Word & World 2/4 (1982)

Healing

RICHARD E. YADEAU, M.D.
Surgery and Oncology, Ltd., St. Paul, Minnesota

The concepts intrinsic in the terms "healing" and "curing" are best analyzed when the individual is addressed as a triune being. Recognizing, then, that the triune being is composed of a physical entity, a psycho-social entity, and a spiritual entity, curing becomes that endeavor which rectifies a disease or disorder in one component of the triune being, while healing addresses the integration of these three components into a single entity, and is independent of the extent to which an individual's physical body is cured.

I. HEALING AND CURING

In a physician's practice there are numerous opportunities for curing which present themselves. A child with acute appendicitis, a young adult with a hernia needing repair, a middle-aged person with symptomatic gall stones, all can be successfully addressed by a single surgical intervention, with little chance for long-term morbidity, and only the rarest deaths occurring incident to that intervention. Likewise, there come numerous comparable episodes in the non-surgical domain. It is in these curing roles that the physician is most comfortable. The patient is under duress, the body integrity is threatened, and a definitive remedial intervention can occur with a high degree of satisfaction on the part of both the patient and the physician. The patient appreciates the return of integrity of the physical person, but does not offer up for discussion or intervention either psycho-social or spiritual needs. Often, the intervention necessary to cure is so well-dictated by the health care professions that no amount of caring need even enter into the relationship. The relationship can function on a parent-child level with the patient presenting the problem, the physician—almost with a sense of largess—providing the solution, and, in essence, things are done to the patient with only the minimum legally required sense of understanding on the patient's part.

While the above illustrations are commonplace, they do not mount the center stage of human concern. Society's distresses today revolve around the ravages of malignant disease, chronic disability (as in paraplegia), or aging, with its infirmities and dementias. In each of these and numerous comparable cases, there are no simple answers as to the appropriate intervention. The feelings that a person has about these diseases and the effects of those feelings upon attitudes and relationships become of greater importance than simple remediation of the disease at hand. It is in these instances that the patient can become open to the

healing adventure, if only there are those around who will seize the opportunity.

There are those persons for whom neither healing nor curing occurs. Their disease

progresses bit by bit, eroding their vitality. Their anger, disillusionment, and often hatred or frank despair is showered upon the shoulders of all around them. Said one such person: "You just walk out of here, I dare you, and go home and have a good Thanksgiving dinner. Just remember while you eat every bite, I lie here dying, and I hate you because of it." For many of these people, their rancor and vilification is directed specifically against their faith, voiced in a sense of betrayal of a covenantal relationship that had promised them better than they deem their current lot. For a tragic few, this stream continues out unto the dying breath.

Intrinsic in the problem of establishing a state of healing is the state of the individual when the disease strikes. I believe that in all likelihood cancer or some other major infirmity is only a touchstone which unmasks the whole process that has been going on within the individual. There is the rarest person to whom none of this applies, that person who keeps at all times all relationships, both spiritual and secular, healed with those around him or her. For the rest of us, the state of disrepair of the healing process in our psychological world or with our spiritual needs can be only further displayed at the time of illness. A lifetime spent laying demands before God in prayers, "My will be done," can only end in the fruition of a prayer demanding total curing and respite from the disease at hand. I remember well an elder in his church who gathered the other elders around him and upbraided them because his malignancy was progressive, accusing them: "You have not prayed hard enough," certainly a distortion of the expectation expressed in James 5:14. Perhaps the native problem here is a failure to recognize the ongoing miracle of life itself, as expressed by a nurse at Bethesda Lutheran Hospital in St. Paul, in whose life a spiritual ministry to patients was always part of her nursing profession: "It is like the person who day after day has been given a $5 bill by a stranger as he passed him on the street. Then, after years of this ritual donation of $5, suddenly the stranger passed him by and gave the $5 to someone else, leaving in the heart of the person passed by anger and the demand that he be given his $5." We are witnessing all too often a person who has had years of life, time enough in which to care, love, nurture, support, build, create, and worship. With the pronouncement that a disease, possibly a malignancy, will soon take that person's life, all of this largess is forgotten, and the demand is made that yet one more year be given. The miracle, then, is not seen as the life that has already been lived, but demanded is the miracle of yet one more year.

II. THE MINISTRY OF HEALING

Healing ministry, then, is the synthesis of both the physician'sand the pastor's role. For a person with progressive malignant disease, regardless of its site, a series of universal questions emerges: Why me? Why now? Why not later? Why not someone else? Did I do something wrong? Am I being punished? Is God cruel?

A person who asks, "Why did I get cancer?," is not interested in a biologi-

cal determinant theory that explains cellular replication and how flaws in DNA and RNA synthesis can eventuate in unrestrained growth of an egregious cell which invades and destroys. Rather, that person is concerned with spiritual questions.

Were I to tell any individual that the studies today conducted upon his or her body show that a malignancy is now out of control, has invaded the liver, bone, lungs, or brain, and that reasoned control of the disease is unlikely—to a person, none of us would sleep this night. And

yet, in the hour of our sleeplessness, the medical answer traditionally has been to use the hypo—an opiate, the pill—a barbiturate, or the Valium/Librium spectrum of drugs to bend and alter the mind beyond care and concern. This is a time when we need none of the above medications, but we need a human presence, someone with whom to discuss, share, reminisce, laugh, and cry. Human consoling and counseling by the hour, fellowship which cares at any hour, be it two o'clock in the morning, is not something that can be bought or sold. We cannot hope to devise a health care delivery system which purchases and trains a sufficient number of professionals for this kind of loving and nurturing. This is an obligation of the Christian community to all of its members, those who are churched with us and those few who have yet to declare Christ their Savior. To make this possible, the physician and the pastor must in the future find some common ground so that such care and nurturing can occur to the end that the patient can be healed.

In this framework both the physician and the pastor must set aside the parent-child relationship inherent in both of our professions, so universally inflicted upon our patients/parishioners. In an adult-adult exchange, the pastor and the physician in their relationships with the patient must commit themselves to doing things "with" the individual, not "to" or "for" the individual. In order to function this way, the patient's pastor must be aware of the patient's diagnosis, the proposed treatment, and a reasonable prognosis. Nothing is more destructive of a pastor's role than the assurance, "Let us pray that everything is going to be all right," when just hours before the surgeon has explained the inevitability of the disease's progress and the failure of medical intervention. To accomplish this end, there is a need for the pastorate to be afforded access to the patient's progress reports within the institution. The pastor can then come, not as a visitor who derives his information about the patient's well-being from the spouse or child, but rather with an understanding of the problem at hand. Such a role lays obligations on both the pastor and the physician. They need both be present at a family conference in which the adult-to-adult dialogue is started by frank discussion of the problem at hand, treatment programs available, the reasonableness of undertaking such programs, and long-term prognosis. Such a relationship between the pastor and the physician requires of the pastor that calling on the sick and dying transcends the rote prayer and delivery of flowers from the chancel. In effect, it requires removing the coat and committing a substantive amount of time. So, too, for the physician, it means a willingness to bond himself to that patient and that patient's well-being, not as a disease entity or a medical problem to be treated with surgery, radiation, or chemotherapy (cut, burned, or poisoned). In essence, the physician must be willing to come emotionally on line and transcend functionary activities prescribed by scientific discipline.

It is not my intent to require that all of a patient's needs for healing and integration of physical, psychological, and spiritual needs be delivered by either the physician or the pastor or the two of them as a team. Rather, together they can identify the elements of an effective support system which will enable these things to happen. As an example, it is reasonable to expect that at least two-thirds of all people with progressive malignant disease could well die at home. And yet, axiomatically, half of us will be predeceased by our spouse. There are those who have never been in a married state. For all of these, someone else must become the family. In this highly mobile society, seldom is there a gathering of children around the family home who can effect these ends. Numerous organizations and resources within a church family are ideal to assume the

responsibilities of family for those without family. Intact and supportive families have need of respite from mind-wearying and emotion-destroying service to a loved one. Relief and respite can only come if there is a community of faith who will gather in the house and provide private time out for sleep or entertainment, and bring joy, smiles, laughter, and richness into the house.

It takes no special training to create in the home the prerequisites for successful care for the terminally ill. These purposes include the maintenance of a life orientation to day-by-day activities, since no one of us can die one year from now without having lived the 365 days in between. Each of us can find value and significance in helping the person who is suffering from disease rise above medications and those concerns about what will happen after he or she is gone. This can be effected through music, song, verse, reading, reminiscences, tapes of joys of the past, and numerous other activities that bring a surfeit of value into a person's existence. We must demonstrate from within the support system an affirmation of the individual's intrinsic value. Together, physicians/pastors and support teams who surround the terminally ill reaffirm the value of life that the individual brings to all with whom the person interacts. We must renounce the concept that the person is no longer to be cherished because of an inability to earn a paycheck, mow a lawn, drive a car, or clean a house. In essence, the support team must set aside the cry, "Why live any more—I am of no value?" for an affirmation that we are enriched by having the person at our side, regardless of that person's physical state.

These things can happen only with the communication barrier between physicians and clergy dismantled. In eighteen years of practice dealing with patients with malignant disease, I have yet to have my first call from a pastor concerning the needs of a parishioner. I suspect that of the many pastors reading this essay, most have yet to have their first call from a physician concerning the needs of one of their parishioners.

III. EXPECTATIONS AND RESOURCES

As I review these thoughts about healing, I am amazed at their commonplace nature, and I wonder why the physician and the pastor have not come to work successfully to these ends in the past. In part, I would suggest that the failure of all of us to provide effective healing services, rather than just curing services, grows from personal stresses. There are not enough hours in the day, or time enough under the stars, to meet all of the needs of all of those who are sick. As a

physician, all too often I myself and many of my confreres walk away from further interaction because we are too tired, too drained, and unable to face one more death and one more family's grief. So, too, the physician struggles with the problem of expectations. Training drives the physician toward total restoration of the patient's physical being in curing. Yet the physician recognizes human limitations, sees many patients die despite best efforts, and carries a sense of failure. It is tragic that this sense of failure rests so deeply in the integument of so many physicians. It is reinforced by the expectations of many whom they serve, particularly the patient who comes not as an adult, but as a supplicant, laying all before the physician for some guarantee that the disease, pain, anguish, and suffering will be set aside. The expectation that the physician knows all and will not err is so heavy a burden that the physician who believes it is destroyed, and the physician who doesn't believe it has a sense of failure. I suspect that both of these issues of time and expectations likewise lie heavy in the lives of pastors. In fact, the societal demand

that each of us as professionals be without error robs us of our humanity and precludes effective sharing and nurturing between patient/parishioner and physician/pastor.

Each of us, then, must seek optimally to insure healing before curing as an end for those we love. To do this, we must first find someone to heal ourselves. We must recognize our own psychological and spiritual needs, and work to the end that we develop the resources that we need. It requires that we recognize that we, too, are human, that we are capable of failing ourselves, our families, our patients, and our parishioners. We must renew ourselves so that we can try again another day.