forty), a duration chosen for its connection to 40-day periods of purification in both the Old and New Testament.¹⁷ Authorities further hoped that the "biblical resonance of quarantine would fortify compliance with the administrative rigor involved and would provide spiritual comfort for a terrified city."¹⁸ By God's providence, forty days exceeded the incubation period of the Bubonic Plague.¹⁹

To Flee, or Not to Flee – A Pastoral Concern

In the modern era, when health and comfort are taken for granted, the current pandemic is awakening believers to the everyday life of our ancestors in the faith. Not a few pastors are benefiting from Martin Luther's works, such as his *On Whether One May Flee from a Deadly Plague*, occasioned by the 1527-arrival of the plague in Wittenberg. The reformer broadens the focus toward spiritual pestilence, while still clinging to the rational aspects of health care.²⁰ For Luther, it is true that "death is death, no matter what form it takes."²¹ However, one of the nuances lost in recent summaries is that Luther acknowledges a range of responses appropriate for varying individuals. For those with a weaker faith, Luther not only allows that they may flee; he provides a prayer for them to recite as they do.²²

¹⁷ Snowden, *Epidemics and Society*, p. 70.

¹⁸ Snowden, *Epidemics and Society*, p. 70.

¹⁹ Snowden, *Epidemics and Society*, p. 71.

²⁰ Neil R. Leroux, *Martin Luther As Comforter: Writings on Death*, (Leiden: Brill, 2007), p. 265.

²¹ Leroux, *Martin Luther*, p. 237.

²² Martin Luther, *Luther's Works, Vol. 43: Devotional Writings II*, ed. Jaroslav Jan Pelikan, Hilton C. Oswald, and Helmut T. Lehmann, vol. 43, (Philadelphia: Fortress Press, 1999), p. 119–38. Accessed in unpaginated form. "Lord God, I am weak and fearful. Therefore I am running away from evil and am doing what I can to protect myself against it. I am nevertheless in thy hands in this danger as in any other which might overtake me. Thy will be done. My flight alone will not succeed of itself because calamity and harm are everywhere. Moreover, the devil never sleeps. He is a murderer from the beginning [John 8:44] and tries everywhere to instigate murder and misfortune."

In addition to these of weaker faith, some clergy may go, so long as others have consented to remain for the spiritual needs of the flock. However, due to the institution of civil authority for the cohesiveness of society, as Luther reads from Romans 13, civil authorities must not abandon their posts, and neither are parents and guardians of children, orphans, and other dependents. Luther implores those remaining not to “tempt God,” insisting they neither overspiritualize healing and neglect medical means, nor act negligently and spread contagions, an act he perceives to be tantamount to violating the sixth commandment.²³

But What about Now?

Where Luther’s writing falls short in the present crisis is that it does not translate neatly to a time in which the overwhelming majority of healthcare is provided not by the Church, but by secular society. Enlightenment thinking marked a turning point in the way theologians conceived of the healing power of Christ, scripturally, and the Holy Spirit, presently.²⁴ Then, throughout the twentieth century, the emphasis in hospitals continued to shift away from the spiritual toward the practice of modern medicine²⁵ Furthermore, government efforts have so supplanted the church’s role in providing healthcare, even financially, that the presence of clergy in hospitals seems now to be better understood as an exercise in mental health counseling or palliative care. Medicine, once a “metaphor for Christ’s efficacy as the antidote for the sickness

²³ Luther, *Luther’s Works*, unpaginated. At the time of this writing, this advice is being heeded by many pastors as they comply with civil instruction not to gather more than 10 persons, including for public worship.

²⁴ Throughout the 19th and 20th centuries, the theologies of Albert Schweitzer and Rudolph Bultmann demonstrated this. At the risk of overgeneralizing their myriad writings, Christ became, to many, a moral individual, just and pure, and his care for people was rooted in morality, just as ours should be. But it was not based in any reality of miracles. Such a theology was friendly toward precisely the medical advancements that have benefited so many over the last century, and yet it cannot account for the nagging transcendent reality that looms large over our postmodern culture.

²⁵ Risse, *Mending Bodies, Saving Souls*, p. 550.

of sin,” as well as a tool for Christian outreach, has now superseded Christianity as the dominant partner in healing.²⁶

Application – A New Paradigm for a New Era

The arrival of COVID-19 marks the first time since the early church that a pandemic of this magnitude has beleaguered the West without the Church being the primary source of care, spiritually or materially. Therefore, we turn to a new theological paradigm for envisioning the church’s role in 21st century healthcare. This paradigm presumes Niebuhr’s “Christ the transformer of culture” paradigm, not mourning that primary bodily care has been taken from clerics and given to highly trained specialists.²⁷ If creation is good and Christ is transforming our culture toward eschatological hope, we may celebrate the advances in medical science that have made this a reality as good human products guided by God. The paradigm also assumes the Anglican “authoritative” view scripture (as opposed to inerrancy), as it aims for a fresh reading of Romans 12, inclusive of the reality of modern medicine.²⁸

The figure below represents the way in which the paradigm consists of varying roles among three institutions: civil authority, the medical community, and the religious community (for our purposes, the church, which in this model is further delineated into two constituent apparatuses - theologians/apologists and pastors).

²⁶ Porterfield, *Healing*, pp. 160-1.

²⁷ Richard J. Plantiga, Thomas R. Thompson, and Matthew D. Lundberg, *An Introduction to Christian Theology*, (Cambridge: Cambridge University Press, 2010), p. 352.

²⁸ I am influenced by N.T. Wright’s metaphor of scripture as the first four acts of a long-lost five-act play, wherein modern Christians are as Shakespearean actors who would be able to write and perform a fifth act in keeping with the form of the original author.

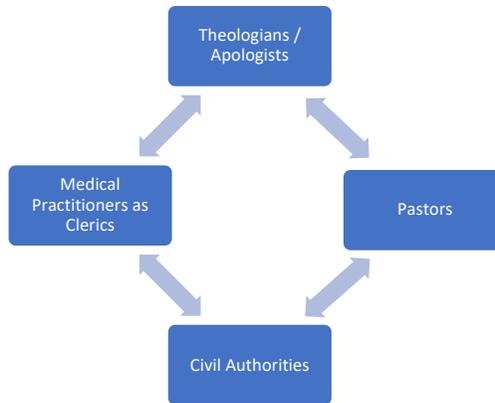


Figure 1: Theological Paradigm for 21st Century Health Crises Responses

All three institutions play a role in informing the others so as to enhance a response to health crises. For example, theologians might inform pastoral reckoning of cooperation with civil authorities. If institutions work toward mutual understanding when the public is at ease, they will be strengthened as partners during crisis.²⁹ The paradigm cannot be explored in detail here; in my own context as an Anglican cleric, the discussion of Luther above must suffice to encompass the provision of spiritual and sacramental care of the sick and dying.³⁰ However, I am personally interested in a unique aspect of this paradigm – an ordained office of physicians.

The writings of Charles Taylor, Jürgen Moltmann, and many others make clear that modern industry and technology have so enticed humankind that the predominant Western mindset has forfeited any sense of divine immanence.³¹ Yet Christians reject the dualism that so strictly separates body and spirit – a dualism that has, until recently, been predominant in medical science. As scientists come to understand more of the human mind, they are less

²⁹ The missing link between theologians/apologists and civil authorities reflects the reality that civil authorities are seldom interested in the theological academy, though civil authorities do partner with religious organizations in meeting community needs, and certainly, they are keenly interested in the work and knowledge of the medical community.

³⁰ Of course, theologians and apologists augment their work by providing the underpinnings of ideas falling under theodicy, or even the Christian’s response to authority when public health experts influence governments to limit public gatherings.

³¹ Plantiga, et. al., *Introduction*, p. 176.

skeptical of spirituality's role in patient improvement, but their view of the spiritual, broadly speaking, is still confined to their own box of healing the body. For example, meeting patients' spiritual needs is seen as "complementary to conventional therapeutics [...] [offering] the potential for earlier recovery and discharge, two goals of managed care."³² Given this, pastoral visits are increasingly viewed as a cost-effective means of improving patients' outcomes.

What this author has in mind is something beyond "pastors as helpers," but rather, "physicians as pastors." As Veli-Matti Kärkkäinen argues, while Christian theology should affirm attempts to establish human dignity on "natural grounds," it must not fail to highlight "the necessary reference to God, including [...] eschatological hope."³³ This line of thought has already been enacted in the field of psychology through the Reciprocating Self model of Jack Balswick, Pamela Ebstyn King, and Kevin S. Reimer.³⁴ Given the modern healthcare context, in which hospitals have become houses of high technology and the bulk of health care delivery is moving to clinics and in-home care,³⁵ I contend that such a development might revive an old pattern: that of cleric-healer. Individuals with a foot in both fields is not a new concept; many such cleric-physicians have and continue to serve in medical missions. Even for the unordained medic, Luther's theology of work and the Roman Catholic vocational concept of the active life have buoyed the Church in her recognition of the value of professional healers. But as this paper has asserted the Christological grounding for healing amid the evolution of biological

³² Risse, *Mending Bodies, Saving Souls*, p. 683.

³³ V.-M. Kärkkäinen, *Creation and Humanity. A Constructive Christian Theology for the Pluralistic World*, vol. 3. Eerdmans, 2015, unpaginated eBook (location 8437).

³⁴ Jack O. Balswick, Pamela Ebstyn King, and Kevin S. Reimer, *The Reciprocating Self: Human Development in Theological Perspective*, (Downers Grove, IL: IVP Academic: 2016). Mine is a synthesis of the entire work, however, for a general overview of what I intend here, see chapter two, entitled "The Reciprocating Self: A Trinitarian Analogy of Being and Becoming." Their model grounds therapy in the telos of the Trinity, understanding that humans, created in the image of the Trinitarian God, have both particularity and communal identity. Thus, therapists are encouraged to have as their goal for therapy a fully "reciprocating self," not just "happy and healthy," but living out God's intent for them in reciprocating relationships.

³⁵ Risse, *Mending Bodies, Saving Souls*, p. 677

understandings, a formal office would assert the call of the Church to care for the sick, affirm those gifted for 21st century healing, and equip them to contextualize their work through studies of theodicy and the telos of the Resurrection. The office might be grounded, scripturally, in a new reading of Romans 12:8, specifically Paul's use of the term *proistamenoι*.³⁶

Just as scripture itself did not so neatly divide the role of *episkopos* and *presbyter*, but the church had the wisdom to understand the need for the divide geographically, so might the Church now allow that, in modern life, doctors, at least those motivated by love of God and neighbor, are very much *proistamenoι*. Paul himself may have acknowledged such had he not written from a first century world view. We have seen the context in which he delivered his teachings on gifts in Romans 12 and in Ephesians 4 (concerning the five-fold ministry), was one in which sin was viewed as the root of sickness, and medicine as a professional practice was frequently tied up in the Pagan practices of the day. We now have a different understanding of medical practices, but to combat secularism's material view of the world, *proistamenoι-medics* would practice their gift as those who have been theologically trained, and upon whom the Church has laid hands and commissioned formally for the important work they affect.³⁷

³⁶ Robert Banks, *Paul's Idea of Community*. Peabody, MA: Hendrickson, 1994, p. 143. He writes, "In the list of gifts provided by Paul in Rom 12 we have reference to someone described as "giving aid," *proistamenoι* (Rom 12:8). This occurs in the participial form, though here with more emphasis on the person involved in the activity. The NRSV translation "the leader" is quite untrue to the spirit of the Greek. In 1 Thessalonians Paul mentions the vigor ("zeal" in Rom 12) with which such work should be undertaken. The construction used clearly demonstrates that no formal office is in view, despite its more direct personal reference and its position (between references to those who make financial contributions and act mercifully)."

³⁷ As far as cross-professionalism goes, one might consider this the medical equivalent of canon lawyers. What might the training entail for such *proistamenoι*? Must we send every doctor who signs up to seminary? This is a topic for further exploration, but since physicians already take courses in bioethics, it is not a stretch to imagine individual churches (led by pastors and assisted by theologians, per our paradigm!) creating the programs necessary to assist physicians in grounding their work in a sound theology regarding Creation, the body, and the telos of the resurrection. Perhaps the inclusion of such an office in theological discussions may even contribute to the paradigm as these individuals bring to bear their unique perspective in shedding light on sin as the source of sickness, in an ecological and authoritative sense if not a personal punitive one, as we have seen with the beginnings of COVID-19 in Wuhan.

Conclusion

This paper has argued that global health crises provide the Church with opportunities to reevaluate her theology and missiology. It discussed the Christological underpinnings of healing in the Kingdom of God, several cases in which the Church has explored the meaning of living out her charge to the sick, and has contextualized the modern COVID-19 pandemic within Luther's pastoral theology and the practical reality of 21st century medicine. Acknowledging the need for additional works to study the issue in closer detail, it has, nonetheless, proposed a proto-paradigm for understanding the Church's evolving relationship with medical practitioners, with a singular example given of recognizing called, Christian medics as holders of a formally recognized ecclesial office. This would contribute to the church's efforts at reevaluating theology and missiology in light of the current global health crisis.

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