THE REBIRTH OF THE CLINIC

An Introduction to Spirituality in Health Care

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Introduction

Foucault's clinic is dead.[1] It was born afflicted with multiple, fatal congenital anomalies—a monster that struck terror in the hearts of many people even as it was slowly dying. Foucault's "clinic" refers to the scientific, pathological approach to medicine that emerged between the Enlightenment and the establishment of university clinics in the nineteenth century. It became the dominant form of Western medicine and persisted as the model throughout the twentieth century. Previously, sick people went to hospitals run by monks and nuns, if they were poor; if they were rich, doctors came to see them in their houses. With the rise of the clinic, however, Foucault saw the meaning of medicine change. With its scientific foundations and empirical successes, the clinic became medicine's living laboratory. Sick people came to a place where the doctors were in control. This shift in location heralded a shift in meaning. With the advent of the autopsy and anatomical pathology, diseases were analyzed by their visible effects on inner organs. Later, pathophysiology emerged as a mode of seeing diseases invisible to the untrained eye. With the birth of the clinic, Foucault saw the fundamental norms of medicine transformed. It became a practice of power; a form of control; a scientific discourse; a form of applied engineering. This revolution in medical practice brought innumerable technological advances and improvements in health, for which the world must be grateful. Despite its intelligence and giftedness, however, Foucault's clinic harbored a fatal illness. And now it has breathed its last breath. Managed care is simply its coffin.

In truth, the clinic was nearly dead by the time Foucault gave it a name. Patients left it for dead decades ago. Now even the clinicians, the

masters of the clinic, have begun to acknowledge that the corpse is stiff and cold.

Where will they go, however? To whom will the sick and their healers turn?

Some have sought refuge in the new clinic of regenerative medicine, where promises of immortality are wrought from somatic cell nuclear transfer. The wise ones, however, have recognized that regenerative medicine is nothing more than the sick progeny of Foucault's clinic, bearing the same fatal congenital afflictions, worse still in each succeeding generation. Others have run to integrative medicine, seeking immortality in chants and macrobiotic diets. This trend also will pass.

Yet the desire for a new form of medicine is real and deep. People today are not ready to give up scientific progress and all that it has to offer, but they rightly sense the need for more. Their desire is spiritual. They want a form of medicine that can heal them in body and soul.

The problem with Foucault's clinic was that it was born without a soul. Paraphrasing Foucault, Ivan Illich writes, "The French Revolution gave birth to two great myths: one, that physicians could replace the clergy; the other, that with political change society would return to a state of original health."[2] Foucault's clinic promised a form of medicine that was liberated from the trappings of religion and based on science and reason. Yet the power of science, untethered from religion's moral constraints, became the source of its corruption and death. The clinic suffocated in the unanticipated by-products of medicine practiced as a merely scientific enterprise. Patients came to feel like scientific specimens rather than human beings. Iatrogenic conditions (illnesses caused by medical practice) grew steadily more prominent with every scientific success. Some side effects have been even more social than biophysical. Children who benefit from scientific medicine and do not die at the age of five now live long enough to develop Alzheimer's disease. Scientific success in treating infertility through *in vitro* fertilization is now the leading cause of premature birth. The solutions to these problems, as proposed by Foucault's clinic in its last dying days, had been diagnostic of its affliction—more nursing homes, more neonatal intensive care

units, more research. Empathy and mutual acceptance of the frailty of our common humanity had come to be considered anachronistic.

The clinic had grown morbidly obese, fattened by the false promises of a scientific practice untempered by humility and unchastened by awe. Medicine came to eschew the mystical. It became blind to the mystery *within* the person of the patient and blind to the mystery that lay *beyond* the range of its scientific gaze. Having reduced the patient to a lifeless corpse—a pathological specimen—the clinic was already participating in its own death. Then, at its apparent apogee, having reduced patients to lifeless and inanimate molecules, the clinic itself became lifeless and inanimate. That is what it means to be dead.

All living bodies need souls. Otherwise, they are formless and lifeless matter. Clinics too need spirit if they are to minister to needs of the living, soulful bodies of the ill and injured human beings who enter them. The death of Foucault's clinic is an inherently unstable historical anomaly. Human beings, body and soul, still become sick and die. Other human beings still reach out to them, to help them in their bodily need, motivated by forces deep within their souls. Hence, we should not be surprised that around the globe there are signs of clinical reanimation—signs of a spiritual awakening in health care. In the twenty-first century, the clinic is being reborn.

People who are sick are looking for what Foucault's clinic failed to offer them. They seek a form of medicine that treats them as persons—a form of medicine that acknowledges what science cannot see or hear or accomplish. They want a form of medicine that does not abandon science but also does not eschew the mystical. Often, they seek this ideal in alternative forms of medical care. Most, however, want soul medicine and scientific medicine at the same time.[3] Numerous volumes about spirituality and health now fill the shelves of bookstores, catering to those needs. Physicians, nurses, and other health care professionals also are exploring the spiritual aspect of care. Some are experimenting with various means of incorporating spirituality into practice. Others are conducting empirical investigations of the effects of spirituality and religion on patients. Still others are taking stock of the spiritual lives of the people who provide patient care. Nursing schools have taught spiri-

tual assessment for years, and courses in spirituality and health care are now becoming common in medical schools.

Yet little of this trend has been subjected to a careful examination. Not all attempts to reanimate the clinic are spiritually healthy. Critics inside and outside the healing professions are raising serious questions about what calls for reintroduction of spirituality into health care mean. Some observers seem to suggest that we should abandon centuries of scientific progress for a new form of spiritual medicine. Others reject all attempts to reintroduce spirituality into health care, fearing that it is nothing more than a disguised form of religious intolerance. Many scholars are conducting research about spirituality and health care, but without any sound theological reflection. Others reject all scientific studies of spirituality and medicine as a series of methodologically flawed investigations designed to proselytize in the pages of medical journals. Thoughtful health care professionals want to know if there is any serious, reflective basis for thinking about spirituality and health care. Above all, they want to know how it might affect their practices. This book attempts to answer some of these questions.

In part I, I explore the nature of illness and the nature of healing in an attempt to establish a solid foundation for reflection about spirituality and health care. I analyze a 2,200-year-old historical text in search of some guidance and attempt to sketch a historical dialectic of the relationship between spirituality and health care over the succeeding centuries of Western health care. I argue that the taking of oaths is the last spiritual residue left in the "official" world of mainstream contemporary medicine and suggest ways to revitalize the meaning of physicians' oaths.

In part II, I examine the recent rash of empirical studies about spirituality and patient care and attempt to separate the wheat from the chaff. I caution that there are profound limitations to the use of empirical methods in studying spirituality and health care. I propose, however, a biopsychosocial-spiritual model for health care and suggest how various kinds of empirical investigation can fit within this model. I then undertake a critique of one particularly controversial form of empirical research about spirituality and health care: randomized, controlled tri-

als of prayer as a therapeutic intervention. Finally, I make the bold claim that health care professionals ought to regard attending to the spiritual needs of patients not just as a moral *option* but as a moral *obligation*. Contrary to much of what has appeared in the medical literature, however, I argue that empirical data have little to do with justifying that claim.

In part III, I take up some spiritual questions that arise particularly in the care of patients at the end of life. I do not intend to suggest that these issues do not occur at other clinical junctures, but the urgency with which they arise at the end of life makes it a particularly fruitful setting for thinking about these questions. In this part of the book I take up the question of praying for miracles; I flesh out some of the major spiritual themes that arise in the care of dying patients and how clinicians should deal with them; and I reflect on the play *W;t* and what playwright Margaret Edson might be able to teach health care professionals about caring for the spiritual needs of dying patients. I conclude with a personal story about the spiritual journey of one of my patients who died.

Readers should have fair warning about two general aspects of this book. First, much of this work has been drawn from talks and essays that were originally intended for a variety of audiences. Therefore the chapters vary considerably in their approach. Some are more inspirational than informational or analytical in their content and aim. Others, such as chapter 5, are philosophical and assume some background in that discipline. Some chapters mix the inspirational and the theoretical. Although this mix might be off-putting for some readers, I am convinced that, ultimately, these approaches are mutually interdependent. Genuine spirituality engages the mind as well as the heart, and complete separation between the two would undermine a significant theme of this book. Nonetheless, readers can feel free to skip any material that seems to assume too much background. For the most part, the individual chapters can stand on their own.

Second, throughout this book, I make no secret of the fact that I am a Roman Catholic and a Franciscan friar. I could not do otherwise. One can write theology in the abstract. One can write ethics in the abstract. One can write about the history of religion or even the history of spiritu-

ality in the abstract. One cannot, however, write about *spirituality* in a manner that abstracts from one's own person—one's deepest beliefs, experiences, feelings, and commitments. I trust that readers will not be offended if I profess my own conviction that the beliefs, practices, texts, rituals, and teachings of Roman Catholic Christianity express the fullness of the truth about God. This conviction does not mean that the book will be pointless for non-Catholics. It simply means that there is no point in professing any religion if one is not convinced that it is worth taking very seriously. I stake my whole spiritual being upon it. If I were not convinced that it mattered, there would be little point in the reader's taking anything that I say about spirituality very seriously.

The precise extent to which this confessional aspect of spirituality is made explicit varies considerably from chapter to chapter. Yet I hope that all of these reflections have value for a wide group of people who are interested in the broad topic of spirituality in health care—including persons of other faiths and persons of no faith. As I argue in chapter 2, I believe that health care is inherently personal and spiritual. My own belief in the doctrine of the Incarnation leads me to conclude that what is most deeply human has been touched by the Divine. If, in the course of these pages, I have pointed to that deeply human core, then I have done all I set out to do—for it is only from that core that the clinic can be reborn.

Notes

1. Michel Foucault, *The Birth of the Clinic: An Archeology of Medical Perception,* trans. A. M. Sheridan Smith (New York: Vintage, 1994). See translator's note (p. vii) for Foucault's use of the word "clinic" as a somewhat technical term.

2. Ivan Illich, *Medical Nemesis: The Expropriation of Health* (New York: Bantam Books, 1976), 151. This assertion paraphrases the discussion in Foucault, *Birth of the Clinic*, 32–33. Foucault describes an idea he attributes to the ideology of the French Revolution that medicine "would be close to the old spiritual vocation of the Church, of which it would be a sort of lay carbon copy" (32).

3. D. M. Eisenberg, R. C. Kessler, M. I. Van Rompay, T. J. Kaptchuk, S. A. Wilkey, S. Appel, and R. B. Davis, "Perceptions about Complementary Therapies Relative to Conventional Therapies among Adults Who Use Both: Results from a National Survey," *Annals of Internal Medicine* 135 (2001): 344–51.

Part I

Rebirth in the Clinic

The incorporation of spirituality into health care requires a theoretical foundation. Such a foundation serves several critical functions. To establish spirituality as the fecund ground for the rebirth of the clinic, one must have a sustainable source. To judge the moral limits and moral requirements for incorporating spirituality into practice, one must have a framework for making the necessary moral assessments. To avoid the pitfalls of charlatanism, one must have criteria by which to judge the authenticity of any proposal for incorporating spirituality into health care. The aim of part I of this book is to provide such a theoretical foundation.

The first three chapters are very general. They set forth the scope of the spiritual in health care. Chapter 4 sets forth how the ancient Jewish wisdom literature tackled the question. Chapter 5 provides my own theoretical foundation. Chapter 6 describes the role that oath-taking might play in the spiritual rebirth of the clinic.

Many good things have been happening in the field of spirituality and health care. Several initiatives, however, have suffered from a lack of focus. I start by examining the spirituality and health care movement through a theoretical lens, beginning with a look at the most basic aspects of spiritual experience in the clinic and constructing a framework for understanding what has already happened and what needs to happen next.

1

Why Surgeons Must Be Very Careful

More than 150 years ago Emily Dickinson wrote a poem that succinctly illuminates many of the spiritual aspects of practicing the healing arts.[1] She lived and wrote when the modern scientific clinic was just coming into its own. She had a keen sense of diagnosis; she understood immediately what ailed the clinic. She wrote, in her typically pithy style:

> Surgeons must be very careful
> When they take the knife!
> Underneath their fine incisions
> Stirs the Culprit—*Life!*

Whenever this poem creeps into the contemporary medical literature, as it sometimes does, it usually is an epigraph at the beginning of an article that emphasizes the importance of good surgical technique. These days, however, this poem might sound more like a stern warning from a risk manager or advice from a newspaper reporter, a judge, a politician, or perhaps an angry patient—or someone else who distrusts physicians and surgeons and is skeptical about their competence, sincerity, or commitment to patient welfare. Be careful, doc!

We should be more careful readers, however, because Dickinson was a very careful poet. She chose each of her words very carefully to be richly suggestive and highly evocative. Moreover, her insights are important for all health care professionals—not just surgeons.

Begin with the word *take*. This word evokes the power one has as a physician, surgeon, or nurse—a power to heal or to harm, even to kill. A clinician's knowledge, as Bacon observed, also is power. Clinicians wield knowledge over their patients, who are at the mercy of that knowledge. Like all power, the power clinicians hold can be used for good or evil—and mostly, if we are honest, for some admixture of both.

The word *take* also suggests the verb phrase *take up*, and this interpretation makes the word more interesting. Medicine is a craft (in Greek, *techne*). One takes up the medical craft, in some ways, just as one says that someone has taken up gardening or pottery. Physicians, however, do not make anything in their craft. The product of their craft is not something of their own making, like a piece of clothing or furniture or a utensil. The patient is given to a physician, and the physician gives the patient back to herself and to her family. Although medicine is a genuine craft, it is, one must admit, a funny sort of craft.

Consider also Dickinson's use of the word *fine*. This word suggests the precision of the physician's work. Technical specialties and subspecialties—such as head and neck surgery, neurosurgery, and invasive cardiology—are especially precise crafts, dealing with the delicate sense organs and the myriad fragile nerves and vessels that traverse the body. Yet even a general internist, pediatrician, or nurse must be precise. An error of a decimal point in dosing can mean the difference between cure and death.

Yet the word *fine* also evokes a sense of the beauty of what clinicians do. Surgery can restore the beauty of a face deformed by genetic processes gone awry or palliate the distortions of injury or cancer. Medication can erase the disfigurement wrought by diseases such as Kaposi's sarcoma or leprosy. Often there is a beauty to the intervention itself—an aesthetic of the craft. Surgical incisions can have their own beauty, running down the natural folds of the neck or the linea alba so that no one who looks at the patient in a few years will discern that a surgeon was ever there. Even case presentations have a beauty—at least if they are done well. Crispness, clarity, brevity, vitality, and precision characterize a good presentation of a case. There is a genuine aesthetics of case presentations.

Dickinson's poem itself has all the qualities of a good case presentation. Yet perhaps it is better to say that a good case presentation is like one of Dickinson's poems. In each art form, every word counts. So we may also read her "fine incisions" as a reminder that all clinicians must be incisive. A pediatrician must know how to sense when something is askew in a parent's reaction to a child's fractured bone. An internist must recognize those moments when therapy is required even in the absence of a precise diagnosis. A surgeon must make incisions, not just cuts. The difference between an incision and a cut must be part of the surgeon's character. Yet the best surgeons are always conscious as they dissect a path through tissue planes and remove diseased nodes that they are opening up more than flesh. Surgeons also expose the *persons* of their patients in a psychosocial and even a spiritual sense. All good clinicians are as incisive about persons as they are about malignancies.

Dickinson therefore seems to be urging the clinician to get "underneath" what he or she is doing—not just underneath the skin (in the anatomical-pathological sense of Foucault's clinic) but underneath the experience that the physician shares with the patient. One might read Dickinson as imploring physicians (or, more broadly, anyone who applies technology to human beings) to resist the urge to be callous or superficial or to trivialize what they do. Such reactions might appear to help in the short term but will return to haunt the practitioner in the long term.

The work of all health care professionals is fraught with deeper meaning than they often realize. Clinicians and pathologists alike often experience the patient in frozen sections—thin slices of flesh, frozen in time. Dickinson seems to urge all health care professionals to remember that the moment of the clinical encounter is also but a frozen section: a thin slice of the patient, frozen in time, revealing nothing about the hopes and fears and loves and sorrows the patient brings to the encounter at levels far deeper than any surgeon can ever reach with any knife, deeper than any medical imaging technique can ever bring to light.

This, then, is what "stirs" beneath the surgeon's knife. Even when a patient is sedated, paralyzed, and ventilated, the mystery of a person

stirs dynamically at the tips of the surgeon's fingers. It is the profound mystery of the person that stirs—not just blood, but Life.

Life is what stirs—in all its richness, power, and mystery. It is Life that health care professionals serve. Clinicians understand this perspective best when they come to understand the way their own lives are deeply connected with the lives of their patients. Yet life in the modern clinic can make this concept difficult to comprehend. Particularly in delivering highly technical medical care—in the endoscopy suite, in the cardiac catheterization laboratory, in the surgical theater—one may be so bound up with the patient that one scarcely notices anything more than the concentration, tension, and exactitude of one's work. Well, one should be fixed on the technical, clinical moment, as such, while it is unfolding. Yet this necessary focus does not excuse any health care professional from the duty to reflect on what he or she actually does, day in and day out. All health care professionals are at the service of Life. It stirs at the bottom of the surgical field. It courses through the physician's veins as surely as it flows through those of the patient.

Dickinson does not suggest that one should worship this Life. She is not a vitalist. Her poem is not a call to never cease treatment, nor is she delivering a moral mandate to maintain the ventilator even if the patient is brain dead. She calls modern practitioners to an attitude that Albert Schweitzer once called "reverence for life."[2] This attitude is one of awe and respect. It commands action to heal and preserve Life—but true reverence for Life is tempered by realism. One should not desecrate Life for the sake of preserving mitochondrial oxidative phosphorylation.

Hence, Dickinson observes that Life is a culprit—and she is right. One might take up the knife or the syringe and think one wields its power, but Life steals that power back. Life ought to make one humble and steal away one's arrogance. Physicians and surgeons ought to grasp (as they are in turn grasped by) the paradox of this Life. Life itself brings both illness and health to everyone. Life by its very nature is finite: Every patient will die one day, and surgery, medicine, and nursing ultimately are powerless to stop it.

Life holds within it the seeds of death—apoptosis. Life is the context of illness. If there were no Life, there could be no illness. Life is

defined over and against Death—the ultimate expression of our finitude. Illness is the mark of the finitude of life. Things go wrong for living things. That is their nature. Illness arises because living things (all living things, including physicians) are marked by mistakes—biochemically, physiologically, socially, intellectually, morally, and spiritually.

Thus, like Life itself, the medical craft is marked by its finitude. Everyone makes mistakes. This is why clinicians feel so much more hurt than angry when their mistakes become the headlines of bad press and the source of lawsuits. Imperfection marks the healing crafts. Yet in the face of the inevitability of every patient's ultimate dissolution, and with the full knowledge of their own metaphysically certain insufficiency for the task, health care professionals serve Life.

Health care professionals sometimes forget that Life itself is the healer, not them. Where there is any success, the craft only contributes to the healing that Life itself offers. Life is the source of all illness and the source of all healing. Health care professionals help, but they are not the source of healing. No matter how sophisticated surgery may be, it would not even be possible if the body did not heal itself.

So, Life is a culprit. Life gives, and Life takes away. Life deals out both healing and sickness. Life deals out birth and death. Life gives health care professionals the power to heal and snatches it away when they become too possessive.

Perhaps the reader might be thinking that this discussion is all too abstract—the irrelevant musings of an internist with a PhD in philosophy who happens to be a Franciscan friar and thinks he can interpret poems. This notion became very real for me in 2003, however. In April of that year my uncle was diagnosed with squamous cell carcinoma of the tongue. In May he was admitted to my hospital, where he underwent partial glossectomy and radical lymph node dissection, followed by radiation therapy.

My uncle asked all the questions such patients ask. "What does this mean?" First, "Is it serious?" Later, "What are my chances?" "How did this happen?" "Should I blame the dentist who kept telling me for six months that the sore on my tongue was due to ill-fitting dentures?"

"Was it my smoking and drinking? But doc, I've been sober for 25 years, and I quit smoking 30 years ago."

I wondered whether my uncle's experience brought up memories of his son, who had died at the age of five of acute lymphoblastic leukemia. Would he blame God again? Would he start drinking again? His wife said simply, "He don't talk about things like that."

Life *is* a culprit. Life gives, and Life takes away.

I helped my uncle navigate the overly bureaucratic U.S. health care system. I ran down a radiologist friend in the hallway just to print out a copy of my uncle's CT scan for him to bring to his PET scan, scheduled for the following day. Apparently a hospital clerk had informed my uncle that the hospital was out of film and would not be able to supply the copy of the CT scan that the insurance company and clerks at the PET scan office had said would be necessary for him to have his PET scan. The PET scan was scheduled for the following morning. I didn't share with my uncle that the reason our hospital was out of film was that the vicissitudes of market medicine had rendered the hospital nearly bankrupt, so it couldn't pay its bills, leading the X-ray film company to refuse to deliver us any more film on credit. I begged and pleaded, and the radiologist and I found some film not already designated for emergencies. We printed a copy of the CT scan for my uncle and thereby avoided a tense and confusing situation for him.

Later that night, however, my uncle called me in a panic. The PET scan center now said they were canceling his scheduled PET scan because the proper managed care authorization form had not been filled out. I called his surgeon, who promptly filled it out and faxed it to the billing clerk at the for-profit, freestanding PET scan center. Stage two of my uncle's potential bureaucratic nightmare had been averted. I wondered, however, what happens to patients who don't have a nephew on the medical staff?

I think my uncle and his wife and daughters and his surgeon lived an experience that makes them understand the importance of what Emily Dickinson had to say. Their story makes the poem real.

This story brings me back to the word *careful*. Why is that word so important in Dickinson's poem? It certainly does not mean a posture of

medico-legal risk management—being careful to cover one's behind. Nor does it mean mere technical precision.

Dickinson urges us, as health care professionals, to be full of care. Care has many meanings that are relevant to the work of a clinician. German philosopher Hans-Georg Gadamer has written some things in his book, *The Enigma of Health*, that can help us understand better what Dickinson means.[3]

In part, care means solicitude. Gadamer reminds us that a careful clinician is solicitous toward the patient.[4]

Care also means that the patient most often is full of cares—*Sorgen* in German; we also render that meaning of *cares* as *worries* or *anxieties* in English. A careful clinician is attentive to the cares of the patient.[5]

Gadamer also explores how the German word for treatment, *Behandlung*, suggests careful handling of the patient. Physicians and surgeons begin with palpation—touching their patients in intimate ways. Gadamer describes palpation as, "carefully and responsively feeling the patient's body so as to detect strains and tensions which can perhaps help to confirm or correct the patient's own subjective localization, that is, the patient's experience of pain."[6]

How can one cultivate such care? In the *Phaedrus*, Plato makes three puzzling claims, one after the other: that rhetoric should be considered the same as medicine, that it is not possible to understand the soul without considering it as a whole, and that—if we are to believe Hippocrates the Asclepiad—we cannot begin to understand the body without considering the whole.[7] Gadamer's interpretation of what Plato is saying can be summarized as follows: that just as philosophy only emerges out of dialogue, the same is true of medicine, and that just as philosophy must be holistic, so must medicine.[8]

In other words, Plato suggests that real medicine must be soul medicine. One cannot know the whole patient merely through science. The medical act emerges through a dialogue with the patient. Even the examination of the patient; one's careful handling of the patient; one's touching without words, is a dialogue. One does not merely touch the carotid artery as an object. One touches the patient's soul. Therefore, one must be very, very careful.

Since the time of the ancient Greeks, illness has been understood as a disturbance in equilibrium. All attempts to heal are always a counterforce. Gadamer reminds us, however, that there is always a threat, therefore, of doing too much.[9]

A story illustrates this point. Dr. John Conley was a famous head and neck surgeon who practiced many years at my hospital, St. Vincent's Hospital in New York City. Conley is considered one of the founders of the field of head and neck surgery, transforming it far beyond "ear, nose, and throat" medicine. As is often the case with pioneering figures, he also was a very colorful character. I have been told by one of his former residents that in the middle of very difficult and complex cancer operations he often would stop what he was doing, put down the instruments, and with a characteristically dramatic flair, begin to ask questions.

"What's that?" he would ask, pointing at something in the surgical field.

A resident would answer, with quivering lips, "The jugular vein."

"What's that?" he would ask again, pointing elsewhere. A knock-kneed medical student would say, "It looks like more tumor."

Then Conley would ask, "Are you sure?" The resident would save the medical student from any possible embarrassment by answering, "Yes."

"And what might happen to this human being before us if we attempt to remove this tumor?" No one would answer.

"Should we proceed?" No one would answer.

Then he would simply say to the nurse, "Scalpel."

Conley was trying to teach the residents and students assembled in his operating room how to be careful surgeons. He was Socratic and dialogical with his students as well as with his patients. His comments concerned technique, certainly. The point he was making, however, was about far more than technique. It was about human beings and human Life. He demonstrated, in dramatic gesture, that before Life, the careful surgeon must give pause. Gadamer writes that when a medical intervention goes wrong, "it would not be because physical force or power was lacking or too little was exerted, but rather because there

was actually too much force in play. But when the act works, suddenly everything seems to happen spontaneously, lightly and effortlessly. . . . Genuine success is accomplished in medical practice at just that point where intervention is rendered superfluous and dispensable. All medical efforts at healing are already conceived from the outset in light of the fact that the doctor's contribution consummates itself by disappearing as soon as the equilibrium of health is restored."[10]

Life gives the physician the power to heal and then takes it back again. That is what Conley's little operating room drama was about. Although not all clinicians have his dramatic flair, at some point—at least symbolically—each clinician should put down the knife he or she has taken up and revere the mystery he or she is privileged to serve.

Gadamer points out, in fact, that the word *therapy* comes from the Greek *therapeia*, which means service.[11] Being a careful clinician means seeing oneself as the patient's servant, not as the patient's lord and master.

Several years ago, a young woman named Helen Yoo Bowne took the knife to my uncle Denis. She is a careful surgeon. She did not take up the knife as an implement of power. Her incisions were very fine. She understood the mystery that lay beneath the plane of all possible dissection. I was very touched by the way she took the time, after eight hours of surgery, to speak with his wife and daughters while her patient was being taken to the recovery room. She engaged them in respectful dialogue. She answered their questions in clear and simple language. She communicated compassion and concern. She broke with hospital protocol to allow them to visit him in the recovery room so they could finally go home rather than waiting until he was out of recovery and in a bed. The first thing he remembered after waking up in the recovery room was the voice of his wife. A careful surgeon, practicing soul medicine, gave him that gift.

These days, in the face of all the troubles (cares, if you will) that beset the health care professions, one hears more and more discussion of physician work stoppages, unionization, and media campaigns to restore respect. I confess to being skeptical about these approaches. Health care professionals often are unjustly beleaguered, but they also

need to earn back patients' respect and trust. There is no better way of doing so than by concentrating on the basics, becoming again who we always have known we should be—physicians, surgeons, nurses, and others who are full of care; humble, sincere, compassionate, and competent. The Culprit that stirs beneath the fine incisions we make in our patients stirs deep beneath the wounds in our own collective psyche. We must never forget that.

Notes

1. Emily Dickinson, number 156, in *The Poems of Emily Dickinson*, Variorum ed., vol. 1, ed. R. W. Franklin (Cambridge, Mass.: Belknap Press of Harvard University Press, 1998), 194. This poem is number 108 in the Johnson edition.
2. Albert Schweitzer, *Out of My Life and Thought: An Autobiography*, trans. Antje Bultmann Lemke (Baltimore: Johns Hopkins University Press, 1998), 155–59.
3. Hans-Georg Gadamer, *The Enigma of Health: The Art of Healing in a Scientific Age*, trans. Jason Gaiger and Nicholas Walker (Stanford, Calif.: Stanford University Press, 1996).
4. Ibid., 157.
5. Ibid., 159.
6. Ibid., 108.
7. Plato, *Phaedrus* 270–71, trans. W. C. Hemhold and W. G. Rabinowitz (Indianapolis: Bobbs-Merrill, Library of the Liberal Arts, 1956), 60–64.
8. Gadamer, *Enigma of Health*, 131–32.
9. Ibid., 114.
10. Ibid., 37.
11. Ibid., 128.

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Is Health Care a Spiritual Practice?

Is health care a spiritual practice? Although this question is central to this book, it must seem odd to most people in the Western world today. Most would agree that health care is the most delicate and intricate form of applied science. Most also probably would agree that what is not science in health care could be called art—the making of particular judgments about particular patients. Many would agree that there is a poetic beauty to some aspects of the practice of this art, as well as a need for a deeper sense of care and compassion in medicine. Yet the question remains: Are medicine, nursing, dentistry, psychology, and the other healing professions really spiritual practices? What would the skeptic say?

"Not since the Middle Ages! The era of witchcraft is thankfully behind us. The era of molecular medicine is dawning." If anything, many clinicians might believe that chaplains could be of some limited use to some patients, helping them cope with illness. This spiritual element would be adjunctive, however. It would not be "*real* health care."

What has spirituality to do with health care, or health care with spirituality?

Spirituality and Religion

The answer may first depend on what one means by spirituality. Many people equate spirituality with religion. Yet although these words are conceptually related, they are not synonymous.[1]

Religious traditions are deeply related at the spiritual level. Religious traditions sometimes even trade spiritual practices back and forth. For instance, prayer beads were common to Hindu, Buddhist, and Islamic practice, and some religious historians have hypothesized that Franciscan missionaries to the Middle East brought the idea back with them to medieval Europe, providing a tallying method for the developing practice of recited Marian prayers that eventually became known as the rosary.[2]

Hence, in a sense illustrated by this observation, spirituality is a much broader term than religion. One's spirituality may be defined simply as the characteristics and qualities of one's relationship with the transcendent. It includes attitudes, habits, and practices in relation to the idea of the transcendent. Thus, everyone may be said to have a spirituality. Many people call the transcendent "God." One also may live in relationship with the transcendent and refuse to personalize it or call it "God." Even if one explicitly rejects the existence of the transcendent, one has a relationship with it—at least by way of rejecting it. By this broad definition, even an atheist has a spirituality because an atheist must search for personal meaning and value in light of his or her rejection of the possibility of a transcendent source of personal meaning and value.

By contrast, a religion is a specific set of beliefs about the transcendent, held in common by a community of persons, usually in association with a particular language used to describe spiritual experiences and a communal sharing of key beliefs, along with particular associated practices, texts, rituals, and teachings. In a religion people share some basic, overarching assumptions about the transcendent. Not everyone has a religion.

It has become increasingly common in the United States for people to describe themselves as "spiritual but not religious."[3] By the definitions I have offered, this description is not oxymoronic or otherwise logically impossible. Whether being "spiritual but not religious" is personally, socially, and theologically sustainable is another matter. It cannot be dismissed out of hand, however. Moreover, this position is becoming more prevalent.

One contemporary consequence of the fact that religions have so much in common at the level of spiritual practice has been the emergence (particularly among people who are "spiritual but not religious") of multiple personal, syncretistic styles of spiritual practice. People in the postindustrial Western world increasingly eschew organized religion, yet they borrow spiritual teachings from multiple traditions to create an individualized set of spiritual practices. Although I write from a particular religious tradition, I hope such readers will not be deterred. For many readers, what I hold to be the fullness of spiritual truth may be merely one voice among many. As I state in the Introduction, however, the fact that one does not share my faith should not be an impediment to reading this book.

Religious traditions do have a great deal to offer to doctors, nurses, dentists, and psychologists, as well as their patients. People who set out on a spiritual quest and already have a religion are very fortunate in one sense. They already have a language, texts, a community, and a set of practices with which to express their experiences of the transcendent and in which to cultivate their spiritual lives. Inventing all this for oneself is immensely difficult. The eclectic approach does not provide a spiritual community. It distances itself from any and all particular traditions. Echoing Wittgenstein's comments regarding the impossibility of private language, I would even contend that the eclectic approach does not constitute an alternative form of religion.[4] There is no such thing as a private religion. There can be private spirituality, but not private religion. Furthermore, private, religionless spirituality will simply always be harder to live than religious spirituality.

I am fully persuaded, however, that if a Christian speaks out of the fullness of Christian conviction, and a Buddhist speaks out of the fullness of Buddhist conviction, and an atheist speaks out of the fullness of atheist conviction, deep spiritual resonances will occur and each can learn enormously from the others. Although in one sense spirituality is broader than religion, in another sense spirituality ultimately is more specific than religion. Within every religion there are groups of people who share the key beliefs of the religion and remain part of the community of believers, yet have slightly different ways of praying, as well as

other slightly different ways of living out their relationships with the transcendent. Thus, within the broad Catholic Church there are charismatics and traditionalists; Dominicans, Jesuits, Benedictines, and Franciscans; people who pray the rosary and people who practice centering prayer—all distinct spiritualities within one religion.

Ultimately, because every human personality is unique, every human relationship with the transcendent also is unique. Spirituality therefore is ultimately personal. Only persons can apprehend, question, and live lives that engage the transcendent. Hence, this book is addressed to *persons*.

Spirituality and Health Care Practice

At this point the reader may ask, legitimately, what does any of this have to do with health care practice? One reply comes from Abraham Heschel, the twentieth-century Jewish philosopher and theologian. Heschel once said in an address to the American Medical Association, "To heal a person, one must first be a person."[5] This understanding is the first step in building a spirituality for health care.

Etymologically, to heal means to make whole. If health care professionals are committed to healing patients as whole persons, they must understand not only what disease and injury do to patients' bodies but also what disease and injury do to them as embodied spiritual persons grappling with transcendent questions.

In the midst of all that is being written and said these days about spirituality and health care, surprisingly little has been discussed about the spiritual lives of physicians and nurses. As Heschel reminds us, if health care professionals are to heal patients as whole persons, they themselves must seriously engage the transcendent questions that only persons can ask. If health care professionals are to be true healers, they must rediscover what it means for health care to be a spiritual practice.

The relationship between health care and spirituality has become problematic in the twenty-first century as it never was in earlier eras—and is not for many non-Western cultures today. A simple story illus-

trates this point. A Roman Catholic couple went to Easter mass on a Canadian reservation where a native North American bishop was presiding in his tribal language. The couple, both physicians, were the only white people in the church. The bishop's sermon was lengthy. As he preached, every once in a while he turned to the couple, acknowledging his awareness that they understood nothing of what he was saying. At the end of a thirty-minute sermon, he turned to the guests and welcomed them in broken English on behalf of his congregation. He offered to summarize his sermon. He paused for a moment and then said simply, "This Jesus. *Strong* medicine."

Efficacious, scientific Western medicine also is strong, but is it strong enough? Western health care works, and very few people want to give up antibiotics or neurosurgery in favor of crystals. Is it not possible, however, to practice excellent scientific medicine, nursing, dentistry, psychology, and other health professions and still be aware of the spiritual dimension of the work and responsive to the spiritual needs of patients?

Illness is a spiritual event. Illness grasps persons by the soul as well as by the body and disturbs both. Illness ineluctably raises troubling questions of a transcendent nature—questions about meaning, value, and relationship. These questions are spiritual. How health care professionals answer these questions for themselves will affect the way they help their patients struggle with these questions.

We know so little about the ways in which we touch the lives of our patients—or about the ways in which we fail them. Some time ago, for example, I found myself in a discussion with a nurse about the role of touch in relation to health care and spirituality. She had misinterpreted something I had said during a lecture, and to demonstrate, somewhat defensively, that I really did believe in touching patients, I asked if she would mind if I showed her how I generally auscultate the lungs, placing my right hand on the patient's right shoulder. I demonstrated: "Like so." She then responded, "Oh. Do you know what that does to patients? What it communicates?" Even more defensive and stunned, I said, "No." She then asked permission to demonstrate on me. She said, "You could touch people like this," and she leaned a bit on my shoulder to

balance herself in a perfunctory manner. "But that's not what you do. Here's what you do." Then she touched my shoulder in such an amazing way that it seemed at the same time as if she were not touching me; in a manner that communicated confidence and compassion at once; in a way that signified respect and connection at once. It felt as if a static charge hovered between her hand and my shoulder. Yet she really was touching me, and there was no space between us. "Is that really what I do?" I asked. "I guess so," she said. "That's what you did when you demonstrated for me."

"Wow," I thought. "Strong medicine."

From my perspective, the transcendent, healing presence of the divine can be found in the interstices of daily practice—in the infinite space that subsists between our hands and the bodies of the patients we touch. Too few of us bother to reflect on it or talk to each other about it. The transcendent, healing presence of the divine is to be found not only in explicitly religious conversation with patients who are dying but in countless moments in the office or the hospital in which we communicate meaning and value to our patients and relate to them as persons. A drug such as adriamycin doesn't necessarily get in the way of understanding the clinical encounter as a spiritual experience, although it can. If we use a drug incompetently, we violate the trust the patient has placed in us—a trust that transcends the relationship between patient and professional and transcends adriamycin. To betray that trust is to deny the spirit.

Adriamycin also can get in the way of the spirit if we somehow come to believe the falsehood that the patient's story (or our own story) begins and ends in adriamycin. There are no transcendent pharmaceutical agents. There are always transcendent questions, however—about meaning, value, and relationship. Spirituality in practice begins when the doctor or nurse becomes aware that these questions arise in and through illness and injury and that they can be addressed in and through health care practice. Paul Ramsey reminds us that patients are first and foremost persons.[6] We must begin to recognize that physicians, nurses, and other health care professionals also are first and foremost persons.

The Emmaus Story

The story of Emmaus, from the Gospel of Luke (24:13–35), may be very familiar to some readers and completely new to others. The story is about two disciples of Jesus, walking down the road from Jerusalem to a town named Emmaus a few days after Jesus had been crucified and buried, their hearts heavy with a sense of profound loss. As the story develops, Jesus comes up to them on the road and begins to walk with them and engage them in conversation. The story says that they did not recognize him at first. Hours later, however, when they stop at an inn along the road and share supper, they suddenly recognize him, whereupon he vanishes from their sight.

A rarely asked question about this story is this: What prevented the disciples from recognizing Jesus? It seems so strange. He was their friend, and they didn't recognize him. What could have prevented them from recognizing him?

A bit of speculation about this question is instructive. Perhaps the disciples were just a little too self-absorbed. Perhaps they were too busy complaining that the glory days were gone. Perhaps they just had too little faith to believe that it was possible for Jesus to appear to them. Perhaps they were too busy telling their story to listen to his.

Perhaps it was just grief—a deep sense of the loss of one they had loved and for whom they had cared. Perhaps it was a sense of failure—that they were powerless to keep him from dying.

The disciples only recognized Jesus later, when they took time to reflect on what was happening in their lives. When they did, they said, "Were our hearts not burning within us when he spoke to us on the way?"

Perhaps health care professionals, like the disciples on the way to Emmaus, simply have been prevented from seeing.

I invite the reader to bring to mind some morning in practice. Whenever it may have been, call it "yesterday." Allow me to share one of my yesterdays.

Yesterday morning on rounds, I saw a seventy-year-old veteran with altered mental status and a recurrent parotid cancer. He lives alone. His

appearance was disheveled. He was confused and tearful. The 10 centimeter incision was weeping pus, and it smelled. He had a new 3 centimeter mass in front of his ear.

I also saw a forty-seven-year-old alcoholic grandmother with AIDS who looked at least sixty-seven. She had *Pneumocystis carinii* pneumonia, thrush, and oral and genital herpes. Yet there was a remarkable, quiet kindness and gratitude in her eyes. I can still see it.

I also saw a thirty-one-year-old man with AIDS and fulminant pulmonary Kaposi's sarcoma. He was on a respirator. His sister was the only member of the family who knew he had AIDS. He was absolutely terrified. The chemotherapy began within an hour after the bronchoscopy. I left the room doubting we would be able to save him, no matter how heroic our efforts.

I also saw a man who had spent the past eleven months in a coma, identified simply as "unknown Hispanic male." He had been hit by a car while trying to cross New York's FDR Drive. Remarkably, he had started to wake up. He still had a tracheostomy and was paralyzed and could not talk. But he was waking up. Painstakingly, we learned that his name is José, that he had been living in Queens before the accident, that he had no family in New York, and that his mother lives somewhere in Puerto Rico, but not in the city of San Juan. He smiled yesterday for the first time in eleven months. He's awake. He's alive. His name is José.

I saw him yesterday morning. You saw him yesterday on your morning rounds as well. Were your hearts not burning within you? Did you not learn from him how much the Messiah had to suffer before entering into his glory? Did he not open up the scriptures for you? It happened just yesterday. Or were your eyes prevented from recognizing him?

Barriers to Spirituality in Health Care

Multiple barriers stand in the way of this "repersonalization" of health care—this rebirth of health care as a spiritual enterprise. The present economic reconstruction of health care surely is one of these barriers.

Health care has been reconceptualized to be like any other industry; the chief virtue in health care no longer is compassion, empathy, or fidelity to trust. The chief virtue of industry is efficiency. Working in a system in which all parts are considered interchangeable and any patient can see any physician or nurse about any problem in any place at any time, believing that questions about relationships have transcendent meaning becomes more difficult.

Working in a system in which financial incentives have been reconfigured to make physician and patient economic rivals, it is hard for either patients or physicians to feel that their value constitutes true dignity—the value that has no price and belongs only to persons.[7] This is the value of those created in the image and likeness of God.

Working in a system in which patient visits have been reduced to seven minutes, it becomes almost unimaginable that questions of meaning can be addressed. Yet these neglected questions of meaning constitute the spiritual in health care.

The spirituality of medical practice therefore must begin with frank acknowledgment of how much health care professionals are suffering today. Many doctors, nurses, and other health care professionals now long to be able to give the spiritual questions of practice their due. Too many, however, find their efforts thwarted by demands to shorten the time they spend with patients, to fill out more forms, to refer patients to specialists they have never met, and to treat patients with formulary-approved drugs they have never used before. This spiritual suffering has two sources. Scientific reductionism has threatened the spiritual aspects of medical practice from within, by denying the existence of the transcendent. The industrialization of health care now threatens the spiritual aspects of medical practice from without, denying the importance of the spiritual.

Yet no amount of economic transformation can alter the fundamental meaning and value of health care, nor can it ever eradicate the interpersonal nature of the healing relationship that begins when one person feels ill and another, highly skilled and socially authorized, asks, “How can I help you?” The spirituality of medical practice at the dawn of the twenty-first century in the United States therefore demands great vir-

tue—courage, hope, perseverance, and creative fidelity.[8] It certainly is not easy to be a health care professional today. When all is said and done, however, we know that we still touch patients in remarkable ways. The spiritual meaning of health care will outlast all mergers, all managed care organizations, all Medicare and Medicaid cutbacks, all bogus accusations of fraud and abuse, all malpractice suits, all direct-to-consumer advertising for drugs, and all manner of profiteering at the expense of patients. If spirituality is real, it is real for times of trial as well as times of triumph. Money can't buy spirituality—and money can't make it go away.

Cultivating a Spiritual Practice

How might one cultivate a spiritual sensibility in health care that will be credible in the twenty-first century? First, if one takes one's own religion seriously, one should begin to deepen one's own spiritual life within that religion. Religion makes grappling with spiritual questions easier, providing a community of faith and support and a ready-made language with which to describe spiritual struggles and joys. Religion can give a doctor or nurse practices and texts that can be starting points for a deeper exploration of the spiritual life.

Patients struggle with all the big questions: What is the meaning of my illness? Why must I suffer? Is there anything about me that is valuable now that I am no longer "productive"? What is broken in my relationships that I somehow feel called to fix now that my body is broken? Can my doctor possibly understand what I am really going through? A doctor or nurse who has begun to explore these questions in his or her own life will be better prepared to help patients struggle with these questions. Christianity and the other major religious traditions do not give pat answers to these questions that are so fundamental to the human condition. Doctors and nurses who have taken these questions seriously will not trivialize or dismiss the questions of their patients or dispense spiritual bromides to those who struggle with the mysteries of being human in the face of illness and death.

Second, one can find fellow health care professionals with whom to engage these questions. What is the meaning of health care? What is its value? What are right and good healing relationships about? These questions are spiritual. They arise ineluctably for believers and nonbelievers—for all health care professionals who take both being practitioners and persons seriously. These questions are not often discussed in the doctor's dining room. Silence can constitute its own conspiracy, however. We can learn from our patients and from each other. How do we deal with our fallibility? With the deaths of our patients? Can we move beyond kvetching about the pressures we now face? Can we see our work as service? Do we ever pray for our patients? Or pray about ourselves as healers? Have we ever experienced the transcendent in our work? Can such peak experiences sustain us? If we do not talk about these issues, we might begin to doubt the fundamental soundness of our own spiritual struggles.

To heal a person, one must first be a person. We are all spiritual beings. Health care is a spiritual discipline.

Notes

1. Daniel P. Sulmasy, *The Healer's Calling: A Spirituality for Physicians and Other Health Care Professionals* (New York, Paulist Press, 1997), 10–12.
2. Anne Winston-Allen, *Stories of the Rose: The Making of the Rosary in the Middle Ages* (University Park: University of Pennsylvania Press, 1997), 13–15.
3. See, for instance, Don Lattin, "Living the Religious Life of None: Growing Numbers Shed Organized Church for Loose Spiritual Sensibility," *San Francisco Chronicle*, December 4, 2003, A1; Barry A. Kosmin and Egon Mayer, "American Religious Identification Survey 2001"; available at http://www.gc.cuny.edu/faculty/research_studies/aris.pdf.
4. Ludwig Wittgenstein, *Philosophical Investigations* (§§ 244–78), trans. G. E. M. Anscombe (Oxford: Blackwell, 1968), 89–96.
5. Abraham J. Heschel, *The Insecurity of Freedom* (New York: Noonday Press/Farrar, Strauss, Giroux, 1966), 24–38.
6. Paul Ramsey, *The Patient as Person* (New Haven, Conn.: Yale University Press, 1970).
7. Immanuel Kant, *Grounding for the Metaphysics of Morals* (Ak 435), trans. James W. Ellington (Indianapolis: Hackett, 1981), 40–41.
8. Gabriel Marcel, *Creative Fidelity* (New York: Crossroad, 1982).