American Osler Society, Inc. - John P. McGovern Award Lectureship

Rx: Hope

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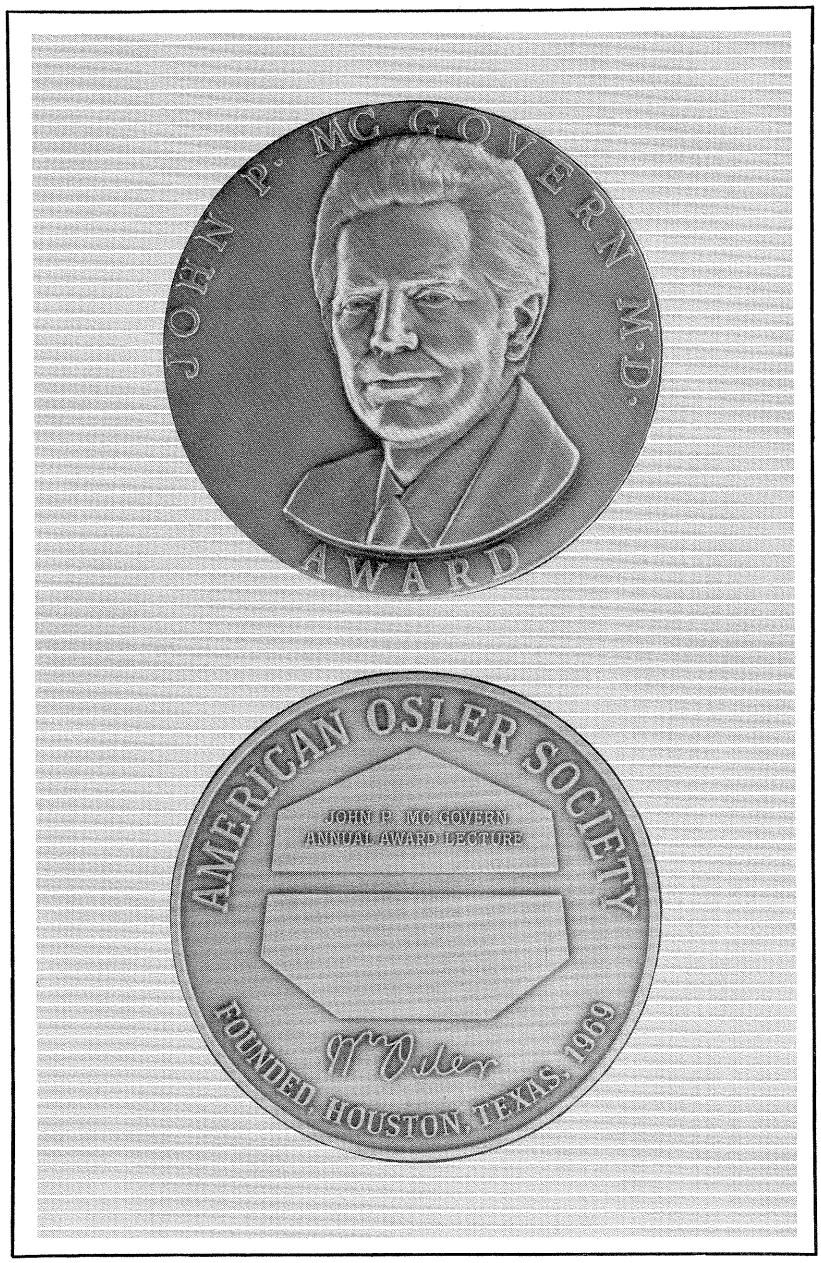

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JOHN P. MCGOVERN AWARD LECTURESHIPS

1. *Our Lords, The Sick* presented by Albert R. Jonsen, Ph.D., April 12, 1986, in San Francisco, California

2. *To Humane Medicine: Back Door or Front Door?* presented by Edward J. Huth, M.D., April 29, 1987, in Philadelphia, Pennsylvania.

3. *Medicine and the Comic Spirit* presented by Joanne Trautmann Banks, May 3, 1988, in New Orleans Louisana.

4. *The 'Open Arms' Reviving: Can we Rekindle the Osler Flame?* presented by Lord Walton, April 26, 1989, in Birmingham, Alabama.

5. *Rx: Hope* presented by E.A. Vastyan, May 8, 1990, in Baltimore, Maryland.

Cover—Obverse and reverse sides of John P. McGovern Award Lectureship commemorative medal which is presented to each annual lecturer.

The Fifth
JOHN P. MCGOVERN AWARD LECTURE

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Rx: Hope

By

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Delivered May 8, 1990
at the Twentieth Annual Meeting of the
AMERICAN OSLER SOCIETY
Baltimore, Maryland

JOHN P. MCGOVERN, M.D.

JOHN P. McGOVERN AWARD LECTURESHIP

THROUGH the generosity of the John P. McGovern Foundation to the American Osler Society, a John P. McGovern Award Lectureship was established in 1986. The lectureship makes possible an annual presentation of a paper dedicated to the general areas of Sir William Osler's interests in the interface between the humanities and the sciences - in particular, medicine, literature, philosophy, and history. The lectureship is awarded to a leader of wide reputation who is selected by a special committee of the Society and is especially significant in that it also stands as a commemoration of Doctor McGovern's own longstanding interest in and contributions to Osleriana.

E.A. VASTYAN

Rx: HOPE

"In the gloom gold gathers the light about it."
—Ezra Pound [1]

LET me open not only with a word of gratitude for the privilege of your invitation, but with a warning as well. In his famous—or as some termed it, infamous—valedictory address at this great institution, which Osler titled "The Fixed Period," he remarked on the "absolute uselessness of men more than 60 years old." That makes the task of my lecture quite carefree, for the men who invited me were fully aware that they had a sexagenarian—well past 60—in hand. So you must be content with listening to uselessness.

One further warning as well. Oslerians like you all know that not only was he born to a father who was a missionary Anglican priest, but that young Osler himself intended to enter Holy Orders. My warning is this: I, too, am an Anglican priest. My primary vocation, despite the fact that I've been a medical educator for a quarter-century, has

been that of ministry. And so, although religion is still often a taboo topic in polite company, my perspective today will be that of religion and of pastoral ministry—and specifically, of the only ministry I know—the Christian ministry.

Although one could make generalizations about hope and spirituality that could be applicable to religion in general, I shall speak admittedly from within the Christian context alone, and hope that the necessary connections to other religious traditions which you may wish to make, can be drawn by inference. I like what Carlyle once said: that he could learn religion only from someone who knew God other than by hearsay. My only experience and knowledge of God—and of hope—are related to my practice of my Christian vocation. I will try rigorously to limit my remarks to what I know from that experience, and hope you will freely draw whatever connections are necessary to connect it with your own spiritual experience, and with your own knowledge and practice of medicine.

One further introductory clarification needs to be made. Let me suggest it with a story. One of my favorite physician-mentors, with whom I frequently made teaching rounds, was not only an excellent clinician, but an excellent teacher. Pithy aphorisms ("pearls" to the students) would fall from him like seed following the sower. Three basic principles, he would tell all medical students, would see them safely through Emergency Room duty: "First, air goes in and out. Second, blood goes round and round. Third, oxygen is good." One day an even wiser colleague corrected him: "Ah, but one more is needed: 'bleeding always stops.'"

So I ask your indulgence for a paper also based on certain very simple presuppositions that I hold, and that I believe

apply not only in an emergency room—but in the emergency situation we know as the human condition. My remarks will be those of one who stands frankly and forthrightly on one side of that great, perhaps most basic, divide in humankind: I am a supernaturalist, a theist. I suspect many of you, perhaps even most of you, are naturalists. Further, I believe hope can be understood only by a supernaturalist; certainly hoping behavior is appropriate only for a supernaturalist—one who believes there is meaning and purpose in a spiritual world that is beyond reason, beyond our finite world.

My presuppositions are also simple, also three:

1. God is God, and is in control of every aspect of life—temporal life, and eternal life.
2. We know God as He reveals Himself to us in his Holy Word and Sacraments; and we know him not by inquisitiveness or imagination or inventiveness—but only by obedience.
3. The basic, most fundamental principle of the cosmos is redemptive, not rational. This may be another way of stating the fourth emergency principle above: bleeding always stops.

Another clinical friend has confided to me that when he speaks of a single case in any paper or lecture, he speaks from "my experience." Two patient histories, for him, constitute "a series of cases." Let me now get to the substance of my remarks with the first of "a series of cases" I want to use to frame our consideration of hope.

For some 20 years, one of my standard courses at the College of Medicine at Hershey has been one titled "Dying, Death and Grief." Since most of my students had

not yet begun clinical rotations, I assign them to clinical preceptors, with the request that they be assigned to specific patients. Their duties were clearly spelled out: they were to pretend to absolutely no professional expertise, but were to seek the patients' permission to interview them simply as person to person, seeking to understand more deeply what it was like to be seriously ill.

One of our senior faculty members refused to act as preceptor; finally, over a serendipitous lunch one day, told me why. "I'd cooperate," she said, "if you taught it to seniors; but I want those students to learn some real medicine before they see any patients." My counter was that, if such were the case, I would be even more eager to have my turn at bat with the students first. Yet that very afternoon she telephoned me, and asked if I would, in a pastoral capacity, see one of her patients. I'll call him "Brownie."

"I was just with him," she said, "to confide to him that I had exhausted all therapeutic possibilities. That there was no way I knew to delay further the progress of his disease. And," she continued, "he met that with effusive gratitude, almost with joy. I was pretty wiped out by that. Would you visit him?"

I did, and a series of daily visits followed. We not only prayed together; we talked together at length. This was the first time in my experience that I fully realized how important reminiscence can be to a dying patient—a recovering and remembering of the times of life that had been replete with meaning and purpose, as a rich way to launch off into the unknown. Many of his stories were of living through danger during his duty as a bombardier in American Flying Fortresses during World War II.

After about a week, his physician called me again. She

had made rather carefully conceived provisions to have Brownie go home, to be with his wife and daughters for his final days. To her surprise, he refused. He wanted to remain in the hospital, and his physician couldn't understand why. Could I shed any light on that, she wondered.

I asked him that afternoon. Instead of responding directly, he began a story: "Our bombing missions would go deep into Germany long before our fighter escorts had the range to go with us. They'd go to the limit of their range, turn back, refuel, and meet us again at their limit on our homeward course. After one particularly rough mission over Berlin, where we had lost many planes, we were limping back to England—badly damaged, with a gunner dead in the tail. Over France, one of our engines had begun to smoke. As I was hunched up there in the bombardier's bubble, an American fighter plane came buzzing past. When he saw how badly we were hurt, he throttled back, pulled almost alongside me in the bubble, and raised his arm in a sign: 'Thumbs up!' I could almost hear him say it. Just as he did it, pow!, an anti-aircraft shell exploded, and his plane disintegrated before my eyes." He paused for a long moment. "That's what I want to do for my family. That's why I want to die here, not at home."

He died a few days later. I wasn't present, but I was later told it had the air of a celebration—with wife, daughters, nurses, residents—singing hymns, and exchanging hugs and kisses and tears.

Experiences like this may be relatively infrequent; they are not unique. Something like it will even be described in medical literature on occasion. Many of you probably saw the moving paper in *The New England Journal of Medicine*—a few years ago—by a self-described "successful, hard-driving and competitive" surgeon.[2] Robert M. Mack

published a very personal account of what he called the "lessons" he had learned from living with cancer, an adenocarcinoma of the lung. After a successful surgical resection he experienced two years of symptom-free life, until a new growth was discovered in the lung, with metastases to at least three sites of bone. Following a time in which he was "devastated, bewildered and very frightened," he wrote, "I am happier than I have ever been. These are truly among the best days of my life."

He continued: "It became poignantly clear to me...that this was a time of real choice. I could sit back and let my disease and my treatment take their course, or I could pause, and look at my life and ask, "What are my priorities?...One of the really ironic things about the human experience is that many of us have to face pain or injury or even the possibility of death in order to learn the real purpose of being and how best to live a rewarding life."

Dr. Mack's experience was even more eloquently expressed by Senator Paul Tsongas, who titled the memoir of his life with cancer, *Heading Home.*[3] In that book, he wrote: "The illness made me face up to the fact that I will die someday. It made me think about wanting to look back without regret whenever that happened...My illness has forced me to understand that I have true spiritual needs whether I am healthy or unhealthy...Now the entire matter of belief is central to me and gives me a truer sense of direction.... These changes, or more accurately reinforcements, are a precious gift. The cancer gave them to me. I treasure them."

Such reactions, however, while not rare, are probably not the norm among cancer patients—or among patients with ominous diseases generally. Patients and families, within experience I suspect is common to most of us, are

much more often torn by anguish, often tragically crushed by the burden of lethal illness and suffering. Perhaps even more frequently, such patients avoid any outward expression of the effects of their illness, bearing in silence and solitude—and so often in depression and despair—their inner agony.

Yet experiences like those of Brownie, Dr. Mack, Senator Tsongas—are not simply anomalies. I have repeatedly encountered that same affirming joyfulness in patients—and so, too, I suspect, have most nurses and physicians who have been willing to let such patients share their inner lives.[4]

Experiences like these are what I refer to as hoping behavior. What happens in the lives of such people? How shall we understand such reactions to life-threatening illness? How should we respond? Suggestive questions abound:

1. What is it that lies at the root of such behavior?
2. What is the nature of such hope?
3. Can religious concepts—specifically, can Christian concepts—help us understand as well as recognize such hope?
4. What implications would such understanding have for medical care of such patients, when we encounter such behavior?
5. Can we foster such behavior amid the dire circumstances of grief, and suffering, and dying? Should we?

Within the category of medical literature, I've been able to find very little that deals with hope, either explicitly or implicitly. *Index Medicus* has no category for hope. There are, of course, categories that index the psychological and behavioral ramifications of illness, but still very little of

hope or hoping. But a few papers can be found. I have long known, and used, one by Brody, published in *JAMA* in 1981 [5] And I was surprised last week by a physician-friend who sent me a clipping from the most recent issue of *JAMA* (May 2, 1990)—entitled, as was Brody's paper, simply "Hope." [6]

Both are interesting papers. And both assume that hope can be a prescription—an "Rx"—something which can be ordered by the physician and can even be dispensed, to order, by ancillary medical personnel.

Indeed, Buchholz, in that most recent paper, writes with tongue-in-cheek of hope as a generic product of the pharmacopeia of wise physicians—as "a naturally occurring substance created by an individual's ability to project himself or herself into the future and imagine something better than what exists in the present." He writes further: "The only limit on maximum dosage is the patient's ability to receive and the professional's ability to administer HOPE at an appropriate rate."

Both papers have valuable suggestions for fostering hope, but I wish to suggest another perspective: that hope is fundamentally a gift to be received—not a behavior or a concept or an emotion that can be prescribed.

Further, I want to suggest it is a gift which is received by physician as well, a gift from the patient, a gift which can be fostered, encouraged, wondered at—but which is, paradoxically, one of the truly great gifts that cannot be given, but must be humbly received, by the "care-giver."

I believe it is a myth that we can either "give" or "take away" hope. Moreover, it's a myth that goes with the arrogance of believing the "care-giver" is a spiritually superior person, or in a spiritually superior position. There exists a vast religious experience and literature, ancient as

well as modern, which suggest the opposite is almost always the case.

Hope has, however, been relatively neglected, both as a philosophical and theological concept, until relatively recently. Within classical theology, it seems to be the poor third sister among the great theological virtues of faith, love, and hope—often being subsumed in discussions about faith.

Within the past three decades, there has appeared a "Theology of Hope"—usually associated with two German theologians Jurgen Moltmann and Wolfhart Pannenberg. This has emerged in a strident Marxist form of politics called "Liberation Theology;" what I know of it has not seemed of much use for our purposes in discussing hope in a medical context.

Much more useful to me have been three other Europeans. Two were French philosophers of the World War II era, Gabriel Marcel and Simone Weil, and the third was a transplanted Dutchman, Paul Pruyser, who spent most of his life at the Menninger Clinic as a psychologist of religion.

Marcel produced an important work under the oppression of the Nazi occupation of France, which he called a "Sketch of a Phenomenology and a Metaphysic of Hope."[7] Simone Weil, during the same period, produced much more modest but, I believe, even more profound, observations in a series of letters and brief essays—the most useful for me being her study of "Affliction and the Love of God." [9] Pruyser both influenced and was influenced by Karl Meninger's own contributions to the study of hope—and is, to the best of my knowledge, the only medically related person to explore the ramifications of Marcel's work. [9-10]

Out of their work, there emerges a strong consensus about some of the basic characteristics of hope. Marcel emphasized a key point: that it is most helpful and useful to talk about the phenomenon as hoping, rather than as hope; to view it always as a verb, rather than a noun. For hoping, he insists, is much more a matter of being than of having, of a process rather than a static entity, of behavior rather than concept.

Hoping, moreover, he sees as a global condition. It affects the whole person, and is directed at what we might term basic purpose or meaning. In this way, it can be clearly differentiated from wishing or desiring—which are usually directed at very specific objects. And to separate hoping from wishing or desiring, understanding its fundamental differences, is key to recognizing it.

The self's involvement in hoping is very different from one's involvement in wishing or desiring. With a wish or desire, I am usually deeply and strongly involved. I develop strong emotional attachment or longing; I engage in obsessive behavior to attain a wish. With hoping, the process is much more quiescent. Hoping always has the nature of humility—of responsiveness, of waiting, really of awaiting.

Another basic, differentiating characteristic of hoping is its communal character. It is different, for instance, from either optimism or pessimism—both of which have an assertive, aggressive element. Both optimist and pessimist tend to say, "If only you could see things as I do." In both there persists a zeal to convert the hearer to my point of view. So, too, to doubt something, or conversely, to assert something, is rooted in the nature of self-assertiveness: *my* point of view should prevail.

Not so with hope. Rooted as it is within calamity or

catastrophe, hoping knows deeply a tragic sense of life. And within that knowledge of suffering and anguish, hoping remains always modest. Hoping knows no assertiveness. While it is intimate and private, it is usually shared quietly, without argument, without aggressiveness. It unites rather than divides, even when the auditor (perhaps physician or nurse) doesn't truly share the hope offered by the hoping person.

It's at this point, Simone Weil observes, that the most significantly spiritual act occurs when hoping appears. She writes, "We possess nothing in this world other than the power to say I. This is what we should yield up to God, and this is what we should destroy." Hoping, for Weil, involves giving up the right to oneself, offering the self as at once a gift-received from God, as a gift-given to God, in an act she terms "de-creation."

These are fundamental characteristics noted by Marcel, Weil and Pruyser. Let me suggest several more.

I have always found hoping behavior rooted in expectancy; desiring or wishing, on the contrary, seems almost always rooted in expectation. And the difference between expectancy and expectation is the difference between freedom and bondage.

A strong wish or desire enslaves me very specifically to the object of my longing, my expectation—whether this be romantic love, sexual obsession, or material gratification. Nothing satisfies Mercedes lust but a Mercedes; that poor person can never again drive either happily or safely in a Cadillac. Expectation is always concrete, always pressing, always urgent.

Expectancy is fundamentally different. It is freeing, for it is openness to an open future—a trusting, even eager, waiting for whatever is about to happen. One patient with

an ominous cancer once put it this way to me: "I'm watching—really eager—to see how God is going to handle this thing." And there's usually an element of joy to the waiting, even to the waiting that is immersed in danger.

For danger is a frequent companion of hope. Hoping appears most characteristically—and some would say, only—under conditions of suffering, of catastrophe, of calamity. C. H. Spurgeon, the great 19th century London preacher, put this point succinctly: "Hope is like a star—not to be seen in the sunshine of prosperity, and only to be discovered in the night of adversity." [11] Even more stark is Simone Weil: "The dereliction in which God leaves us is his own way of caressing us."

Another element must be strongly emphasized. Hoping never emerges as some decorative aspect of confident living; it is no part of the power of positive thinking, or living. Hoping appears if, and only if, the tragic human condition—of vulnerability, of mortality, of helplessness—is forthrightly faced, accepted—and, finally, both affirmed and celebrated. "Life is the destiny you are bound to refuse," W. H. Auden warns, "until you have consented to die." [12] Symbolically manifested in the sacrament of Holy Baptism, that dying—giving up one's right to oneself—Auden sees (in common with traditional Christian theology) as the key to hoping behavior, the key to life.

Explore this a bit further with me in our own context in contemporary medicine. Medicine has provided us such awesome relief from suffering, pain, anguish—that we can be easily sidetracked from facing our own personal vulnerability. Indeed, we tend to think it morbid to face either disease or death as an inevitable condition of humankind. And yet, though anesthesia, analgesics and medical technology have all been remarkable achievements of the past

century, the fourth rule of Emergency Room medicine still holds immutable: bleeding always stops. Death comes.[13-14]

Hoping suggests that this basic vulnerability must be recognized, faced, even cherished—in the midst of, in spite of, our technological prowess and human ingenuity. Otherwise our lives are lives of denial, self-deception, and illusion. The prophet Jeremiah expressed this long ago—

"They have healed the wound of my people lightly,
saying 'Peace, peace,'
when there is no peace.
(Jeremiah 7:14, NIV)

The Biblical attitude is "always robust....there's not the tiniest whine about it....there is always a sting and a kick all through the Bible." [15]

The most basic Christian understanding goes even further, suggesting that *living vulnerably* is the only true sharing of the broken human condition, the only true living of hopeful lives, free lives, in this world. [16] Look for instance at the most hallowed teaching of Jesus of Nazareth, in the Beatitudes:

Blessed are the poor in spirit,
for theirs is the kingdom of heaven.
Blessed are those who mourn,
for they will be comforted.
Blessed are the meek,
for they will inherit the earth.....
Blessed are those who are persecuted because
of righteousness,
for theirs is the kingdom of heaven.
(Matthew 5:3ff, NIV)

This is an insistence that losing is finding, that sharing is

possessing, that vulnerability—accepted, affirmed, cherished, lived—is the very key to fulfilled, purposeful life. This was put simply and starkly in a fragment of verse by Puritan divine, Richard Baxter: [17]

> I preached as never sure to preach again,
> And as a dying man, to dying men

Living hopefully, living vulnerably, in this fashion means one is willing to celebrate the temporary—to accept with a sense of joy all of that which finite, mortal, limited, conditioned, suffering, tragic, broken human life has to offer—as today's life, temporary life, abundant life, all of life. It is this affirmation which lies behind the provision of daily manna to the Israelites wandering in the desert: it was food for today. If you picked enough for tomorrow, it would spoil. If you didn't pick enough, your neighbor had enough to share. So, too, it undergirds the petition in the prayer Jesus taught: Give us this day our daily bread. John Donne emphasized the point eloquently: "We ask *panem quotidianum*, our daily bread, and God never says you should have come yesterday, he never says, you must come again tomorrow, but *today if you will hear his voice*, today he will hear you." [18]

My final point is perhaps but a repeat of all the others—hoping is basically intense concentration on God's point of view. Hoping behavior is a living, daring confidence in God that is so sure, so certain, the hoper would stake his life on it a thousand times. Paul of Tarsus, who lived through shipwrecks, floggings, imprisonments, stonings, could write from his final prison in Rome, before his execution, a letter to the Philippians that is the New Testament's paean to joy—and to hope. To vulnerable,

joyful hoping. He concludes: "I have learned to be content whatever the circumstances. I know what it is to be in need, and I know what it is to have plenty...I can do everything through him who gives me strength...And my God will meet all your needs according to his glorious riches in Christ Jesus." (Philippians 4:10ff, NIV)

Let me conclude with a simple story from personal experience. The wife of a close friend, (I'll call her Hannah) had been rushed to our Emergency Room, and then to intensive care, with severe internal hemorrhaging. Physicians had told her husband that the situation looked bleak. Following a Sunday church service, he asked if I would go with him to visit his wife, and share with them prayers for healing. We went to her bedside in the ICU—where tubes and wires, as usual, stretched everywhere. He greeted her, and began what I thought was superbly understated encouragement: "You are brave, you are superb, you are my love. You're doing well. Hang in there, hang tough." It was a good sermon.

She rasped a response neither of us could understand. He asked her to repeat. She did so in the same words, apparently. Again we couldn't understand. Once more he asked her to repeat; once more with the same result. At the fourth time, she finally opened her eyes and virtually yelled, with feeble strength and failing breath, distinct, individual words, spaced out and clear: "My.....hand....is ....in....the....hand....of....Jesus."

And it clearly was, for whatever outcome was impending—neither of us could any longer have doubt about that. Hannah survived.

Are there clinical ramifications to these observations? I suggested that I'd explore some, but most, I suspect, have already been readily apparent. Yet my major points

perhaps should have stark, simple emphasis: There is no technology of hope. There is no technique of hope-giving. There are no professional hope-givers. "RX: Hope?" No, that's not a prescription a single one of us can write for any human being.

Hope is a gift, a gift of grace to the sufferer, in the midst of suffering, whenever it appears.

It can be a gift from the sufferer, when hope appears, to us—to anyone privileged to be a "care-giver" in the midst of suffering, if we can expectantly accept it.

We can find the gift, and recognize it, accept it—only when we are willing to admit our own vulnerability, our own final helplessness.

And my strong conviction is that we'll find it much more often than we have—if we look for it, if we're willing to find it, if we're willing to accept it, from those who suffer in our presence and under our care. We'll find that hope, and see it in our patients, if we're willing, from time to time, to put aside our expertise and our professionalism—and let heart speak to heart. If we're willing to be free, as one writer put it, "free to be merely man." And, I'll add, free to let God be God—the God of hope.

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