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Update

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## Update - October 1998

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# Update

Volume 14, Number 3 (October 1998)

## The Practice of the Ministry of Medicine

by Margaret E. Mohrmann, MD, PhD

I am greatly honored to be giving the Provonsha Lecture this year. I am grateful not only for the opportunity to address this conference, but also for the opportunity this invitation gave me to expand on some of the thoughts included in my book *Medicine As Ministry*. I must say that I was also interested—and honored—to learn that I am the first woman to hold this distinguished lectureship. Knowing that to be the case makes me particularly pleased that my talk, as you will hear, is in fact permeated by such classic themes of feminist thought as experience, immanence, and mutuality.

Nevertheless, I'm going to start off with quotations from two men to frame my remarks—one from Arthur Miller, one from Hippocrates—a nice juxtaposition of art and science in medicine. The Arthur Miller quote comes from his play, "Death of a Salesman." Early in the play, when Willy Loman is still desperately trying to salvage some meaning for his life, his wife pleads his case to their sons this way: "He's a human being, and a terrible thing is happening to him. So attention must be paid. He's not to be allowed to fall into his grave like an old dog. Attention, attention must be finally paid to such a person." If I were to choose one simple but encompassing title for my reflections on the ministry of medicine this evening, it would be "Paying Attention."

The quotation from Hippocrates has to do with what it is that requires our attention. Speaking of medical practice, Hippocrates said: "It is especially necessary for one who discusses this art to discuss things familiar to ordinary folk.

For the subject of our inquiry is simply and solely the sufferings of these ordinary folk when they are sick or in pain." His words remind us that in our diagnostic evaluations, our teaching, in biomedical research, in all the conferences and seminars, like this one, devoted to the improvement of health care—in all our inquiries, the ultimate subject is the suffering familiar to ordinary folk—not just the diseases themselves, but finally, and most importantly, the suffering they cause to actual, individual, and interdependent human beings. An understanding of suffering requires of us far more than an analysis of the pathophysiology of disease, and it compels from us far more than prescriptions and procedures. Above all, suffering compels our attention. The practice of the ministry of medicine is the practice of paying attention.

Paying attention to those who suffer—hearing their pain, seeing their damaged selves as damaged selves and not just as sick bodies or as vehicles for interesting diagnoses—paying attention means, more than anything, listening to the stories they have to tell us.

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Presented during the Jack W. Provonsha Lectureship for the Alumni Postgraduate Convention on March 9, 1998



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*"The telling of the story to someone who is paying attention is often the only way for healing to begin. If we wish to be agents of healing, we have to listen, even if we also have to weep."*

After almost 25 years of practicing medicine, one of the things I believe I have learned is how to take a history or, more precisely, how to hear a story. I think much of what we teach medical students about taking histories from their patients is significantly flawed. We teach them, in effect, how not to listen, how not to hear the human experiences that have brought the patients to seek their help. We accomplish this by teaching the student to force the patient's experience into a prefabricated structure, using categories that are reasonable but nevertheless arbitrary—HPI, PMH, SH, ROS—categories that sort and separate information in ways foreign to the patient's story as it has been lived. One's social history is not really separable from the history of one's present illness. This structure is designed to reconfigure the original story into a medical problem we can then focus on and, we hope, fix. But in this process of reconfiguration the story itself can be missed or lost. Just receiving that story as the patient knows it and tells it, may be one of the most important healing techniques we have—and certainly one of the most important ministries we perform.

Any one who teaches clinical medicine has probably observed that hospitalized patients in medical centers often love the green third-year medical students assigned to them, and look upon them as their primary doctors during their hospital stay. I am sure there are many reasons for this phenomenon, but one in particular, I am convinced, is that the students have not yet "mastered" history-taking as it is taught to them.

Students are given a long list of questions to ask and, usually, some method of selecting appropriate questions for particular complaints. But they cannot remember all the questions, and they get nervous, playing doctor for the first time. When they go in to take a history, they often end up just listening to the patient's flow of words, hoping that

somehow the answers will appear by chance or that something in the monologue will jog from their memory some question to ask. They do not yet know enough to direct the story into the structured lines they are taught to use and, perhaps, this allows their patients to feel that they have finally been heard by someone.

When I talk with medical students or residents about taking histories, one of the first things I tell them is that all the lists of questions are to be used, but only to flesh out the story. Standard questions may help clarify details, or stimulate further revelations, or recall a rambling storyteller to the main plot, but they are never a substitute for the story itself. There is so much to be learned from the way patients tell their own tales of suffering—what they emphasize, the chronology as they experienced it, the side events that sound unrelated to us but clearly are not to them, what they fear it all means. Only when we hear all of this can we dare to insert our own questions—about whether a certain symptom is also present, or whether the pain has this or that character—so that the answers fit into the patient's story. Otherwise, the answers just create our own fiction: a description of a patient whom we have not heard, a human experience we have not touched.

Understanding illness is mostly a matter of getting the description right, and the description involves far more than just a diagnosis. Diagnosis is one of the extraordinary powers given to physicians—the power of naming. I fear, however, that more often than not we get the name wrong, or at least dramatically incomplete. We often get the diagnosis right, but diagnostic labels primarily serve as shorthand tags that physicians find useful for encompassing a theory of pathophysiology and related treatment. A diagnosis is not always a helpful or meaningful label for the illness as experienced by the patient.

An example from literature: John Updike's story "From the Journal of a Leper" is told by a man who suffers from psoriasis. Although we of a certain age and television experience learned to laugh at the phrase "the heartbreak of psoriasis," the way the narrator describes the disease makes it clear that heartbreak may be a truer name for the illness than the term psoriasis, which he calls "a twisty Greek name it pains me to write." Here is his diagnosis:

"I am silvery, scaly. Puddles of flakes form wherever I rest my flesh. Each morning, I vacuum my bed. My torture is skin deep; there is no pain, not even itching. We lepers live a long time, and are ironically healthy in other respects. Lusty, though we are loathsome to love. Keen-sighted, though we hate to look upon ourselves. The name of the disease, spiritually speaking, is 'Humiliation.'"

And an example from my own experience: When I was a resident, I had a patient, a bright 12-year-old girl I'll call Sandy, who had acute myelocytic leukemia. It took about two months to get her disease into remission—two stormy, painful months of needles and nausea. Before she was discharged, I had the task of telling her the name of her disease. When I told her she had leukemia, she stared at me in horror and wailed, "That means it can come back!" I had been all prepared to draw pictures for her of the renegade white blood cells pushing out the red cells and the tiny platelets, to explain at the level of a 12 year old the infec-

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tions and the anemia, and the bleeding problems and how those nasty medicines were really helping her. I knew the disease cold, but the disease was not what concerned Sandy. For her the problem was the illness—the months of vomiting and homesickness that I had called chemotherapy and isolation. And now I was revealing to her not just the name of her disease. I was giving her the intolerable information that her suffering was probably not gone for good. I saw her situation as “disease in remission,” but she knew it to be “illness waiting to return.” Sandy’s disease was acute leukemia, but her suffering was not describable in terms of cell counts. Her suffering was nausea and baldness, and being out of school and not sleeping in her own room, and watching the fear in her parents’ eyes. Not one of those demons was exorcized with chemotherapy.

It is important to get diagnoses right: to recognize psoriasis and lupus, cancer and schizophrenia, AIDS and alcoholism. But it is no less important to get the name of the illness right. It is no less important to recognize—to pay attention to—the fact that, for the sufferer, the name of the disease, spiritually speaking, is humiliation or fear, or malaise or endless pain, or loneliness or despair, or the end of a career or the end of a life. It is no less important to recognize that this is a human being to whom a terrible thing is happening and, whatever other name this terrible thing bears, its name is “Tragedy.”

Part of what all tragedies have in common is that they are sad stories about flawed heroes. I’ve already stressed the importance of recognizing our patients’ lives and medical histories as stories, so I won’t belabor the definition of tragedy as story. But I do want to emphasize the part of the definition that reminds us that these stories are sad.

So let me tell you another story. About two years ago, on a Tuesday, a woman I’ll call Ms. Martin, the mother of a patient of mine, asked to speak with me privately during her child’s visit to the clinic. I had known her and her family for some years. She was in her mid-30s, divorced, with three children: one 20, and now bringing her own baby to the clinic; the others 15 and 13. Ms. Martin wanted to talk about her concern that her 13-year-old daughter was getting far too interested in a 22-year-old man and she was at a loss to know how to talk with her. So I asked her what it had been like for her at 13. She was quiet for a moment, and then she started crying and told me her story. She had been raped daily by her stepfather from age 11 to 13; at 13 she eloped with a 21-year-old man in order to get out of her house. She had her first child when she was 14. She had never told anyone about her stepfather’s abuse. We talked then about how her own experiences could intensify her fears for her daughter and make talking with her more difficult, about the importance of counseling for herself, and about some practical steps she could take. We arranged to speak again soon.

On Friday of that same week, the morning paper reported a terrible car accident in which Ms. Martin’s three children had been killed instantly. Her year-old grandson, Timmy, survived but was in intensive care with head

injuries. Timmy has since recovered fully; Ms. Martin has legally adopted him and now brings him—he’s now three years old—to the clinic for his health care. But she does not offer her story to the residents who examine Timmy. They describe her to me as they see her: an older mother abnormally attached to her only child and hopelessly incapable of disciplining him. When I then tell them what happened to her family—I do not, of course, tell them about her sexual abuse—they see that the real story is unimaginably different from what they had assumed, and they begin to understand what she readily acknowledges to me: that she cannot consistently correct Timmy’s behavior—or feed him anything but the bacon and french fries that are all he wants to eat, or train him to use the toilet, or get him to stop drinking from a bottle. He’s all she has and she cannot risk another loss.

The stories we must hear are sometimes overwhelmingly sad, but the telling of the story to someone who is paying attention is often the only way for healing to begin. If we wish to be agents of healing, we have to listen even if we also have to weep.

The sorrow we feel when faced with these sad stories is for the flawed heroes, the ones who suffer the action of the tale. The word “flawed,” in the medical context implies the defect of disease: the disintegration or unwholeness caused by the attack on self-identity that illness inflicts. For some of our patients, the word “flawed” can also carry an additional spiritual sense, a sense of the spiritual imperfections we always bear. Sick and well alike, we are all flawed heroes in our own stories.

But for me, the word “hero” is at least as interesting as the word “flawed.” It may seem somewhat out of place in talk of sad stories and tragic suffering. But I think that identifying sufferers as the heroes within their own stories—recognizing Ms. Martin as the hero of her very difficult tale—is itself a healing move, similar to the healing power evoked by recognizing and drawing out the complex stories of our patients’ lives.

Seeing the patient as the hero—whether in the midst of enormous losses like Ms. Martin, or in the throes of devastating illness like Sandy, or in the depths of chronic despair like John Updike’s fictional character—seeing them as heroes should, of course, make us think twice about imposing our own heroics—whether as chemotherapy or psychotherapy—on one who might not choose that particular form of courage. More importantly, such recognition can add significantly to the re-empowering of a person otherwise trapped in the impotence of illness and desolation. This empowering requires the patient’s re-integration—the restoration of his or her wholeness. The process begins with our enabling patients to regain their voice by our paying attention to them and their story, and it continues with our unwavering recognition of who the hero truly is in this tragedy.

By paying careful attention, we can see the patient and his or her suffering in the context of a continuing life story. By paying careful attention, we can also see that it is within that context that we shall find the ethical questions we

*“The ministry of medicine is  
the practice of paying  
attention.”*

must address as part of our ministry—questions often deeply embedded within the extended history of a patient and a family. It is also within the story that we shall find the moral context we must have in order to comprehend the ethical issues at hand and to know how best to approach them.

Let me tell you another story to illustrate that point. Mary Jackson is a 12-year-old girl who was brought to the clinic by her mother because she had had her first menstrual period four months before and had not had one since. Her mother feared Mary might be pregnant and, therefore, wanted her to have a pregnancy test. Mary stated, both in front of her mother and privately, that she had never had intercourse and could not possibly be pregnant. She had no symptoms or physical findings suggestive of pregnancy. Ms. Jackson was told that it is very common for girls to have no menstrual flow for several months soon after menarche, but she insisted on a pregnancy test.

This summary was the resident's presentation to me. He had not met this family before. He did not intend to do a pregnancy test, but he knew Mary's mother would require some convincing, which he thought might be more effective coming from the attending physician.

I had first met Mary and her mother a few years earlier when Mary came to see me for a minor illness. At that time I had immediately recognized her mother because she had been on the local television news the night before, speaking in tearful outrage about conditions in the low-income housing complex where she and her two daughters live. The news story reported that earlier the same day a random bullet had flown through a window of the Jacksons' apartment, entering just over the sofa on which Mary lay. Had she been sitting instead of lying on the sofa, she probably would have been struck in the back of the head by the bullet. Ms. Jackson, already known as a community activist, was spurred on by this event to an even more vigorous fight for safety and a decent environment for her family and for the other children living by necessity in a neighborhood that is the top crime area in Charlottesville.

Ms. Jackson and I had talked during that encounter, and again on subsequent visits, about her determination to see that her children fare better than she had—that they not make her mistakes, such as becoming pregnant in adolescence and dropping out of high school, and that they have every chance of a life that will not include low-income housing. It had been clear, in all those visits, that her daughters were proud of their mother and valued her efforts on their behalf. They teased her about her passions and her outrage, but they seemed sure that they would not want her to be any different.

It is with this history in mind, gleaned over years of listening to Ms. Jackson and her daughters, that I went in to see them after the resident's presentation. I agreed with his assessment, that Mary was manifesting a normal post-menarchal menstrual irregularity, and I discussed this with Ms. Jackson. She listened politely, agreed that I was probably right, but insisted that Mary be tested for pregnancy anyway.

I turned to Mary and asked her what she thought about a pregnancy test. Before she could answer, Ms. Jackson

interrupted, saying: "Have things changed so much? How is it that a twelve year old should have any say-so in this? When I was twelve, no one would have asked me what I wanted. I'm her mother, and I want this test; why isn't that all there is to it?" She did not seem angry, just puzzled and a little chagrined. We talked then about how things had indeed changed, and about the practical and emotional aspects of attempting to draw blood or extract urine from a 130-pound youngster against her will. We also talked, as we had many times in the past, about trust and about uncertainty. I turned again to Mary for her opinion and, as I expected, she smiled at her mother, rolled her eyes a little, shrugged and said, "You can do the test; it's fine with me." We did the test; it was negative. I saw Mary again several months later; she was having regular menstrual periods and all seemed well.

This encounter with Mary Jackson and her mother could be presented as an ethical dilemma, if we focus on the question of whether to do the pregnancy test. One can frame that dilemma in terms of performing an unnecessary medical test, but then the meaning of "unnecessary" would have to be challenged. Or, an ethical dilemma could have arisen if Mary had refused the test, but had she done so we would not have tried to override her refusal. Perhaps this "case" does not represent an obvious moral quandary; nevertheless, it is clearly a situation that called for an ethical practice of medicine. It would surely have been unethical practice for me to have dismissed Ms. Jackson's concerns, to have refused to honor or even acknowledge them, to have simply rejected the request for a test that my scientific medical training assures me is not indicated. On the other hand, it would also have been unethical practice for me to have played the part of a biotechnician selling services on demand, and to have done the test without dealing with the meaning of it within the particular context of this family and their history.

The situation as the resident first presented it is a terse summary, taken out of context. It is the case of a parent requesting a test for which there are no apparent medical indications, to be performed on a child who is below the age of legal consent but within the age of reason. If we choose to read it that way, then we can certainly apply models of biomedical ethics to it. It can be construed as a case that illustrates the thorny problem of deciding where the locus of moral autonomy lies between a parent and a young adolescent. It can raise a question of justice in the use of common resources to perform a test which may not be necessary. It can even exemplify physician beneficence in the attempt to seek the good for this family.

However, this "case" abstraction has little to do with the real Ms. Jackson and her daughter Mary, little to do with the years of trust built between the two of them and between this family and me, little to do with Ms. Jackson's particular hopes and reasonable fears for her daughters. So, these ethical frameworks used to interpret the case may then have little to do with determining the form that my healing action needs to take for the Jacksons.

To treat this story as a contextless case in order to apply bioethical categories to it—as though one were applying a math formula to a word problem in order to find the solu-

tion—to treat the story that way would be to miss the significant and fundamental ethical tasks at stake in this physician-patient encounter, including the moral obligations to honor Ms. Jackson’s care for her daughters under difficult circumstances, and to work toward helping her set aside her fears long enough to see that her daughters are, in fact trustworthy, and largely so because of all she has done in their behalf. Doing or not doing the pregnancy test is not the critical question in this situation; a decision either way could be “correct” if it were part of accomplishing the actual ethical tasks at hand.

Bioethics often tends to focus on the abstracted, timeless case that frames a clearly delimited question. But people’s lives—the lives they bring with them when they come to see the doctor, the lives within which both their illnesses and their healings dwell—are much more like novels than sets of separable scenarios. The ethical questions that fill human lives are neither sharply etched nor frozen in time, nor always amenable to the sorts of categories used by bioethics. The ethical questions are more like plot threads that weave through the novel, always there even when the action has shifted for a while, surfacing now and again, rarely rising to a point of resolution. This is because they are fundamental questions about how one lives one’s own particular life, and questions like these can never be asked or answered once and for all.

It is the unique story of Ms. Jackson and her daughters that gives rise to the moral questions here—not just the limited, situational question of whether to do a pregnancy test, but the huge and limitless questions of how Ms. Jackson can best care for her daughters given her own history and their circumstances, and of how and whether we can help her do that. Their unique story also gives rise to the particular moral context within which those questions must be placed in order to be understood and in order to be responded to appropriately. And the same is true for Updike’s character with psoriasis, for Sandy with leukemia, and for Ms. Martin rearing her grandson. It is their unique stories, in their entirety, that teach us the questions to which we must respond and that show us the context into which our responses must fit. We can practice the ministry of medicine, we can practice moral medicine, only if we pay attention to the stories and the questions and the contexts.

There is so much about our medical education and the pressures of our practices that leads us to believe that our job is solving problems, that the task of the physician is to find out what’s broken and fix it. But each one of us who has been in practice longer than 24 hours knows full well that many of the “problems” that our patients bring to us are just not the kind that can be fixed; they are, instead, the kind that have to be lived with, one way or another.

Certainly some problems, like strep throat or a broken arm, can be eliminated sooner or later. But many others, like chronic arthritis, alcoholism, cancer, grief, poverty cannot really be fixed. They are problems that can’t be eliminated, but they can find a kind of solution by being acknowledged and incorporated into the ongoing whole of a lifetime’s narrative. “Incorporate” is the Latin-based equivalent of the Anglo-Saxon word “embody.” What some problems need is embodiment; they need to be given

bodies that allow them to fit into the story, forms that are compatible with the story. In our ministry of medicine, I believe we offer more than a focus on simply fixing simple health problems. By paying attention to their stories, we can help our patients find their ways of going on despite the presence of unfixable problems, despite the presence of the unresolvable moral dilemmas that complicate all our lives. We can help them and ourselves see the process of healing—healing of spirit and mind, as well as of body—as a process not of solving problems, but of giving narrative form to the events. I call it the process of “writing the next chapter.”

The stories of all our lives have always been under joint authorship, even though we may each be the chief author or editor of our own tales. Parents and siblings, school friends and teachers, children and colleagues, all the people we love and those to whom we commit ourselves—all these people participate in varying degrees in writing the chapters of our life stories. And when a time of medical crisis arrives, the members of the healing community—the nurse and the doctor, the comforter and the therapist, the counselor and the pastor—will also be part of the composition that solves the problem by continuing the narrative. Together with the family and friends who are old hands at this particular manuscript, the healing community will help the flawed hero embody this newest episode within the story of his or her life.

There are several criteria for the writing of that next chapter. First, it has to be part of the hero’s story and no one else’s. It is undeniably true that our contributions to the stories of those we serve are also important parts of our own narratives. But it is essential that we remember whose crises we are involved in, and that we ensure that the paragraphs we add are crafted to fit those persons’ tales and not our own.

Second, the next chapter has to make sense. It has to fit the story as it has unfolded to that point. There is no sense in trying to tack the last chapter of *Anna Karenina* onto the first half of *Gone With the Wind*. Scarlett would never have thrown herself in front of a train, even if there had been any railroad tracks left in Georgia, and there is no point in considering such an incongruous outcome.

The meaning of the next chapter has to include and somehow continue the themes that have defined the hero’s life. This requirement may entail a strenuous examination of previous parts of the story in order for the significance of past activities to be understood, so that the content can be continued even if the activities themselves cannot, because of changes wrought by illness or injury. The process of ensuring continuity may call for an expansion or an altered comprehension of the meanings that animate the story, but such rethinking characterizes healing and growth in their most basic forms.

This work of finding new interpretations and new expressions for the essential meanings of one’s life satisfies the third criterion of a good chapter: the new chapter should be able to lead the story on to the other chapters that are to follow. It must be not only continuous with what has gone before but also generative of what is to come—the reformed, reintegrated life of a whole person.

Sometimes when the next chapter is actually the final chapter in the story, it can lead to the continuation of important threads of the hero's tale in the lives of others who have shared the story. Sometimes the succeeding chapters can be read only in the lives of those left behind to remember and sustain the meaning of that memory.

Let me give you an example to clarify this notion of "writing the next chapter." Some years ago, when I was director of a pediatric intensive care unit, a 6-month-old infant whom I'll call Rebecca was admitted to the unit under my care. As a result of a freak accident involving a plastic bag, Rebecca had suffocated. She had been resuscitated by the rescue squad and was on a ventilator. Over the next few days, it became clear that she was not brain dead, but she showed no signs of recovering from the hypoxic insult to her brain. Her parents and I spent hours each day—some in the morning, some in the evening—talking together about the situation. Over a five- or six-day period, we reached the decision to take Rebecca off the ventilator and allow her to die.

The process of decision-making was not one of assessing who had the right to decide, or how parental rights and obligations balanced off against the use of scarce resources, although all those issues were part of the discussion. The process was also not one of weighing information from neurological exams or statistics about likelihood of survival in the persistent vegetative state or speculations about Rebecca's chances of regaining some degree of cognition and movement, although all the medical knowledge available was part of the discussion. The process resembled neither ethical dilemma resolution nor scientific calculation. What Rebecca's parents and I talked about was who they were as a family, who Rebecca was in their lives, how they envisioned their future, what their two older children were like, and how they were responding to this crisis. We even talked about what their childhood families had been like, about their courtship and marriage. We talked about their ideas and dreams as individuals and as a couple, about what life is and where it might lead. All of these issues came up not because I asked about each of them specifically, but because we talked about whatever arose, about all those things that come to mind at such a dreadful time, all the experiences and influences and hopes that form us and that we bring with us to our crises.

The decision to allow Rebecca to die was less a decision than it was the obvious next step that emerged in the process of replaying the story of all their lives together. It gradually became clear to each of us that the fitting next chapter in their lives included releasing Rebecca from her critically wounded body and getting on with being the family who had suffered this huge loss. We reached a silence—a quiet mind, I would say—that carried in it a sense of completion. I asked, "Shall I turn off the ventilator now?" Almost in unison, they said, "Of course." I did so immediately, and they held Rebecca until she died.

The next chapter in the story may be the last chapter, it may be a chapter so shattering that finding strands of continuous meaning and creative hope seems scarcely possible. To acknowledge this is to recognize once again that the part of the story we are concerned with often is

indeed a tragedy. Beyond all poetic talk of tragedy as a sad story about a flawed hero, the fact remains that tragedy is dark confusion swirling around a conflict of good intentions and, most painfully, around a gathering of evil possibilities.

The conflict that characterizes tragedy is perhaps most evident in situations that ask for impossible decisions, situations that seem to need ethics consults. In the case of a terminally ill patient in great pain, for example, the good of preserving life may come into uncompromising conflict with the good of relieving suffering, and the evil of failing to respond to pain may confront head-on the evil of ending a life. However, the multiple evils and conflicting goods that create and intensify suffering appear long before that final decision point is reached. It is characteristic of the tragedy of human suffering that it is always a compound insult; the attack is always on more than one front.

Many authors have correctly described illness as an assault on the identity of the patient, and I think—following William May—that our human identity may be usefully understood as having at least three dimensions: that of the body, our physical presence in the world; that of the community, our relations with each other; and that of the ultimate, our perception of transcendent reality, which for many of us is configured as our connection to God.

With this compound notion of identity, illness can be understood as a simultaneous assault at all three levels—physical, communal, and spiritual. One conclusion to be drawn from such a perspective is that to be fully restorative, healing must attend to all three levels, an approach that affirms the essential observation that healing involves all the segments of the healing community—medical and lay and clerical. Medicine is a ministry in which doctors are not the only ordinands.

The physical dimension of illness, which involves some sort of disruption of the patient's unique embodied state, is preeminently the domain of medical professionals. It is the obligation of the physician, nurse, or therapist to witness materially to the will of the healing community to relieve physical suffering and to reestablish the patient's physical participation in the world of sense, activity, and communication. Specifically, much can be said about the primacy of medicine's obligation to do everything possible to alleviate the illness and pain, to remove the impediment to health, to attend to the patient's physical well-being.

But the suffering that a serious illness inflicts results not only from the assault on the person's physical health and sense of embodiment, but also from the threat to that person's relations with those who comprise his or her community. For example, we may finally be able to relieve the devastating physical pain of a severe burn, but the psychic pain of permanent disfigurement and its inevitable alteration of relationships does not respond to analgesics. The damage done to a person's self-identification as part of a community can be healed only by the ministrations of that community.

Just as it is medicine's task to witness to the will to relieve physical suffering and restore the patient's damaged embodiment, so it is the task of the community—which includes the caregivers surrounding the patient: nurses, therapists, counselors, and doctors to witness the will to

sustain a relationship with the afflicted person. In doing so, the community confirms the patient's continued identity as a whole and treasured member. By our refusal to allow suffering to separate the patient from us, we repeat the scriptural truth many of us hold that nothing can separate us from the love of God. We also proclaim an essential fact about human existence, spiritually understood: none of the negative aspects of life—sickness and crime and grief and meanness and pain—none is absolute in this world. Their elimination is not required for us to live a fully human existence. What is required for a truly human life is not the absence of pain but the presence of others, the maintenance of living bonds with other human beings. It is these relations that are threatened during any self-assaulting illness. As part of their healing—healing of spirit and mind, as well as healing of body—those who suffer require from each of us assurance that our relationships with them endure.

The third dimension of illness is its direct assault on one's spirituality—specifically on one's relation to God or to one's particular idea of transcendent reality. This is the level of suffering to which ordained clergy may be called to respond, but to which all of us need to pay attention. In general, within what I call a religious worldview—and by that phrase I intend to encompass all manner of spiritual beliefs and practices that invoke some idea of transcendence—the restoration of wholeness of body and spirit is often particularly a matter of the restoration of harmony and inner peace. At whatever level of sophistication it is practiced and in whatever terms it is expressed, the religious or spiritual aspect of healing is a process of realigning oneself with the power or energy that creates, sustains, and interconnects the world and its inhabitants. Illness in this view is always more than bodily dysfunction; it is also, and sometimes even primarily, a matter of being in some way out of tune with that connecting and embracing power.

To be out of alignment, because of sin or carelessness, or ritual violation or inattention to one's spiritual life, is to be both already spiritually sick and susceptible to what we would identify as physical or emotional disorder. Nothing in a religious worldview need necessarily contradict or disallow more conventional medical notions of disease etiology; the emphasis is not on how the disease happens, but on why it has happened within me, now.

In some traditions, especially within some branches of Christianity, the problem of not being right with God is expressed just that way, and uses language of sin and guilt. For those who hold that view, confession, restitution, and reconciliation may be what is needed to effect complete healing. And it is important here to make the point that even what may appear at times to an observer to be a punitive and theologically impoverished focus on sin and guilt as causes of disease, for some persons this focus may nevertheless serve to place them and their tragedy within a coherent narrative that makes some sense of the illness for them; and that by making sense of it, despite an appearance of destructiveness, it actually gives the patient and family the strength and pathway they need to find their healing.

For others, the problem of illness is not primarily one of sin and guilt but one of confusion and doubt, of ques-

tioning God's love, a love that apparently would not keep them healthy—and of questioning God's power—a power that apparently could not keep them healthy. In the face of such a crisis of faith, spiritual healing may require that the patient come to a new understanding of God and of the way transcendental power behaves, or does not behave, so that the fact of illness may still make sense within the bigger picture, and reconciliation may happen.

For yet others whose spiritual beliefs are not theistic at all, the questions are usually not about sin or theodicy, but are explicitly issues of harmony, of being attuned to the flow of energy that connects us all and that may be felt most easily in nature or in silence or in communal rituals. Healing in that case may require time for meditation to seek the source of the misalignment, and corrections may involve such steps as changes in diet, or life practices, or in how the illness itself is conceptualized in order to retune oneself to the rhythms of sustaining transcendence.

Our task, as part of the community that ministers to the sick by paying attention to them, is to listen for the language and themes of our patients' beliefs, to ask about them if they're not forthcoming, and to help patients then identify what may be needed to further their spiritual healing simultaneously with their physical and communal healing. In the face of the spiritual anxiety that can also afflict those who suffer physical illness or injury, the task of ministry requires attention not to fine points of theological doctrine but to the reality of the patient's experience of pain, and to our offering of transcendent sustenance and reconciliation, manifested first of all in our willingness to pay careful attention.

By our attentive responses to the several dimensions of illness—the physical, the communal, and the spiritual—we can enable in our patients and ourselves the sort of transformation of vision we need, not only to see the suffering itself, but also to see the meaning in the pain. It is not that the suffering will necessarily make sense, but that it can now be given form. It can be incorporated, embodied in that next chapter, a chapter that does make sense, that does have meaning.

I believe that our willingness to hear and acknowledge—to take seriously—the heartfelt concerns of a Ms. Jackson is at least as healing for her as the negative result of a pregnancy test, and part of helping her move on to new ways of articulating her concerns in the light of her daughters' maturing. I believe that, in the midst of the grief of a Ms. Martin at the loss of her children—and the loss of her own childhood—the healing we can offer is our willingness to receive and hold her painful story, and to stay with her through the construction of her next chapters as she struggles to be a mother for her grandson. I believe that, in the case of a 6-month-old Rebecca, our medical skills can allow us to evaluate her situation accurately and support her life as needed; but it is our willingness to practice the ministry of medicine that can help her parents begin to conceive the form the next years of their lives might take.

Giving suffering its voice is the beginning of healing. When we practice our medical ministry by paying attention to the stories our patients bring to us, it is the voice of suffering we shall hear, and the healing can then begin—the restoration of wholeness of body, mind, and spirit by the continuation of the story. ♦



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