Revelation in Triage: Faith Illuminating the Clinical Encounter

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Introduction
Religion in Medical and Nursing Practice

Narrative Inquiry in Bioethics Editors

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Abstract. Twelve personal narratives address the challenges, benefits, and pitfalls of integrating religion with medical and nursing practice. Three commentary articles explore these stories and suggest lessons that can be learned from them. The commentators come from backgrounds that include bioethics, medical practice, and spiritual studies.

Key Words. Bias, Ethics, Faith, Humility, Medical Practice, Moral Courage, Nursing, Personhood, Prayer, Religion, Spirituality, Stigma, Virtue, Wall of Separation

There are many people who think religion is integral to health care. There are many others who think religion has no place in a health care setting. For some people religion is a part of who they are and informs their decisions and actions. For others it is something they want no part of—these people find it intrusive or even offensive to have spirituality or denominational religion introduced into health care. We wondered how do religion and health care mix? Should they mix? How does a doctor or nurse know when to introduce religion into their practice?

These and other questions inspired us to pursue, "Religion in Medical and Nursing Practice," as a narrative symposium topic. We worked with experts in various fields to create a call for stories and to find excellent commentators for the issue.

The Call for Stories

The call, which was open to anyone working in medical or nursing practice, asked potential authors to consider:

- Have you ever prayed with or offered spiritual support to a patient? Why? How did it go?
- How have your religious convictions affected your practice of medicine or nursing?
- How has your clinical practice affected your religious development?
- Have you faced any problems involving peers, the law, chaplains, patients, or others, based on your integration of religion into clinical care? How does your institutional setting affect your integration of religion and medicine?
- How would you recommend that healthcare providers integrate their religious conviction into their practice?

The call was sent out on various listservs, posted on *NIB*'s webpage, and sent to colleagues and experts.

Response

In recruiting stories, we tried to represent a broad range of perspectives. We received quite a few proposals from people who describe themselves as atheistic and agnostic. While their stories were often interesting and important, we did not want those to be the only stories told. It was more difficult to find people from a broad range of faith communities to discuss how their faith informs their work. In the end, we managed to recruit stories that relate both positive and negative experiences by people who describe themselves as agnostic, atheistic, Catholic, Protestant, Jewish, Mennonite and Moslem.

Commentary Articles

Erin Bakanis, MD is a practicing physician at Saint Louis University who teaches medical students and chairs the Saint Louis University Hospital ethics committee. She also completed an MA in theology. In her Commentary, Dr. Bakanis addresses several themes: the virtue of humility; empathetic openness; good communication; and moral courage. All of these are things she sees the authors drawing from their faith and bringing into their work with patients.

Farr Curlin, MD is the Josiah C. Trent Professor of Medical Humanities at Duke University, where he works as a hospice and palliative care physician and holds appointments in both the School of Medicine and the Divinity School. He has created a large body of work in religion, ethics, and the practice of medicine, with a special focus on how these fields can influence one another. In his commentary, Dr. Curlin focuses first on how those who bring religion into health care are "transgressing" a long taught ideal that faith and patient care must be separated. While he freely acknowledges that there are good reasons for this separation, he sees, through the narratives, that this separation is not always possible or even the best practice for the patients or the medical community. He draws out the patients' need for meaning in their illness. He also sees a need for grace to care for patients and humility to learn from mistakes.

Mark Lazenby, PhD, MSN is an Advanced Oncology Certified Nurse Practitioner and an assistant professor at the Yale School of Nursing. He holds a Master's in Theology and a PhD in Philosophy of Religion. He has done work focused on the role of religion in the wellbeing of cancer patients and other projects on the crossroads of religion and medicine. Dr. Lazenby's commentary looks closely at the idea of a person bringing the entirety of self to all parts of life—being faithful both in health care and religion. He sees this need to be faithful played out in outward and inward practices. He concludes that the key to balance is personhood. All actions must, as he says, "preserve or restore personhood." It is in this spirit that he expresses how important it is that medical professionals never violate a patient by forcing religion or spirituality on them.

Conclusion

This narrative symposium draws out the importance of allowing people to be fully themselves—religious or spiritual people *and* practitioners of health care. It also offers a cautionary tale that bringing the spiritual into health care does not help all people. For some patients the separation of religion from health care is essential to their comfort and well–being.

We hope that this symposium will help to foster a deeper understanding of a controversial topic, leading people of diverse persuasions to reexamine their perspectives and perhaps even practices.

Personal Narratives

Helping a Muslim Family to Make a Life–and–Death Decision for Their Beloved Terminally Ill Father

Bahar Bastani

I live in a city in the Midwest with a population of around two million people. There are an estimated 2,000 Iranians living in this city, the vast majority of which belong to Shia sect of Islam.

However, the vast majority is also not very religious. Over the past two decades that I have been living in this city, professionally in the capacity of a physician and university faculty at a school of medicine, and socially as one of the community leaders with a particular role in religious matters, I have acquired the trust of my community. Following one of my yearly routine travels to my homeland, Iran, I had just returned to work when I received a phone call from one of the Iranian community members. He informed me that his father was very ill and was hospitalized, and that the physicians had introduced the idea of stopping life support. The family was experiencing a significant emotional, moral and religious dilemma as to whether they could consent to this. I was requested by the patient's children to help them make the right decision.

I requested that the oldest son, who had called me, to ask the three other siblings and their mother to be present at the bedside of the patient that night, so that we could discuss the matters face–to–face. That same night, all requisite family members and myself gathered at the bedside of this 88–year–old husband and father, who had developed multi–organ failure, which commenced with an infection following a heart valve replacement, followed by bacteremia and sepsis. Moreover, the patient was hypotensive, had developed respiratory failure requiring intubation and artificial ventilation, and had also developed hematologic coagulation abnormalities secondary to sepsis. Because of the sepsis, hypotension, and multiple drugs, including antibiotics and vasopressors, his kidneys had also failed, and there was a need to start hemodialysis if his life was to be maintained. After speaking with the intensive care physicians who were taking care of this elderly gentleman, it became clear to me that further care was futile, and there was absolutely no hope for him to recover from his multiple organ failure. I presented all the facts that I had acquired to the family members, and expressed my own viewpoint that I agreed with those physicians and that further care of their beloved, terminally ill husband and father was futile and only extended his dying. My assurances made it easier for the family members, particularly for his four sons who were present, to come to the decision to withdraw life support. After I informed the intensive care physicians of the family's decision, the patient was heavily sedated with morphine, and the intravenous fluids, antibiotics, vasopressors, and the ventilator machine were all stopped. Over the next several minutes, the patient developed agonal breathing, his blood pressure dropped to zero, and his heart stopped. During the last few minutes of his life, I held the hands of the family members, we all prayed Islamic prayers to bless his soul while departing from his body. The next day, I supported the family with funeral services that included the Islamic prayers for the dead, the ceremonial religious washing of the body of the deceased, and the ceremonial religious burial.

The dilemma that this family faced was multifactorial: (1) the children had spent all of their adult life in America, and were unfamiliar with Islamic end of life and funeral traditions; (2) they had been asked by their father's physicians to make a decision regarding the withdrawal of life support, which posed a moral and ethical dilemma; (3) they did not know whether it was religiously acceptable to withdraw life support; and (4) they did not know what type of funeral service would be acceptable to the religious beliefs of their deceased father.

My presence as a trusted community leader, physician and religious leader was reassuring to the family members that the decision to stop life support for their loved one with a terminal illness and multiple organ failure was neither ethically, morally, nor religiously wrong. They were reassured that they were not committing any injustice to their beloved father, and that they were not breaking any religious mandates, i.e., they were not committing a sin, and that they were not acting immorally or unethically. All these reassurances from someone whom they could trust made it possible for them to make such an important emotional life and death decision for their loved one.

The above case shows the critical importance for minority communities to have in place the following three components: a trusted community leader, a trusted physician (when dealing with a terminally ill patient), and finally, a trusted religious leader (to provide appropriate advice and spiritual support). In a minority community, one or two people, who

over time have gained the trust of the community, may fulfill these roles.

Communication with the family members and the physicians who are taking care of the patient is essential to give proper advice and emotional and spiritual support for the family, and to help them to pass through such a difficult time with feelings of peace and harmony.

The 12–Minute Journey

Heather A. Carlson

I met Jack for the first time when he was in the intensive care unit as he was just waking up from his emergent tracheostomy surgery. As I walked into his room he opened his eyes in panic and he struggled to take in a deep breath, fighting the ventilator that was trying to deliver slow steady breaths for him. His face was flooded with fear and the ventilator alarms were blaring. He was surrounded by nurses and respiratory technicians all trying to calm him down, while adjusting the settings on the machine. "Just try and breathe slowly," they instructed him, though this seemed to be impossible for him as he continued to try and suck in as much air as possible through the new hole in his throat. As his arm flailed out I grabbed his hand and while holding it in mine I just tried to emulate tranquility for him. I thought to myself this is exactly how I would react if I woke up in this condition and could imagine the fear that he was now feeling. While nurses rushed around with suction equipment and the respiratory technicians made adjustments and monitored the results I stood there holding his hand silently praying that he become calm. With all of our support he did eventually relax and find the ability to sync his breathing with the ventilator settings.

I am a palliative care nurse practitioner and had been asked to see Jack to help with symptom management and establishing his goals of care as he had recently been diagnosed with head and neck cancer. He had presented to the hospital with complaints of difficulty breathing and it didn't take long for the emergency room physician to determine that his airway was almost completely occluded by tumor. Jack had actually been diagnosed with this cancer the month before, and had met with a radiation oncologist who planned to start radiation as soon as possible to avoid tumor growth that could impair his breathing. Unfortunately Jack was so anxious and scared about this treatment plan that he never went back to the cancer center. Instead, he stayed in his room in the boarding house that he lived in, smoking cigarettes to calm his nerves. Jack was a recovering alcoholic who had previously been homeless and out on the streets for many years before becoming sober and finding shelter at the boarding house where he now lived. He was a heavy smoker and found that it was one thing that helped to ease his anxiety. The thought of being strapped down to a table with a tight mask over his head while radiation zapped the cancer in his neck had terrified him. His anxiety and claustrophobia had prevented him from following through with his cancer treatment.

My initial visits with Jack were spent trying to treat his anxiety as well as the pain he experienced in his neck and head.

Because he had undergone a tracheostomy and was now on a ventilator he was unable to speak. To communicate he pointed to a picture board that had common sayings on it, like "I have pain" and "I have to go to the bathroom". He also used a clipboard with paper and pen and could write what he wanted to say, but this was a time consuming endeavor. Despite this, he was a very animated gentleman who had a lot to say and he wasn't going to let the loss of his voice impair him. I found myself enjoying my visits with him each day, as he would tell me more about himself. I quickly discovered that he was a very spiritual man and his faith was his inspiration. He wrote on his clipboard "this cancer is actually a gift" and went on to explain that he had been on a fast track toward self destruction, but now feels as though he has been given another chance at life. He spent his time in the hospital reflecting on his life's journey and how he would be able to help others in similar circumstances. He wrote on his

clipboard multiple times that he felt God "wanted him to teach others" and he was accepting that mission as he battled his cancer.

Jack spent several weeks in the hospital before transitioning over to rehabilitation. The oncologists wanted him to start radiation as soon as possible, but he had to heal from his surgery first. He seemed to settle in to his own space at rehab, posting magazine cutouts and newspaper phrases around the room to offer him inspiration. The sign on his tube–feeding pump read "fast food" and on the wall above his bed were the lyrics from his favorite Bob Marley song. Despite what he was going through had a wonderful sense of humor.

One morning when I went to visit him I found that he had shaved off all of his scraggly facial hair and his long gray hair was slicked back neatly into a ponytail. He told me that he was going to start his cancer treatment the next day and he wanted to make sure that he was looking his best. He showed me some motivational words that he had cut out of a magazine that he planned to bring with him to the cancer center to help keep him relaxed and focused. I made sure that he had medications available to be given to him before his treatment to help him be comfortable and promised that I would see him after his treatment.

When I returned the next day I was relieved to find Jack sitting up in bed and smiling. Knowing that the radiation treatment would require him to lay still with a mask securing his head to the table I was expecting him to have difficulty tolerating it, and feared it may be similar to his experience on the ventilator. I pulled up a chair next to his bed and asked him how his day was. He smiled and shook his hand back and forth demonstrating that is was okay. He then mouthed the words "only twelve minutes" indicating that he could tolerate it for that short period. I asked him, "Where did you go during those twelve minutes", and with a spark in his eye he pulled out his clipboard and proceeded to write about the journey his mind went on during that time. We spent the next two hours talking.

Jack told me that ten years ago his maternal grandmother died and left him some inheritance money that he quickly spent on alcohol and drugs. A few years later his aunt passed away and also left him some inheritance. Learning his lesson from the previous time, Jack decided not to waste the money on alcohol and decided instead that he wanted to travel. He called up a friend who was an avid traveler and they booked a trip to Peru. He wrote feverishly on his clipboard about his adventures exploring this South American country and I was most fascinated by his experience in Machu Picchu. As he wrote I pictured the lush green mountain and ancient ruins that I have seen in pictures. He eventually grew frustrated with the time it took him to write and began mouthing sentences with great enthusiasm, and using animated gestures told me of the long train ride and the even longer hike he took up the steep mountainside. He reminded me that it is quite difficult to breathe that high above sea level and the lack of oxygen almost produces a euphoric feeling. He overwhelmingly felt God's presence there and spent hours sitting and taking it all in. He explained that after spending years living on the streets, drinking alcohol and doing drugs he had begun to think that was all life had to offer him. He learned on that mountain top that God had other plans for him, but he was not sure what they would be. He now feels that his mission is to help others going through similar situations and is motivated to help people stop smoking. He feels that his cancer is a gift, which has given him the chance to live a better life. He feels that he is answering God's calling to be a role model and teacher.

At the end of our conversation I felt that I myself had journeyed to this magical place with him and could appreciate the tranquility and strength that it provided him. I thanked him for sharing this beautiful story with me and had a better understanding of the core of his inner strength and faith. Before I became a nurse practitioner I had participated in a spirituality fellowship, which helped me to learn that the best way that I can care for my patients is by seeing the person they are, not just the diagnosis they have. That human connection allows me to join them in their journey and has become a very fulfilling part of my spiritual practice and nursing career. Jack is a shining example of this.

The Emperor's Daughter, the Wise Rabbi, and the Realtor's Facelift

John Davidson and Ruhama Weiss

Four decades ago during the clinical years of medical school, my (JD) first patient–care efforts included serendipitous contacts with three non–physician mentors. Each a rabbi. Each a Texan. Each of a different generation. Each acting in a pastoral care role in Houston's Texas Medical Center. By sharing with all–comers their command of the two–millennia–old rabbinic literary corpus, especially its aggadic, or nonlegal texts, they changed me forever. Theological dogma was not their passion. Caregiving for their hospitalized congregants was. And in so doing, they opened gates of discovery to rabbinic stories (aggadot) as articles of faith to be put into action for patients, staff, students, and doctors alike. These unexpected gifts have catalyzed and sustained my medical career and personal life ever since.

The most influential of those stories was the famous Talmudic tale of the eminent Rabbi Eliezer (Babylonian Talmud, Bava Metzia 59b) using every conceivable means to support his view in a dispute, including miracles and a voice of approval from Heaven. His colleagues refused to assent to the singularity of his methods or arrival. They insisted on reasoning their way through to a majority decision based on consideration of the evidence at hand with the tools available. The tale ends with a joyous, proud, yet defeated parental deity declaring, "My children have bested Me, my children have bested Me."

The legend empowered me as a student to speak my mind in seeking to value the methodical, collaborative process of clinical decision–making over the sometimes ferocious voices of "the experts." It continues to resurface decades later in daily efforts at finding common ground with both patients and other clinicians as we try to figure out, "what to do." For more on this topic see my article, "Empathy and Integrative Thinking: Talmudic Paradigms for the Essentials of a Medical Interview" found in *Medical Humanities.*

Just as those rabbis in the 1970's told their stories in order to make sense of worldly and spiritual matters, so have I come now to appreciate the value of similar narratives for my patients and myself. Sometimes stories are shared in a near prescriptive fashion. Sometimes they are recalled silently as a compass suggesting the next step in an interview or treatment process. These rabbinic tales come to mind during clinical encounters after years of personal reflection on favorite texts and even more often in the midst of weekly if not daily textual study as a central element of my Jewish religious life. This practice has led to a realization that recalling rabbinic texts in contemporary clinical contexts is neither far–fetched nor irrelevant. At times it is uncannily helpful. Two millennia are not so long ago.

During the past year, an Israeli colleague (RW) and I have revisited various Talmudic passages on a regular basis. Unlike Texas four decades ago, now I have learned with a pastoral care clinician who is a "*hevruta*," or study partner, from the same Hebrew root as "*haver*," meaning "friend." Ours is a centuries–old way of study consisting of a pair of learners conversing freely on equal footing as they wrestle with interpreting a chosen, often familiar, text in a new way. My *hevruta* and I parse verbs. We examine articles. We question redundancy and grammatical reversals. We search for allusions. We read closely. We do all of this for its sake alone. It is part of our spiritual journey. It is one way we search for God. We engage the words on the page or screen and talk to each other.

It is also a dyadic effort whose process and content bear a likeness to that of a doctor and a patient as they try to dialogue together regarding a patient's concerns and the doctor's capacity to help. Here, too, there is give and take, an attention to details, a reinterpretation of the past, and a reconsidering of the present. It is not surprising that the fruits of an ongoing dialogue on one stage with a *hevruta,* related to rabbinic stories and grammatical puzzlements, is of use on another stage when the *hevruta*/physician strives for attentive presence and understanding with a patient.

In my experience, this way of study sooner or later has an impact upon my clinical practice as a general internist. As I try to understand and care for my patients, the recollection of a study session often helps me maintain a sense of equilibrium and intention. It is the nature of abiding literature and nurturing relationships to resurface again and again from the courts of our memory into present circumstances—an old text with a *hevruta* in a new context with a patient, a recalled dialogical relationship with a *hevruta* folded into a new one with a patient.

One instance in recent months came during a week when my *hevruta* and I considered a Talmudic legend describing an imaginary encounter between the Roman emperor's daughter and Rabbi Joshua. Rabbi Joshua, a first century CE Palestinian scholar, was known both for his extraordinary knowledge of Torah and his physical unsightliness.

> The emperor's daughter said to Rabbi Joshua, "Such comely wisdom in an ugly vessel!"
>
> He replied, "Learn from your father's palace. In what is wine stored?"
>
> "In earthen jars," she answered.
>
> "But all commoners store wine in earthen vessels. And so do you? You should store it in silver and gold vessels."
>
> So she went and had the wine transferred to silver and gold vessels. But it turned sour.
>
> "So it is with Torah," he said to her.
>
> "But aren't there handsome people who are learned as well?"
>
> "If they were ugly, they would be even more learned," he replied.
>
> Babylonian Talmud, Nedarim 50b

At the very least, the text suggests that our looks are less important than our awareness of ultimate matters, like the Torah. In fact, our preoccupation with looks likely lessens our appreciation of more important concerns. But questions remain. What is the meaning of her first remark? Does the juxtaposition of "comely" and "wisdom" refer to a wisdom as to the how's of achieving "comeliness" or to the "comeliness" of being wise, or to both? Surely, it is more than a joking tease. Why is the Roman emperor's daughter seeking counsel with a rabbi of the nearly vanquished Jewish community over which her father rules? Why does a powerful woman seek counsel from a less powerful man, then or now? What does she fear? Why is this woman asking this man to be the arbiter in such matters as the relative importance of beauty and wisdom? Is she herself comely, wise, both, or neither? Is she afraid of losing the valued identity which comes with any measure of beauty and unsure how to replace it? Why does the rabbi refer her back to her father's house? How does this empower her while also offering an answer to her question? And lastly, what do we make of the final line? Dare we say that at the end of a serious exchange, the rabbi also offers a joking tease? After all, Rabbi Joshua and Groucho Marx are kin. Is the pericope itself bookended by jokes? Is this holy humor not offered as an invitation to consider the wisdom of the ugly and weak as preferred to the inevitable loss of beauty and wealth even for those of royalty? These were among the questions that my *hevruta* and I considered.

In the midst of that same week, a patient tentatively said to me after her sixth consecutive annual exam in our office, "I think that you are wise. So I have a question for you. Should I get a facelift, so my outsides will match my insides?"

At that moment, I wished for Rabbi Joshua. But my Israeli *hevruta* was also immediately imagined sitting in the corner of the exam room rather than in her Jerusalem study. The patient reminded me of her high–pressure, very successful career as a realtor. She was a modern day, highly achieved, attractive businesswoman akin to the "emperor's daughter" above. Yet afraid of losing her looks, she found herself asking me, a male medical staff consultant of more pedestrian arrivals, what to do. She wondered about the importance of her appearance to clients, many of whom were males. She stated that her sister had undergone a facelift herself and had suggested that she also do so. But my patient had spent a lifetime assessing real estate value with its variables of location, appearance, structural integrity, age of construction, and other "outside" and "inside" factors. She sensed more complex issues being at hand. She approached me like the emperor's daughter approached Rabbi

Joshua. Should her wrinkles and creases be erased? Or, on the other hand, was this assumed mismatch of her "outsides" and her "insides" so important? Other priorities might merit attention. What was my advice?

I reflected upon what a doctor's ethic was supposed to be in this conversation. This was her decision not mine. But she was asking for a counterbalance to her own thoughts and the suggestions of her sister as well as others. She had previously mentioned the years of hectic, unpredictable schedules, inadequate exercise, and various diets. They may have left her with more than wrinkles. She wanted a response that was not a politely stated dismissal to do as she was most comfortable. She wanted more than a condescension of tolerance.

I searched for a reply. The above text stepped forward. It had been on my computer screen several times during the week. My *hevruta* had sent it. I wondered if it could help my patient consider her "insides" as well as her "outsides." Could Rabbi Joshua and the emperor's daughter speak to her as they had to us? I responded, "What if your outsides do match your insides, or worse? What would that mean? What if your insides need more attention than your outsides? What if the wrinkles are accompanied by other things on the inside?"

"I don't understand," she said.

"What if you're not as healthy inside as you think? What if the wrinkles are just part of the story?" I countered.

I then briefly shared some gleanings from the Talmudic legend with her. I told her their source. She seemed bemused but curious. She listened quietly. She then responded, "I've never thought about my health this way before. Maybe we should look into it."

In addition to the usual laboratory screens, we then agreed to add a treadmill stress test to assess her physical conditioning and to screen for any hint of coronary ischemia. We agreed to reconsider more closely her elevated cholesterol, her diet, her weight, her sleep, her lack of exercise, and her stressful life style.

A few days later she returned. Her stress test did reflect suboptimal physical conditioning. Her labs indicated a high risk for cardiovascular disease. Suggestions were made for diet and exercise changes, a coronary artery calcification study, and an overnight polysomnograph. With this news, she calmly expressed gratitude for our efforts. She did not seem surprised. She dismissed the facelift question and indicated that she would pursue the additional workup at home. She said that she wanted "to come back next year to check up on things".

My patient has become a *hevruta* with me in the arena of her health. In planning to return, she wants to "check up" on our relationship. The emperor's daughter and the medical consultant. She is coming back next year to see what the two of us may discover again, perhaps with the help of more rabbinic legends.

When she returns, I will share with her another text. It depicts the obligation of a *hevruta* to a partner. It also depicts the obligation of a Jewish physician/*hevruta* to his Protestant patient/*hevruta* after being taught by her once more that rabbinic stories can serve as articles of faith to be put into action for the benefit of all, whether emperors' daughters and rabbis two millennia ago, or physicians and patients now:

> One who learns from one's friend a single chapter,
> or a single rule, or a single verse,
> or single expression,
> or even a single letter,
> must show him honor.
> Pirkei Avot 6:3

My continued gratitude for her question and my hope for more are her honor.

The Intersection of Medicine and Religion

John C. Dormois

The practice of medicine offers a host of rewards to the practitioner. Besides the obvious intellectual satisfaction of solving a difficult diagnostic problem or the ability to make a comfortable living, I have found the greatest personal sense of moral gratification when helping

families negotiate the most challenging event in life: making decisions at end of life. Whether the condition was a ruptured intracranial aneurysm with brain death or a patient with far advanced cancer struggling with the choice between experimental chemotherapy or choosing comfort therapy at home surrounded by family for the remaining days of life, the moral courage required to provide the best guidance was considerable. In my early years of practice I didn't call my actions in these situations "courageous" nor were there moral "guidelines" providing a blueprint. I knew I responded with empathy and compassion and that this ability had a lot to do with being raised in a religious or spiritual home. At the same time, I suspected that some of the lack of empathy and compassion I witnessed in some of my colleagues was related to the very training programs of physicians. This essay traces the origin of my moral and ethical concerns about medical education and my intention to reinvigorate the spiritual or existential voice in medicine.

An early life experience had a great deal to do with shaping my moral development. At age seven my family traveled through the West Indies. My father's amateur radio hobby meant that at every stop we would be greeted by one of his radio contacts. One stop in particular was life changing.

Port au Prince, Haiti was an unknown place to this seven year–old, but to say it was a culture shock to a boy from Kansas would be an understatement of epic proportions. It was during this visit that I experienced true poverty in its most blatant form. In downtown Port au Prince I saw limbless beggars and the deformed from polio and malnutrition. But it was the sight of the garbage dump near the center of town that changed my world forever. There, among piles of detritus, I saw children and families making their home in the dump. They had hollowed out a sort of cavern in the piles of trash that served as a place of refuge from both the rain and the sun.

This experience in many ways has served as a framework and background for my life. Although seen through the eyes of a seven year–old, the picture can only be adequately understood within the context of being raised by religiously faithful parents, parents free of hypocrisy whose lives personified the best in Christian virtues and practices. These early experiences planted the seeds that would only fully blossom some 60 years later.

Medical school was a demanding but exhilarating experience. Each day was a day of discovery . . . anatomy, physiology, pathology . . . all subjects opening up a whole new world to explore. Internal medicine suited me best since it was the specialty that most closely integrated all the basic sciences necessary to arrive at a diagnosis. I loved the elegance of endocrinology in particular where a given hormone mediator could cause widely different effects if present in excess or completely absent. But I was in the end drawn to cardiology since it combined complex physiology with my avocation, the love of running.

There was, however, a disturbing aspect of medicine education that I observed affecting many of my classmates. Although I can vividly recall the enthusiasm that all of us shared as we donned our white coats for the first time and envisioned a future of caring for our patients, things gradually and insidiously changed over the next four years. The altruism and empathy that was so evident in the early years gradually lessened as graduation approached. I could not help being struck by this change and wondered at the time why that should happen. I had no insight then that what I had observed was a well recognized consequence of the medical school experience. I'm sure that the passage from professional training to practice in the "real world" is always accompanied by the clash of idealism into the harsh reality of life. Lawyers must be disappointed that the blindfold on Lady Justice must seem transparent at times. Ministers must despair that the message of love and forgiveness they preach often falls on deaf ears. But I was determined to retain my empathy and compassion in spite of forces working against it. After all, medicine is a moral enterprise and these virtues ought to be fundamental.

A definition of terms is always useful. Empathy is an understanding of another person's experiences and emotions or the ability to share those emotions. Compassion, although also reflecting an emotion in response to the suffering of others, carries with it an active desire to alleviate the suffering of others.

It did not seem difficult to be empathetic and compassionate towards my patients. All it required from my perspective was to spend adequate time listening to their concerns and complaints, avoiding excessive wait times, and providing timely access when emergencies arose. But serving as a consultant in a hospital exposed tensions for which undergraduate education had not provided training. This was particularly evident in the intensive care unit where patients with hopeless situations were maintained on life support far beyond any chance of meaningful survival. It seemed that the courage necessary to accept the inevitability of death and have frank and honest discussions with family members was commonly absent.

There were no ethics committees in the 1970s. Establishing a "no code" designation for patients was a major step forward. And as the growth of technology accelerated, there were more and more instances of patients and families suffering due to new ways to forestall the dying body from reaching its natural end. The Hippocratic ideal of "do no harm" was particularly at issue with the development of improved mechanical respirators and drugs to support failing cardiovascular systems. Multiple rounds of unsuccessful chemotherapy even in the face of progressive cancer were often insufficient to lead to a discussion of goals of care. Where was the beneficence in this? Hippocrates had an opinion about those who have been "overmastered by their disease" and being beyond the reach of medicine; continued therapy in these instances merely delayed the dying process rather than prolonging life.

Demonstrating benevolence far from home was much easier. This is the appeal of engaging in foreign "mission" trips to underdeveloped countries where the activity itself exemplifies empathy and compassion. Whether it was treating malaria in central Africa or rheumatic fever in India, there was real satisfaction that I had performed unselfish acts of benevolence. But the satisfaction was short lived for no sooner had I returned to my practice than the chronic shortcomings of medicine at home came back into sharp focus.

Health care inequities are such an example. Some of the problems are based on poverty and others on race. The poor often have no insurance and seek medical care only when circumstances are frequently beyond help. What is the appropriate response from a Christian perspective to care "for the least of these"? What seemed the correct moral response was to act against the injustice in favor of the common good. One answer was to establish a free clinic for the medically indigent. Along with a group of volunteers I formed such a clinic in 1990 that continues to provide both medical and dental care to community members lacking insurance and not eligible for Medicaid. This has been a satisfying solution on a personal level, but far from an answer for the larger issues of a broken health care system.

These examples from my own personal journey gave me at least some satisfaction as I witnessed an increasingly adversarial medical system of patient against physician, physician and patient against insurance companies, and a progressively expanding uninsured and underinsured population. These larger systemic issues seemed completely beyond my reach. Addressing the erosion of empathy and compassion among my physician colleagues, however, did seem something I could possibly influence.

As I noted at the beginning of this essay, I saw an "empathy problem" developing during undergraduate medical education. Since my Christian values would seem to limit the destructive effects of what I had witnessed, I began to consider how those values could be reintroduced into the formation of physicians. I had often thought that the hospital chaplain was a good model for a caring physician. The chaplain addresses those spiritual/existential issues that reflect the person with illness rather than simply the account of the body. I wondered how the practice of the chaplain could be incorporated into the education of the physician.

The answer to that question came when I was introduced to Clinical Pastoral Education (CPE). CPE was created for seminary students to have a hospital experience since ministering at the bedside to their parishioners would become an essential component of their pastoral care.

CPE was a transformative experience. It required that I meet patients in an entirely different place compared to a practicing physician. Instead of inquiring about physical symptoms, I was responding to a variety of spiritual needs that were often unrelated to the medical reason for hospital confinement. Medical issues were obviously present, but the chaplain's visit was more about the human response to illness and questions that relate more to meaning than physiology. If I were to attempt to bring this perspective to medicine, I would have to learn to speak in the theological and philosophical voice.

In 2010 I closed my practice of cardiology and entered divinity school. I chose a school that had physicians on the faculty with emphasis on the care at end of life. I gradually learned that the person is more than just body, but rather an embodied soul. The latter concept emphasizes the person *qua* person that exists with the body. And I came to understand that the primary reason that empathy and compassion are frequently lacking is due to the one–sided view of medicine that focuses on the body at the exclusion of the person. Diseases never suffer; only persons can suffer. A clinical example is useful.

I'm reminded of the woman who had breast cancer treated with mastectomy, lymph node dissection, and courses of chemotherapy and radiation therapy. Although free of cancer, she continued to suffer greatly. Her suffering was not due to her disease. Her suffering resulted from the fact that the lymphedema of her arm prevented her from her most meaningful life activity—being a sculptor. So how to bring this awareness of the importance of person to medical education?

As I approached the end of my divinity school education, it became apparent to me that the best venue to embody the virtues of empathy and compassion was in palliative care. It is the place in medicine where the tension between curative care and comfort care is most obvious. In order to resolve this tension, spiritual and existential issues must be addressed. Honest discussion of these differences can only be done when empathy and compassion are guided by benevolence and prudence along with a sense of justice. My thesis is that palliative medicine provides a way to bend the curve back from a purely bodily view of illness and suffering, allowing the spiritual and existential to ascend to equality with the material. This is how I visualize my religious background and theological education impacting medical education. It is a voice that needs to be heard, to recapture the importance of these virtues in health care and as a consequence build greater character among its practitioners.

Blind Faith

Daniel Finkelstein

A young mother, Spanish speaking only, brought her 7 year old son to see me, as a retina specialist, referred by her local doctor; the young woman and her son entered my office with a Spanish interpreter from our International Office. From the boy's limited testing so far, I was pleased to see that the sharpness of vision was excellent at 20/20 in each eye, but I was concerned with the loss of peripheral vision which had shown up in the visual field testing. My examination of his ocular fundus demonstrated peripheral retinal pigmentation in bone spicule form, that along with the visual field change was diagnostic for retinitis pigmentosa, an untreatable and slowly progressive retinal degeneration that would probably, over the next thirty to forty years, slowly rob him of useful vision for him that, by family history, as translated to me, was inherited in autosomal recessive form.

I explained the slow progression, through the translator, to the mother, emphasizing that the slow progression was untreatable, but that I had every expectation that her son would otherwise develop normally and adjust to the handicap as it progressed.

Because this young mother had been hoping for a cure for her son that prompted her international trip to our hospital, this bad news for her was devastating. I recognized this in her quiet sobbing as my information was transferred to her through the interpreter.

It was clear to me that she had no way of knowing my usual depth of concern for her and for her son in transferring to her what was for her unfortunate bad news.

I did notice that she was wearing a Rosary ring, a ring that devout Catholics wear to aid with their sacred prayer, The Rosary, a ring particularly useful to keep track of the decade of Hail Marys that is part of the Rosary prayer. Through the Spanish interpreter, I let the mother know that I recognized her ring; and I acknowledged that a special day was coming the following week, a Holy Day of Obligation. In recognizing her faith, she knew then that I was part of the Catholic community and, therefore, part of her community, and had the best interest of her son in my heart. And so, "the healing" could begin.

The disease born to her son, a progressive handicap, could not be cured. The seven year old, I knew from my past experience with other children, needed no emotional "healing" at this time; but the mother certainly would appreciate help with what was for her devastating information. She was imagining future hardship for her child. And so I was able, through the interpreter, to have the full attention of the mother, through her understanding that I was part of her community and appreciative of the community that Catholics share. When I spent time with her with the interpreter explaining that the slow progression would not provide, for her son, a handicap that would prevent him from a productive life, with her loving guidance, her tears ceased and she knew, and I knew, that there was a bond of importance through the professionalism of our communication. This emotional "healing" is a great treasure of professionalism of our medical calling that can be enhanced through this spiritual compatibility.

A Prayer for the Baby

Katherine J. Gold

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We didn't talk much about religion in medical school. Rightly so, it seemed to me at the time. I didn't know how or why it would fit in to my patient care other than respecting patients who used their faith as a coping strategy. I was not at all religious and didn't like the thought of talking about such things with patients. And in my clinical experiences, it rarely came up.

When I got to my last year of school, I signed up to work for a month with an obstetrician–gynecologist in her outpatient clinic. I don't recall how I met her but remember she was respected for her outpatient teaching so it seemed like it would be a good experience to work with her. (I'll refer to her by a fictional name here.)

"Call me Maria," she told new patients, enveloping them in a warm, supportive style. They did, and I adjusted to her caring approach, shadowing her as we saw patients during pregnancy, those with abnormal uterine bleeding, patients with pelvic pain, others needing pelvic surgeries. It was an odd experience for me, six months pregnant myself, to be seeing other patients during their own pregnancies.

One day, about a week in to my rotation, a couple came in together for an appointment two weeks after an early miscarriage. I watched Dr. Copeland (as a student I just couldn't call my attending by her first name) give them a hug and we sat down. She asked how they were doing and they shared their story, tears flowing as the mother recounted her emotions over the last week and support from their friends. I had the impression that they attended the same church as Dr. Copeland from their conversation. At the end of the visit everyone stood up.

"Shall we pray?" Dr. Copeland asked, and they all took hands. I edged back, away from their small circle, uncertain what to do. I had never seen prayer in medical practice and certainly not initiated by the doctor. Not being religious myself, I felt uncomfortable. I didn't know the protocol. This was not a setting where I knew what to do. So I leaned

quietly against the wall, trying to be unobtrusive, feeling my baby kicking while I watched. All of them bowed their heads and Dr. Copeland said a brief prayer. I watched the mother as her shoulders relaxed. They said "amen" and squeezed hands and hugged one last time. I thought about that interaction for weeks afterwards. I was uncomfortable, but clearly the patients were not. If there were a role for religion in medicine, I reflected, this might be a place for it. It had been accepted by the family without hesitation, so somehow Dr. Copeland knew it would be alright. It had been used in a healing way.

There were several other visits where Dr. Copeland prayed with patients. Sometimes she seemed to know them from her church; at other times, I wasn't sure. But there never seemed to be a misstep—patients never seemed surprised or awkward with her approach. Did they choose her because of shared beliefs? Did she have a reputation of using faith in her practice and patients selected her for this reason? I wasn't sure. But it was always the same. They would bow their heads and pray. I would stand back a little uncertainly, but the patients were always grateful and appreciative, thanking Maria by her first name as they left.

As I spent more time with her, I looked for other ways that faith might impact Dr. Copeland's practice and asked questions when I thought there might be relevance. I knew from others that she was opposed to abortion, though I never heard her talk about it openly and I was unsure how this might be manifest in her practice. I watched her prescribe birth control (I knew some religious physicians who did not). I watched her send a patient with a second trimester fetal death to the hospital to be induced for delivery. I wondered if someone who was pro–life would be comfortable hastening delivery if the fetus had already died. I felt like I should know this, but I didn't. I couldn't quite figure out what was acceptable and what was not. Finally I gathered enough courage to ask her directly.

"I don't kill babies," she said to me tartly. I sensed this was not something to bring up again—the distinction was clear to her but I was really just trying to understand, the same way I tried to understand when she prayed with patients.

One day we saw a lesbian couple with a pregnancy loss in clinic. I was curious how she would react to this couple, because I guessed same sex relationships would not be supported by her faith. But it never came up. She was kind and compassionate with them, even in the face of unexpected anger toward her from the patient when she diagnosed the loss. She managed the hostility gracefully and calmly, and I was impressed. She never mentioned the same sex relationship. But we didn't pray with that couple. As I drove home that night, I wondered: was that because of their relationship or because she hadn't known them before the appointment?

A couple of months later I graduated from medical school, anticipating the imminent birth of my own baby. I was thinking a great deal about my own family's future but little about prayer in medicine. Ten days before my due date, I went to triage to find out why the baby wasn't moving. Within minutes, I had the answer: my own baby was dead. Just like that.

A decade later I still remember the image of that triage room and the staff—the nurse's blank face as she tried to find heart tones and couldn't. No reassurance or touch from her—just blankness. I remember the attending who repeated the ultrasound for confirmation, his face and hair covered by a surgical hat and mask, so I could only see his eyes. It was clear on the ultrasound pictures that the baby wasn't moving. They need not even have said it aloud.

A nurse admitted me to a room for induction of labor. I remember my relief when Dr. Copeland walked in. It turned out to be her day on call, and I was grateful for a familiar face in the midst of feeling like everything else in my life had turned upside down. The residents stayed away from the room, coming only when necessary and saying little, but Dr. Copeland would pop her head in and check on me throughout the day. Her calm, relaxed, supportive demeanor meant a lot. At night I rapidly progressed and delivered; Dr. Copeland was there through the whole process, stepping softly out of the way when my personal doctor made it in just in time for the actual delivery. After I delivered my

son, I was overwhelmed with nausea and went into the bathroom to throw up. Dr. Copeland followed me in, and I remember her holding my head as I retched. She didn't say anything, but handed me a cool cloth and gently stroked my hair.

The next day I was sitting in my room alone when Dr. Copeland came in. I was in a daze at that point. The night before I had held my baby who came out pink and warm but rapidly became gray and cold. Today he was gone and I was not sure what the next step was. I was surprised to see Dr. Copeland, surprised she had come back even though she was no longer on call. She set a bouquet of pink flowers on the table and sat down on my bed. She gave me a quick hug and sat back.

"Do you pray?" She looked at me intently.

"No." I squirmed imperceptibly.

"Do you believe in a god or a higher power?"

"No."

I thought she would change the topic, but she didn't. There was an unexpected pause. I moved uneasily in the bed. I was waiting for her to move on, to ask how I was feeling, to talk about the sunshine or the weather, to stop asking me these questions which were making me feel that I wanted to move backwards, out of her determined gaze. What came next was totally unexpected.

"OK, I'll pray for you."

She took my hands, bowed her head and began to pray aloud. I sat there, painfully uncomfortable. I vaguely heard the words but felt like I was watching the scene from afar—like I was floating above this strange scene. I hardly knew what to do. I reflected on of how much my life had changed over the last 24 hours. How well–laid plans had turned upside down, without my consent. How I had held my beautiful son just the night before. The son who had no heartbeat. How I had made it to full term and then let my baby die. While Dr. Copeland murmured, my mind flashed back to the day I first stood against the wall in her office, watching her pray with the couple after the miscarriage. I sat and waited. Again, I felt ill. I remember thinking: "this is not about me."

She finished, smiled at me, gave me another hug, and disappeared.

When she left, the room was quiet. I sat, alone again, now aware of nausea. I didn't know what to do when she started praying. It was so opposite of what I wanted. It was not what I needed in the stark emptiness of the morning. The sun shone in, belying my grief and sense of violation. I had not asked for her God to be brought to me. But I had been given no choice. Like my stillbirth, I had been given no choice.

That day I learned the flip side of religion in medicine—there may be times it can be used appropriately in a healing way, but it can also harm. Make no assumptions that it is always benign.

Doctor at War, Doctor Washing Feet

Luke Miller

This man is any one of my patients. Cancer is in his body, he has been told, and now this story has become connected with some fact of bodily functioning. The tumor is now in his brain, the MRI report says, and now some weakness, headache, confusion, or dimming of his sight corroborates this finding. In the white–walled clinic room he speaks with me, the resident doctor, as the attending doctor studies the pictures of his brain on a computer screen. He sits on the edge of the examining table, and his wife, or daughter, or concerned friend looks on. She is the one with the anxious face, the tightened lips; he is more open and still, relaxed into his position, sitting on the edge of this table in this white room, as the cancer sits inside him, growing and changing.

The neurologic exam starts from the head and works its way down, to the very end of the big toes; at least, that is how I was taught to perform it, and that is how it is organized in my mind, so that is how I must carry it out. There is the highest—the thinking skills that process the world and express it in intelligible language—and the lowest, the most distant nerves I imagine as simple conduits of a binary signal: off or on, yes or no. My exam, however, betrays this simple hierarchy of nerves. In everything I measure, there is some

participation of high and low, of brain and distant simple nerve.

Two years bridged college and medical school. I lived in Rome for four months during this time, learning Italian, visiting churches large (Saint Peter's, San Paolo Fuori le Mura) and small (San Carlo alle Quattro Fontane, Santa Maria della Vittoria). I had graduated from a small Midwestern Mennonite college, where most of the people I passed and greeted on campus every day were my friends (and relatives, given the tight–knit ethnic heritage of most Mennonites in the United States.) In my previous travel to Europe I had been studying Mennonite history with a class, tracing the stories of the Anabaptist martyrs, the ancestors of the Mennonites, and the centuries of persecution that started in the time of the Reformation and stretched to living memory. In my childhood their stories had mixed with stories from the Bible: the fires of the faithful burned at the stake, the tongue screws to keep them from witnessing to their beliefs as they burned, the Anabaptist prisoner who turned back during his own escape across a frozen river to save his drowning pursuer, giving his own life for his enemy's, like Christ. We are not a people of war, these stories taught us; we are a people of God's peace. We are not a people of this world, we were taught; my ancestors emigrated to Russia and North America to found their own separate communities to live out their vision of God's kingdom on the earth. We are citizens of a country, but do not pledge allegiance to a national flag. We will give our lives to save others, even our enemies, we are taught, but will not kill or do violence even to protect our own. In my travels after college, my story, the martyr stories, the story of my small people, seemed so minor next to the beauty of Rome, the aqueducts, fountains, bright mosaics, ancient churches made of heavy stone.

New images and new stories continued to fill my world as I began medical school. In a single afternoon's lecture the embryo became a blastocyst, and then exploded into a multitude of cells, folding as it grew. "My" cadaver, opened with a simple blade, presented new lessons for me every day: nerves to trace, organs to map, muscles and vessels to name. Inside the whole, the human, were a hundred organs, each with its own secrets and sicknesses, a trillion cycling cells.

Mennonites wash feet. It's a ritual, or as close as a non–sacramental, non–clerical community might have to a ritual. We do it every year. Sitting in a circle on the Thursday before Easter (often before a shared meal of soup and bread), I will bend low to wash the feet of the person next to me, and then my feet will be washed, and dried with an old towel. The basin of cooling water circles the room, and washing a neighbor's feet often ends with a hug and laughter. Jesus did this for his friends, and told us to imitate him. We must humble ourselves to serve others, and allow ourselves to be served.

In the white exam room, I bend myself over my patient's feet to test his proprioception, his inner ability to sense the position of his body's parts. He struggles to remove his shoes and to pull off his socks. I grasp his big toe, and he shuts his eyes. I ask him to tell me which direction I am moving it, and we breathe together and wait to know if his toe and his nerves and spine and brain still speak, still know each other fully. Afterward, still bent, I replace his socks, and then his shoes, and I don't feel like a doctor. It's an exhilarating moment; an escape from my role as a powerful being filling the room with my knowledge and presence. Suddenly I feel like I did when I was a teenager washing the feet of an old man, a man with a beard like my father's: small, humble, beneath him, connected by this small act of service, hand touching foot. Something in the room breaks; my egocentric self is gone. I feel almost sneaky, guilty, stealing a secret moment outside in the spiritual sun when I should be inside working. I am afraid my attending doctor might notice that I have broken this thing, and be annoyed, or impatient. He doesn't think I'm serious enough (I tell myself) as the moment ends. I don't know what the patient notices; he thanks me for helping with his shoes.

Mennonites sing hymns a capella in four part harmony. When I was young, and learning, I would watch the shape and curve of the notes on the page and fit my voice to the basses around me, as the hymns worked their way into me. Now I sing the

bass line strongly and confidently, although I can't sing a solo in tune. When I'm singing with Mennonites now, there might be a boy with my voice in his ear, vibrating to the music as he learns to take his part. During clinic rounds in the wards, or during a weekly case conference, I (like every medical student or resident) am often called on to answer a question about the evidence for a particular course of treatment for a patient. As I begin my attempts at half an answer, I find myself waiting for its echo to come back to me, for some resonance I can fit my voice to, guiding me closer to the right note. It rarely works. Speak clearly and confidently, a mentor tells me; the answer won't be given from the outside—it must come from within myself. There is no one to resonate with.

In the next room, a young woman has an aggressive cancer of the sinuses. An eye has been lost in the battle, and the enemy continues to grow and invade. Will I join her in her battle? Can I lead her to victory? Can I lend ammunition for the final counterattack, the honor of a valiant fight—if she is to fall, can she at least do so knowing she has been a courageous warrior? She wants to know, needs to know, if I am in this battle with her.

Military metaphors catch in my throat before I can utter them with any conviction. In my native language, the merciful and meek peacemakers are the blessed. In my medical world, fighting and battling are virtues. Living is surviving, and to die is to lose the war. Cancer is the enemy, and the enemy must be eliminated. Why do these metaphors have such power? Is there an enemy, and is he Death? Does he live inside you, growing and invading? When I meet my enemy, and he strikes my cheek, my long–taught instinct is to kneel, and to offer the other cheek. Who is your enemy, and can you learn to love him? Can I? This woman—my patient—needs to know if I will join her battle, and I answer "yes," but in my heart I feel that I must be answering another, secret question, a question I'm still straining to fully hear.

Doctors talk too much and don't listen, I'm told. I'm too quiet, I'm also often told during evaluations. My people have always been separate from the "world"—but here , in this world, my patients look to me and ask for healing. I once read the words of an Indian holy man, who said: when a sick man comes to a doctor, half of healing comes through the medicine, and half through the doctor's gentle, caring voice. I am still learning to use my voice, and to find the source and meaning of healing. Does this medical world have a place for the song I sing with my people, a favorite Mennonite hymn, "Will you let me be your servant, let me be as Christ to you? Pray that I may have the grace to let you be my servant too?"

A Prayer for the Dead, A Prayer for the Living

Vincent J. Minichiello

As a first year resident physician, I am just beginning to understand the responsibilities and the practice of medicine. I have difficulty telling people "I'm a doctor," because I'm not sure I believe it myself. And yet within the past eight months, I have already been challenged to mediate situations that bring me to not only fully accept my vocation as a physician, but also to grow on a mental level, a human level, and a spiritual level. In the following reflection, I recount one of those moments that occurred during a rotation in the medical intensive care unit.

At 6 p.m. I was coming on for my night shift knowing that the family of one of the patients I would be caring for had decided earlier in the day to withdraw medical care for their dying sister. The woman had been admitted to the ICU the previous night unconscious and in multi organ system failure—heart, lungs, liver, kidneys, all failed—as a result of chronic alcoholism and most recently drinking daily for three weeks with barely any other dietary intake. She was being kept alive with mechanical ventilation and three IV drips of medications to maintain her blood pressure. She was 45 years old. After a few more hours of saying goodbye, her sister came up to me and said that the family was ready to proceed. To withdraw care. I thought a lot about this phrase we use

"withdrawing care" that night. This encounter was the first time I had ever been the physician entering these orders into the computer. To me, what I was doing that night was in fact the complete opposite of "withdrawing" care. I felt, instead, that I was giving even more care. How?

First, by caring more for the patient. By making sure she was comfortably extubated, by helping to reposition her in the hospital bed in a way that appeared more natural, and by praying. I prayed that when we stopped the pressors and the ventilator, she would pass quietly and find peace in Heaven, when she perhaps found very little on Earth.

Second, by caring more for her family. It was my responsibility to guide them through this dying process, a process that I had only encountered two or three times previously in my life. I felt unsure, frightened, and nervous, not wanting to make a mistake or be inadvertently insensitive. Once again, prayer and what I perceive to be God's grace filled me with the love I needed to outline the process, to encourage family members to hold her hand and to speak with her while she died.

Once the medications were stopped and she was breathing unassisted, her lungs gasped once . . . twice. Was the soul being released from the body or was the body clinging onto the soul? And then, within two minutes, silence. I left some space to pause and then when the time felt right, stepped forward for the death pronouncement. "The heart is not beating, the lungs have stopped breathing" was all I could manage to say. Why did I remove the "she" and "her"? Why could I not say, "She is dead"? At the time I could not have answered those questions. Thinking back, I believe it was easier for me to vocalize that her body had simply stopped functioning, while I quietly held on to the belief that her soul continued to exist. Should I have held back as I did? Would it have been better for the family to hear that their sister was unquestionably dead? Perhaps. Nevertheless, the family understood, they cried, they held their sister's hand. And then let go.

At this point I took a breath, left the room, and without pause stepped straight into . . .

A 46 year old woman with a history of drug and alcohol abuse was being wheeled into the ICU on a hospital bed right in front of me as the door behind me closed. Her nose and mouth were caked with white powder and she was in the embrace of some hallucination, clawing at the air. She was incomprehensible, uttering gibberish. Her mother arrived a few minutes later—carrying a bag that she wanted to make sure her daughter had by her side. "Makeup," she told me, "She loves her makeup!" Bewildered, I asked what happened, and the mother related a tale that involved an unknown man over the Internet forcing her daughter to buy bath salts from Louisiana and then convincing her that she must take the bath salts while he watched or else he would hurt someone.

Stop! I felt like shouting. Stop! The shift was too fast for me—one minute deep in prayer, the next stumbling over an overdosed patient and a ridiculous story. And makeup?! I felt my self getting overwhelmed, my heart beat quickly, my face felt hot, my breathing quickened and my concentration was completely non–existent. I felt disgusted by this ludicrous situation. Angry that this new patient was destroying her body. If only she could see what had happened to my other patient—if only she knew what the consequences of her actions would be! And then cynicism crept in. Why bother? Why should I care for her when she clearly doesn't care for herself? She'll just end up dead anyway.

Looking back, I feel ashamed that these thoughts crossed my mind—all in a flash, all in a few minutes' time. And yet there they were. I cannot deny that. Afterwards I asked myself, "How may I be the compassionate and loving doctor–healer I have always felt called to be when I have such loathsome thoughts?"

I stepped out of the room, picked up my cell phone and called my wife. I was too frazzled to ground myself. As I spoke and she listened, I was able to distance myself from my visceral *reaction* to this patient and her situation. My heart rate slowed and the heat settled down from my head as my wife empathized with me. Gradually, I was able to perceive and *respond* objectively to the thoughts and emotions that had risen within me. The Buddhist community refers to this difference between "reacting" and "responding" to situations—reacting

being the quick, unchecked, often thoughtless reply (verbal or emotional) to a situation, while responding involves a non–judgmental, mindful reply to a situation.

So how was I able to return to this patient's room with the same love I had felt for my dying patient and her family? I acknowledged my feelings—the disgust, the anger, the cynicism. I took some deep breaths, having grounded myself with the help of my wife. With another prayer for God's grace, I made a choice to return. The choice was not easy—I did not want to go back to that room, honestly. What drew me back was my desire to show her and her mother the compassion and care they deserved as human beings.

I prayed that night—for the dead and for the living. While touching other people's souls that night, my own felt rattled, raw, and overwhelmed. And still, from that night came growth in my faith that whether I draw from my own Catholic religion or from other traditions, the healer's touch may always be found.

Incorporating Religion into Psychiatry: Evidenced–Based Practice, Not a Bioethical Dilemma

Mary D. Moller

For over sixteen years I was the owner and clinical director of an advanced practice nurse–managed outpatient rural psychiatric clinic staffed by APNs, a social worker, a licensed counselor and several graduate students. Many of our patients were victims of severe and often brutal trauma and abuse suffered at the hands of family, friends, and various professionals including spiritual leaders. We also uncovered sources of abuse suffered from those involved in occult practices ranging from seemingly innocent white witchcraft (Wicca, Paganism, New Age) that includes such activities as astral projection and remote viewing to the darkest possible black witchcraft (perpetrating evil, incanting evil spirits, casting spells and hexes, creating dissociative identities) such as occurs in ritual abuse and satanic rites. Both types of witchcraft also typically involved family, friends, various professionals, and spiritual leaders. Recognizing the controversy surrounding the reality of witchcraft I am sharing a story that I hope will help break down the barriers that prevent many patients from receiving the treatment that would provide the most benefit to recovery.

Seeking services for these patients led me on an intense personal and professional journey that included a profound Christian born–again experience at almost 50 years of age. My professional career grew in nearly indescribable terms as a result of the incorporation of prayer and deliverance ministry as part of the services we selectively provided. Today I always include assessment of spiritual experiences a patient has as well as spiritual supports that are available with every new patient intake. For patients who indicate that prayer is one of their supports, I ask if they would like prayer at the conclusion of the session. The gratitude that is expressed by individuals who appreciate being able to pray with a psychiatric provider is often profound.

In the field of psychiatry there has been a long–standing and distinct taboo regarding incorporating religious and spiritual aspects of life experience into treatment unless it is to frame most of these discussions within the context of psychosis. This stems from the advent of psychoanalysis in which religion was deemed a neurosis and atheism became the goal. Some still hold to that belief and there certainly remains controversy regarding the incorporation of prayer into routine outpatient or inpatient care. The essential starting point is the determination of accurate differential diagnosis, which can often be a lengthy process. The clinician must be careful about distinguishing between religious experiences and religious delusions, and often this takes time to sort out. The determination of the etiology of hearing the voice of God or the devil or demons must be carefully parsed and framed within the context of the situation and culture the patient describes. If the clinician denies the existence of God or the devil or demons or the practice of witchcraft, the patient's descriptions of such experiences will be quickly

labeled psychotic. The patient may then experience a lengthy hospitalization and treatment with psychotropic medications that can have an extremely negative effect on the possibility of recovery. Once I witnessed the level of healing that occurs with carefully administered spiritual interventions that are related to specific spiritual experiences that are based on the patient's belief system, there was no going back to using only allopathic medication and non–spiritual psychosocial interventions, even in spite of the criticisms from others. The key is to understand and respect the patient's belief system, if this is not congruent with the practitioner's belief system, then practitioner must refer out.

In the United States, an increasing persecution of Christianity and a devaluing of the Judeo–Christian heritage of our Constitution are creating a climate of intolerance to the expression of religious values resulting in an expectation that Christians should compromise their beliefs for the sake of political correctness. As a doctorally prepared psychiatric–mental health advanced practice nurse I experienced a profound born–again Christian experience that ultimately led to study of the Hebrew roots of Christianity and I now worship in a Messianic Jewish synagogue. It is impossible for me to not include the concept of spirituality into the assessment process and when appropriate, God and prayer, into my clinical work with patients. This has not come without intense criticism and scrutiny by others.

Here is my story. In 1992 I started the first outpatient rural psychiatric clinic in the United States independently owned and operated by advanced practice nurses. The clinic focused on providing private psychiatric services (50 minute visits) for public sector patients (Medicare/Medicaid) with serious and persistent mental illnesses (schizophrenia, bipolar disorder, mood disorders). My specialty is helping people with schizophrenia learn symptom management through improving wellness and health. I also conducted revolving 12–week series of weekly community education courses that focused on teaching patients, family members, and health care providers together how to understand and manage serious mental illnesses from a wellness perspective. One of the sessions focused on managing hallucinations. This class always brought in a large number of interested people. Many of those people started seeking services in our clinic and I was faced with the staggering fact that a number had been diagnosed with schizophrenia, but their symptoms were rooted in trauma and what they were really experiencing were *auditory flashbacks*, not auditory hallucinations. Many people with trauma–related PTSD frequently hear in their heads the negative and punitive voices of their abusers and this has often led to a misdiagnosis of a psychotic illness. This led to intensive study in trauma recovery, which had not previously been a specialty of mine. In the winter of 1997 one of our patients ended up at a local mission and I received a call from one of the program directors regarding his concerns about this patient that he didn't want to share over the telephone. He came to our clinic and delivered a presentation on the local satanic cults, which he was quite certain this patient had been involved with. At that point in time I was not at all familiar with any kind of cult activity and was of course intrigued, but didn't give it any further consideration. In fact, because of all the controversy about false memories I was reluctant to have anything to do with any aspect of evil. In March of 1997 a patient came from a great distance out of state to be evaluated for schizophrenia, having been in and out of the hospital several times with no success. Through the course of the interview I learned she had been a victim of repeated satanic ritual abuse at the hands of her father, the head warlock of a coven. At least ten times she reported she had been ritually impregnated and then ritually aborted to provide a live fetus for human sacrifice rituals. She had never spoken of any these rituals or her severe, horrific abuse before. In the back of my mind I wondered why I needed to be exposed to this, as it certainly was not in my skill set. Not realizing of course that this was part of God's plan for both my personal and professional life. I told her I believed her and, after explaining to her mother, I asked both of them to make the long drive home and immediately report this in person to their local police department. I never heard from her again.

In May of 1997 I had to have surgery and was literally flat on my back. Several years prior, I had been given a copy of the book, *This Present Darkness* by Peretti, which vividly describes cult and new–Age activities. One morning, the book was brought to my mind and I took it off the shelf. On page three my eyes were literally opened and I began to recall various patients that never seemed to get any better and I started wondering what else may have been in their background that had contributed to symptoms. This led to intense personal introspection as well as a new developing worldview in which to evaluate patients who described and experienced psychiatric symptoms that didn't fit typical diagnostic categories or treatment paradigms. I began to explore the concept of evil and was greatly influenced by *People of the Lie* by Peck. I then started studying spiritual deliverance as a method of healing beginning with the classic book *Pigs in the Parlor* by Hammond & Hammond. Although disturbed by what was written in that book about schizophrenia, the ability for victims of violence, trauma, and abuse to receive spiritual healing was something that called to my soul. Recognizing that spiritual healing was not in my skill set, I reached out to the local Catholic Church to discuss finding help for these patients. I was strongly encouraged to not have anything to do with this type of work or learning about cults. After being rejected by three different priests I started looking at other churches for assistance. In my area, I learned the local Assembly of God pastors were experienced with this type of work having been located in various communities where these activities were occurring. This led to several intensive years of personal and professional growth that ultimately resulted in several trips to Israel and a deep love of and daily dependence on the Bible. I attended conferences and engaged in focused training on Christian deliverance and met many psychiatrists and psychiatric advanced practice nurses who were discovering the same things in their practices. I was always cautioned about not talking about these experiences.

In the fall of 2003 I was invited to speak at the International Conference of Police Chaplains and delivered a talk entitled "Is It Schizophrenia or Is It Satan?" I relayed the story of the woman who had come to my office six years earlier stating I had never heard back from her but felt that she was okay. There just happened to be two police chaplains from that particular city who confirmed that the patient had indeed reported the situation to the local police and that the coven in which her abuse had occurred was shut down and her father was in prison. This confirmation is what has given me the boldness to talk about my story.

I strongly encourage every psychiatric provider to explore their own personal spirituality in order to have a point of reference to explore the same with patients. For me, the beginning question is always 'do you find prayer or meditation helpful'. Not only is this question in keeping with the JCAHO requirements for spiritual assessment, but it also allows the patient to know it is not an off–limits subject. Providers need not fear when patients share unfamiliar and seemingly strange spiritual experiences, but rather look at the situation as an opportunity for personal growth in both the patient and the provider. I recommend that you develop a list of spiritual leaders of various religions and denominations that you can refer patients to. You may be the first person that truly leads your patient on the path to complete recovery—body, soul, and spirit.

The Right Thing to Do

Jane Rogers

In stark contrast to getting my graduate degree in bioethics in which I discovered that I am inclined to favor an ethics based on my religious beliefs, in nursing school I learned that I had to take my religion out of nursing care. As a bioethics student, I read in my textbook, *Bioethics: A Systematic Approach*, that " . . . just because an action is rationally allowed does not mean that everyone agrees one ought to act in that way." Yet often in nursing I found that we nurses knew what was best for our patients, even if they did not. At least, we believed that we did. This general paternalistic belief spread into every area of the care we gave except for one, and that was religion.

As student nurses, we learned to separate our religion from our care to focus on the patient's religion or spiritual needs. Our patients should never know of our religious beliefs or even if we had a lack of them. We needed to be completely neutral on all religious issues and focus solely on the patient's preference. If our patients needed spiritual care, we would find someone to provide it and we would incorporate it into the nursing plan of care. Providing care of the whole patient including their religious needs was the definition of a good nurse. Certainly I wanted to be a good nurse, so I swore I would always include the spiritual needs of my patients as part of my care, while never expressing my own.

As fate would have it, as a new nurse I found myself overwhelmed running around just trying to give medications, admit and discharge patients, start IV's, insert catheters, note doctor's orders and get my charting done. My time was engaged in trying to calm confused and combative patients, running to grab an emesis basin for a patient to throw up in or answering the phone, so thinking about religion or spiritual care for my patients most of the time amounted to "God help me and my patients get through this shift." My goal of being a good nurse was starting to look dismal as I realized I had no idea if I could find the time or means and ways to incorporate religion into the care I gave, or if it even mattered if I did.

Fortuitously for me, most of my patients never mentioned religion, although at times they did leave some nonverbal clues. I could see a rosary laying on a bedside table or a bible or prayer book next to them in bed. While I would make sure their religious item was always within reach, I remained respectful yet distant in religious matters, never offering any spiritual care or assistance. I was quite accepting of my first Mormon patient wearing the garment under the traditional hospital gown. I was appalled when an unconscious Jehovah Witness patient was nearly given blood. When a minister or priest came to visit, I'd excuse myself quickly so that the work of their God could do what I could not or should not do. Occasionally I was asked by family members to call in a minister or a priest or chaplain and I did that with a great feeling of satisfaction as I was surely providing the spiritual care they requested.

Eventually however I did start to indulge in highly spontaneous and random acts of religion. These were always done secretly. The patient or family must never know. Thinking it would help I once covertly gave a patient a special rosary I had with Lourdes water in it thinking it might heal him. I waited to see a miracle. It never came. Despite the absence of that miracle I was still hopeful that perhaps my prayers or another rosary could heal or at least help some of my patients. After all, as a nurse I witnessed lots of healings that astounded me. People I never thought would get better sometimes did anyway.

Although I was cognizant that some healing was the direct result of superb medical intervention and excellent nursing care, there were always the few cases of those who surprised even the most jaded members of the healthcare team, those whose cure or recovery from illness baffled all. Perhaps it was the power of prayer. No one knew I was praying for them, and so that meant there could be many clandestine prayers from many nurses or others in health care going up to the God we believed in. I didn't think about praying much, I just did it.

Years passed and many things in medicine and nursing changed. Still one thing I could not do was to ever tell my patients that I left them a rosary or that I said prayer after prayer for them. I was after all still the neutral non–denominational nurse I had been taught to be. I was always going to do the thing I had been trained to do.

But was I really doing what I had been taught? I prayed to God to make them well. I begged God not to let them die. I Pleaded. Bargained. Left a rosary or two. Occasionally I had a temper tantrum yelling at God in my car driving home from work. But I kept praying for them even though my job was to be their nurse not their minister. I needed to facilitate things so that their family and friends could pray, not so that I could. To call the priest when they wanted me to, not when I wanted him there. I was there to help their pain, to feed them, to change their sheets, to fluff a pillow or warm a blanket when there was

nothing else that I could do. After all, I was the non–spiritual nurse who met their spiritual needs yet I might have been meeting my own.

Many years went by and I in due course got a master's degree in bioethics. It suddenly troubled me that I had done those things. It really conceivably wasn't ethical for me to leave rosaries and worse, to pray for someone who had no use for my prayers and would even possibly be quite offended to think or know I had done such a thing. In fact I thought how would I feel if for example, a witch said prayers for me? So now in this ever–growing secular society I feel determined to make certain my patients never knew what I'd done, or was still doing.

I never did and never would be able to tell the young husband about the nights and days I cried over the loss of his wife, the mother of his three very young children. After all, I had three young children too and I knew they needed their mother as much as their mother needed them. I shouted at God. I bawled, like a baby, lost in a dark tunnel of grief. I thought the world had ended for me. I had only known her for a few weeks. How could I share my pain with a family who had much pain already? I couldn't so I prayed that God would comfort them and me.

I begged daily for God to save the life of a patient that I cared for as she felt like a friend. I enjoyed her and didn't want her to leave me. He took her from me anyway. I prayed that patients would not suffer, that their pain would ease, that they would sleep. I prayed that a doctor wouldn't yell at me when I called at three in the morning and that the day shift staff would come to work. I prayed that families would visit lonely nursing home patients I had, or that we could have more staff. Some prayers worked, others didn't. I still kept on. I prayed for a family member to be able to let go of a loved one so we could stop doing so many hurtful procedures on her. That prayer worked. I'd pray in the patient's room, outside the room, in the work area by the nurses' station, in my car and in my bed. No one knew. It had to be that way. It still does.

Most of my patients will never know my religion. I'll tell them if they ask, but otherwise they won't know. They will never know how I prayed for them or their families. They won't know because at first I wanted to be the best nurse for them and later I wanted to do the morally right thing for them. Maybe praying in secret was part of that; maybe surreptitiously leaving a rosary was the best nursing care I wanted so badly to give to them but wasn't really supposed to be doing. Was it rationally right to pray if no one knew? Did it harm the patients or help them? In the end all I hope is that it mattered in some way that was beneficial to them. But maybe more than that, I hope it was the right thing to do.

In Search of Faith

Kate Rowland

Sometimes I'm jealous of my patients' faith. As a former happily religious person I miss the benefits I used to get from an active faith. I know that some of my patients must struggle with their faith, and I know the struggle probably affects their well–being. For those who simply believe or those who simply don't believe, it's easy. And for those who do believe, there can be so much serenity and so much reward.

As a doctor, I spend a lot of time reading science, weighing evidence, and making recommendations. Religion has been a respite from this. Faith, for me, has never been a series of decisions based on the best available evidence. I could analyze it as much as I wanted, peel its layers apart, question it, but in the end, it was just faith, not a hypothesis. It has always been something that I believe (or don't), and practicing my faith had always been a relatively pleasant decision of figuring out what kind of community I want to share in.

My faith life has been in shambles for the past several years. I feel distant from and unwelcome in the church where I was raised, and I haven't found anywhere else to land. I cannot decide how to raise my own small children. I want them to have grounding in God, but I can't decide how much I believe in God anymore, and I am fixated on the idea that I don't want to be hypocritical or lie to

them. I don't want them to see me worshipping in a way that is not really authentic to me.

My husband is agnostic—literally—on the issue. He is open to introducing a loving, kind, forgiving God, but unsure about a God incarnate. We both worry about the identity with a particular religion usurping the actual relationship with God: I am [religion], therefore I believe [this], therefore my God does [*this*] or is [*this*].

And so all of these fears and doubts have led us to live with no religion, and no outward faith. Our children attend a parochial nursery school run by a religion other than one where we were raised, and they have an apparently happy but neutral opinion of religion and God. They understand ceremonies. At age four, they have a more active faith life than I do, since they attend weekly services at school. But then, they have fewer choices than I do. They do what the teachers tell them. They would do what I told them to do, if I could ever decide what I believed in.

I spend so many hours a week with my patients that they have become my main source of demonstration of active, living faith. I know that they share mostly good parts with me. I see so much of the good because I mostly see patients who get to choose how to practice their own religions; they don't feel oppressed by religious or culturo–religious demands or expectations. It's interesting that I see the positive sides of their faith, not the struggle, because I otherwise see a lot of the struggling parts of their lives. I see the flinty, edgy woman, the patient who has spent more time in the hospital in the past month than I have, the woman who is sick of her low platelet count that keeps her from living a normal life. And every day she has some message of faith: she tells our medical team what Bible passage is keeping her strong, she tells us how God watches over her when we tell her that her counts are better, she tells us to have a blessed day. Sometimes she curses at the hospital or her condition or at her medications, sometimes at us. So far her faith is unshaken.

I take care of a woman who has burning mouth syndrome, a chronic condition that causes her lips, her tongue, and her palate to feel as though they are on fire. Eating makes it worse, drinking makes it worse, breathing makes it worse. We worked together for months, first to diagnose and then try to find medications and therapies that would alleviate the pain. We started with pills for neuropathic pain, and she was back in a few weeks. Side effects, she said. She couldn't take them. We tried a different one. She lasted two months on this one, then a third month on a bigger dose, but it made no difference in her pain and cost her $80 for a non–preferred medication, so she stopped. We tried a tricyclic antidepressant that she stayed on even when it made her deliriously groggy.

I was starting to dread seeing her. I felt terrible that I was not able to help her. And then one day I walked into the exam room, and she seemed happier than usual. She was usually pleasant. But that day she was . . . happy.

Doctora, she said. I still have the pain. It is as bad as ever. But I have decided to give it over to God. I will take the pills if you think I should, whatever I can do to take it away, I will do. But if God wants me to have this pain, then that is what will happen. And when he wants it to go away, then it will go away. I trust in God.

We both felt immensely better. She felt secure and happier because she let her Almighty have control. I was relieved, somewhat, of the burden of having to find a cure or a fix for her pain. My patient used her faith, her religion, her understanding of God, to give context and meaning to her condition. I wonder what I will do when I am in her situation, what I will draw on to explain my pain.

Another patient chanted "Jesus is in my heart and in my soul" to get her through a very difficult labor. She could have chosen something else, but for her, it was the belief that Jesus really was in her heart and in her soul that moved her through to the eventual birth of her son.

One of my patients sustained a musculoskeletal injury during her church services. I told her I had never known anyone to get hurt by praising the Lord.

"You have never been to my church," she said.

"Maybe worship with your other hand next week," I suggested.

"Okay, but you know I'll be there. It fills me up."

Over time, she developed another, more serious (non–church–related) musculoskeletal injury that led to a chronic pain condition. At one of our office visits I inquired about her mood.

"I'm okay," she said. "If I start to get depressed I just pray it away. Keeps me from getting worse."

I felt such envy! Even if that model of mental health care is not an ultimately successful one, even if it someday keeps this patient from accepting the conventional medical care that I might recommend, her faith gives her a place to land. She can always return to it, even if the pills fail and even if the pain returns. It doesn't depend on side effect profiles or comparative effectiveness or a number needed to treat. I felt like she was better off for having it.

I know that, as their family physician, my job will never encompass a real understanding of my patients' faith lives if their faith is anything other than simple. I probably rarely have a good understanding of what my patients' faith lives mean to them. Religion and faith are so important to sickness and wellness and healing for some people. But if they are not a "yes, please" or a "no, thank you", I won't ever be able to spend the time with them to learn the nuances of their faith life. If I were a patient, I wouldn't understand my own faith situation, even though it matters to me.

For now I meet people with my mind open. No one has to believe in God in my practice, and lots of my patients don't. I'm open to that—I think it is a way of believing. For my patients for whom God is a really important factor in their lives, I'm open. I understand how it matters, and I wish I joined them. I miss having that part of my life that could be questioned and prodded, but since it wasn't science, didn't have to be held to the same scientific scrutiny as my work. Faith is as nuanced and complicated as science can be, but in the end, it is always unknown. I could believe whatever I believe and not feel bad about just believing it.

So until I can share the benefits of faith by having a robust faith myself, I will share in the benefits of my patients' faith. Most of them are happy to tell me about the good while we share in the good and bad times of their lives. I may not be able to thank God for my patients, but I'm thankful for them.

The Oldest and Most Respected Uniform in the World[1]

Zelig R. Weinstein

> "And all the peoples of the earth shall see that the name of the LORD is called upon thee; and they shall be afraid of thee." (Deuteronomy 28:10)

Rabbi Eliezer the Great says that this verse alludes to the Tefillin Shel Rosh, the small leather box containing Biblical verses that are worn by Jewish men on their head. During Talmudic times and for centuries after, devout Jewish men would wear Tefillin the entire day. This practice is now only rarely seen. Since the 1960s, there has been a resurgence of public display of one's adherence to traditional Jewish practices. It is increasingly common to see Jewish men wearing a yarmulke at work and in public spheres. There are perhaps thousands of Jewish doctors who don't hesitate to wear their yarmulke in their places of practice–hospital, clinic, private practice.

In the 1980s I joined the staff of the Department of Radiology at the Bethesda Naval Hospital as the Director of Neuroradiology and Interventional Radiology. As the hospital's Neuroradiologist I presented the radiological findings for the cases presented at the bimonthly "brain cutting" sessions. These sessions were well attended by staff, residents and medical students from the Departments of Neurosurgery, Neurology, Neuropathology and Radiology. I was the only traditional Orthodox Jew at the hospital, clearly recognizable as such by the yarmulke I always wore (very unusual in the early 1980s). My yarmulke would provoke occasional good–natured kidding particularly from the neurosurgery staff and residents.

1 All names have been changed to protect privacy.

During one of these sessions, kidding about my yarmulke from a small group of residents was reaching a crescendo. The kidding came to a sudden halt when the Chief Resident of Neurosurgery, a born and bred Louisianan, demanded everyone's attention. When it quieted down he very sternly ordered everyone to carefully look at their uniforms. Everyone seemed perplexed but all followed suit. Almost a half–minute passed before the Chief Resident, with his thick Southern drawl, spoke. "Our [naval] uniforms are, at most, a couple of hundred years old." He then pointed toward my yarmulke and said: "Dr. Weinstein's uniform is thousands of years old and a lot more respected than our uniforms."

This was my initiation into the alluring, usually positive and unexpected fascination and respect that my obvious religiosity had on my patients, their families and my many colleagues during the almost seven years I spent at Bethesda.

The story I will tell is very poignant. It involved the family of one of the most senior Chief Petty Officers of the United States Navy.

Late one Sunday evening, I received a call from the Chief Resident, Dr. Steve Henning, informing me that the family matriarch had been admitted to Bethesda with relatively acute onset of significant neurological findings. The emergent workup confirmed the presence of a large mass, a meningioma, of the frontal lobe region with significant surrounding edema and mass effect. Neurosurgery requested embolization of the feeding vessels prior to surgery. The interventional procedure and possible serious complications were fully explained to the patient, her husband and her two daughters. Consent was signed and early Monday morning the patient was brought to Special Procedures to have the tumor embolized.

Prior to the procedure I introduced myself to the patient's family and spoke to them about the procedure. The patient's husband and two daughters, one of whom was an active duty Navy nurse the other a minister of a fundamentalist church in the South, were very attentive and expressed concern about the procedure and its outcome. I tried to reassure them and told them I would speak to them during and after the procedure.

All went well. Medically, the patient did well during and after the procedure. She was discharged from our care to neurosurgery. The patient and her family thanked us.

After the patient left the Special Procedures area the Chief Technologist, Al, approached me and very cryptically asked if I was aware of what happened when the Chief Resident, Dr. Henning, spoke with the patient and family the night before. I was puzzled and replied, no. He then proceeded to tell me the following:

When Dr. Henning spoke with the patient and family about the procedure the night before, they were very attentive and expressed their concern about the procedure and possible serious complications. Each member of the family carefully reviewed the written consent. When the daughter, the minister, reviewed the consent and saw my name on it she became very excited. She turned to her mother and ecstatically proclaimed: "Ma, Dad; we must thank the Lord and give praise to Jesus. Our prayers are being answered. We have a *Jewish* doctor treating you." When he told me this, I smiled broadly and said to Al that hearing this had made my day. I started to walk away but was stopped by Al. "Dr. Weinstein, Sir, what I have told you is not even half the story." He then told me the following:

Dr. Weinstein, earlier this morning when you came through the doors to the Special Procedures suite the patient's daughter who is a minister saw you when you arrived. It seems that she not only saw you, she must have somehow seen your yarmulke. Immediately after catching this glimpse of you she turned to her mother, and very excitedly exclaimed "Oh my G–d Ma, the Lord has surely answered our prayers. Not only is Dr. Weinstein Jewish, he is a devout religious Jew! Hallelujah, praise the Lord!"

I was unable to respond, as I was deep in thought. I remembered that when applying to medical school I was advised by family and friends not to wear my yarmulke for any interviews. I did not want to be defiant in the face of this advice but felt very strongly about expressing the pride I had in identifying myself as a devout Jew. I did pay

for my pride; I had interviews that were clearly unsympathetic with my display of pride in my identity.

These stories happened almost thirty years ago. They have had a lasting impact on me and how I see myself in the larger world and in my chosen profession. The impact on me surely has affected how I see and deal with the numerous patients I have been and am privileged to care for. There is no question that the relationships I have with all my colleagues have been molded by my identification as a devout Jewish doctor.

The yarmulke is a powerful symbol, capable of transmitting powerful messages. It serves as a constant reminder that G–d is above us at all times. This reminder helps to create a sense of humility, a character trait considered so important in Jewish ethical writing, that everyone is urged to cultivate this character trait, even to the extreme. Occasionally even we doctors could use a small dose of humility to serve as a reminder that we do not have all the answers.

For me the yarmulke has enabled me to have what I would characterize as transcendental experiences with patients, patient families and numerous colleagues with whom I have been privileged to work during three decades of practice. During all my years of practice there have been many times when I was acutely aware that being a devout Jew somehow provided enhanced reassurance and comfort to patients and their families. Being cognizant of this effect has placed an increased responsibility on me to excel. After all "Ma, Dad; we must thank the Lord and give praise to Jesus. Our prayers are being answered. We have a *Jewish* doctor treating you." Fortunately I have rarely encountered outright hostility or even negative feelings because I am an obviously Orthodox Jewish doctor.

Most importantly, the stories I was a part of and have told remind me of the awesome responsibilities I, as a G–d fearing Jew, have when caring for G–d's creations. I frequently will read and ponder the Prayer for Doctors, which is attributed to Maimonides. Most importantly I hope that as long as I practice I will follow the dictates of Maimonides who so compellingly prayed to G–d asking that He "Inspire me with love for my art and for Thy creatures . . . Preserve the strength of my body and of my soul that they ever be ready to cheerfully help and support rich and poor, good and bad, enemy as well as friend. In the sufferer let me see only the human being."

Revelation in Triage: Faith Illuminating the Clinical Encounter

Morgan Wills

It was a stormy spring night outside a local hospital. As the tired, "moonlighting" physician covering the small emergency room that evening after a full day at my own internal medicine practice across town, I was thankful for the turn in the weather. It usually meant a lighter volume of patients who were not truly sick. Sleep–deprived as I was already from the not–so–circadian rhythms of our three young children, my hopes were set on a "light" night shift at the hospital, perhaps even a little shut–eye. Spiritually charged patient encounters were the furthest thing from my mind.

Around 1 a.m., however, my hopes were thwarted by the arrival of one more patient just as the place was emptying out. Finishing up a note on the computer, I noticed an apparently healthy young man walking into triage. Two of the nursing staff were rolling their eyes at each other in sarcastic, knowing fashion.

The signs were clear: we had a "frequent flyer."

I quickly scanned his electronic medical record to see what was coming. I learned that "Nick" was a 27 y.o. veteran from an outlying small town. He had a history of a low–grade astrocytoma, a type of brain cancer, and had undergone a successful surgical resection, chemotherapy, and radiation. He was no longer immunocompromised and was being monitored regularly in the oncology clinic. Despite this, he had also presented over half a dozen times in the past year to the emergency room with vague complaints that were concerning to him for a recurrence of the tumor.

As the past medical history emerged from the pixels on my screen, I began to rehearse my cranial nerve exam, anticipating the need to "rule him in or out" for an intracranial mass. Sure enough, Nick's symptoms—some ill–defined dizziness, numbness in a non–dermatomal pattern, and occasional nausea—did not suggest any serious pathology. His neurological exam was similarly unrevealing. I did my best to listen empathetically, explain the lack of cause for alarm, and reassure him that he could safely wait to be seen again at his routine oncology clinic visit the following week. Above all, I would not be calling in the radiology team from home to do cranial imaging in the middle of the night!

Nick did not seemed to buy my explanation, but he agreed to wait for his routine lab tests to come back before making our final judgment. After getting his discharge orders ready, I trudged off to the call room to lay down. About a half hour later, the nurse notified me of the lab results: completely normal, as expected. I gave her the go–ahead to share the results with Nick and send him home. I then rolled over to get some sleep at last. Game over!

Or so I thought. Just as my lids were getting heavy, I started having my own set of vague symptoms. There was a growing sense of unease in my mind and body. Second thoughts. Justifications. A vague nausea. It did not take long for me to recognize the tell–tale signs of a guilty conscience.

As a practicing Christian, I also interpreted this process in spiritual terms. I was being convicted of sin—awakening to the ugly reality that my heart was, in the words of St. Augustine, "curved in on itself." I cannot say that I consciously called to mind the obligations of the Hippocratic Oath or some specific words of Jesus from Scripture (such as his radical exhortation towards hospitality in the 25th chapter of the gospel of Matthew), but I increasingly somehow *knew* that I had failed Nick and myself by pawning off the messy work of patient care that I needed to finish.

And so I went back down to talk with Nick. I walked down the stairwell slowly, prayerfully. In devotional terms, each step became a miniature form of repentance—a "turning" of my heart back towards God and others. It's never fun to admit you're wrong, as I soon did with the nurses and Nick himself. It is definitely a lot easier, however, when you are convinced that you are loved. And if there's anything that my faith teaches about God, it is that he loves us in a deep and costly way. In this light, my repentance was humbling, but it was also freeing. It became, for me, the "on–ramp" to a bigger story of the Spirit's work in the world.

Freshly aware of my own failings, I approached Nick with a different mindset this time. He still wanted a complete tumor workup; but instead of resenting his fixation as an impediment to my own rest, I found myself instead growing curious about this young man and his story. What would motivate him to badger the health care system in this way? What was he crying out for—really?

At this point, old habits kicked in. I normally practice medicine at a nonprofit clinic for the uninsured, where the majority of patients are refugees and immigrants from other countries. Due to limited resources and complex presentations, extended social histories are often the key diagnostic tool. And so I found myself asking for Nick's backstory. Perhaps not surprisingly, he began to let his guard down a bit. After learning about his family life, education, and military service, I asked him about his faith background. Was there anything here that might influence the way he approached his diagnosis and treatment?

Nick grew visibly suspicious at this question. I could tell that he was sizing me up, as if to assess whether an MD could be trusted with this part of his story. Then he blurted out, somewhat defiantly, "I'm a pagan." I quickly grasped the significance of what Nick had just shared. Knowing the area well, I was pretty sure that there were not many, if any, other self–identified pagans in Nick's rural Tennessee community. He had evidently chosen a very against–the–grain spiritual path. Yet as one who came to my own personal experience of Christian faith later in life, I identified with his intentionality.

"Cool," I answered. "Tell me more about that."

At that point we were off to the races. What followed was less "history–taking" than a late night, mutual dialogue about fear, faith, science, and even rudimentary epistemology (the study of how we

can know what we know). It turns out that Nick had been seeing an alternative medicine healer who was reading his energy fields. That same day, the healer had insisted to Nick that his tumor was recurring. At no point had any of the clinic notes commented upon this alternative medicine practice—nor had Nick been inclined to tell his doctors.

In the spirit of bridge–building, I reciprocated with Nick by sharing some of my own life and faith story. I acknowledged that I—as a believer in a living, personal God—agreed that there were forms of knowledge that could not be verified on a scientific basis. In fact, I explained, I had just experienced such a "revelation" upstairs! (At that point letting his guard down further, Nick exclaimed, "So you're a *real* Christian!") But I also shared my conviction as a physician that the two forms of knowledge were not always in opposition, but often complementary. It required experience, wisdom, and community to discern the difference.

At this point, Nick surprised me again by asking me to pray for him. When I reminded him that the only way I knew to pray with integrity was as a Christian, he was unfazed. As one who is used to engaging some of my continuity patients at this level, I complied with his request. We bowed our heads, held hands, and I prayed—briefly, instinctively, and out loud. Perhaps channeling his childhood background in the church, Nick joined me in concluding with an audible "Amen."

To be honest, I do not remember the precise words of this prayer, nor do I think a record of them would adequately convey the reality of what happened. What I do know is that we both felt a tremendous sense of peace and relief afterwards. Nick and I agreed to disagree, but he was willing to return home with follow–up at the oncology clinic a bit sooner than previously scheduled. Meanwhile, I took pains to document the encounter in the medical record—the first time in close to a dozen visits that any reference was given to the spiritual determinants, which were driving Nick's disproportionate utilization of the health care system.

What did I learn from this encounter about the integration of faith and the practice of medicine? I think the first point to note is that the most overlooked locus of spirituality in the clinical encounter is often in the heart of the physician him– or herself. As I have told this story to colleagues and students in subsequent years, they tend to fixate on Nick's hidden use of alternative medicine or the act of spoken prayer with my patient. But in my mind, the critical dimension was the unspoken dialogue in the call room and stairwell. The humbling self–knowledge I received there opened my mind's capacity to learn clinically relevant knowledge about my patient. As Socrates would say, it is critical for the clinician to "know thyself."

A second lesson concerns the importance of developing practical wisdom in this arena through the formation of habits. As a clinician who has worked frequently in cross–cultural and faith–based clinical settings, I have developed hard–won familiarity with various approaches to spiritual history taking and how to negotiate a culture gap in the clinical encounter. Along the way, I have also made plenty of mistakes! But as long as the engagement has been a component of authentic, patient–centered relationship building—and not merely a mechanical checking of boxes—patients have been remarkably forgiving of my missteps. In fact, such patients actually seem appreciative of such compassionate risk–taking, even when we come from vastly different faith backgrounds.

Finally, I would say that this encounter encouraged me all the more to bring my whole person to the care of patients. Not every encounter will merit this degree of self–disclosure. And we need to be continually wary of unwittingly exploiting a power imbalance to foist our own belief systems onto our patients. But as Nick's case reminds us, the implicit materialism of modern biomedicine can be just as oppressive for some patients as any "religious" belief system. Until we recognize this—or perhaps until it is "revealed" to us—we may miss out on the some of the most rewarding and deeply human elements of medical practice. Not to mention spending a lot of unnecessary time and money!