Suffering can be defined as the state of severe distress associated with events that threaten the intactness of the person.

Eric J. Cassell

A frustrated Florida physician complains that doctors have been “sold a bill of goods.” “We were taught that the secret to good medical care was to spend time listening to our patients,” he adds. “Instead, we hear the economic hounds baying at the door of the consultation office, asking us to see more patients in an hour than we know we reasonably can.” He laments, “To survive, we have had to run faster and faster...[and have] become “the Red Queen in Through the Looking-Glass, except that life is not so wonderful ... We do not see our spouses and children, bound as we are to the yoke of perpetual medical motion.”

A “disgruntled” California physician, who fights “little scheduling battles” daily, states flatly, “I am fed up, and even though I am only 49 years old, I have already cut back to half-time. Within two years I will be fully retired. It is just no fun being a doctor anymore.”

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exasperated clinician practicing in an ambulatory medicine center in Montana argues that the “financial incentives in managed-care systems,” such as the “incentives to physicians to limit referrals,” amount to “reverse fee splitting.” He adds, “I must admit that I am more than slightly confused about this ...” A young pediatrician in Chicago, who cares for uninsured patients, compares her work to “practicing medicine with my hands tied behind my back.” A San Francisco physician-in-training complains, “We young physicians are forced to learn ‘billable diagnoses,’ formularies for different health plans, key diagnoses for which medication costs will be paid, and insurance codes ...” She adds dispiritedly, “I find it hard to believe that any young physicians who went into medicine because they loved taking care of patients, loved science, or both would not be frustrated and anguished by the current system.”

American physicians are restive. Many medical professionals, especially clinical physicians, or clinicians, are awash in a surging tide

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5This vignette and those that follow, unless otherwise noted, are drawn from my experience as a spiritual director for clinicians, a friend to clinicians, and as a primary care internal medicine specialist working as a clinician-educator in affiliation with the Kettering Medical Center (Kettering, Ohio) and the Wright State University School of Medicine (Dayton, Ohio), as well as with Native Americans on the Red Lake Indian Reservation (Red Lake, Minnesota), on the White Earth Indian Reservation (White Earth, Minnesota), on the Pine Ridge Indian Reservation (Pine Ridge, South Dakota), on the San Carlos Indian Reservation (San Carlos, Arizona), and at the American Indian Health Service of Chicago (in affiliation with the University of Illinois at Chicago College of Medicine [Chicago, Illinois]) from 1991 to the present time (all through the auspices of the Indian Health Service of the United States Department of Health and Human Services. The particular vignette presented here is drawn from my conversation with the pediatrician quoted at a gathering in Barrington, Illinois, where physicians met to discuss issues pertaining to medicine and spirituality, on 11 February 2000.


7The phrase “American physicians” in this context and throughout this essay denotes “physicians practicing medicine in the United States of America.”

8They find themselves, as Cassell puts it, in “the state of severe distress associated with events that threaten the intactness of the person” (Cassell, “The Nature of Suffering,” p. 15).

9The term “professional” is a reminder to medical practitioners of their public profession of the Hippocratic Oath and their participation in a cohesive practice, which
of discontentment, which — though presently less apparent outside the community of practitioners — is "widespread and growing," according to physician and editor-in-chief emeritus of the New England Journal of Medicine Jerome P. Kassirer. In an editorial in the New England Journal of Medicine, Kassirer observes, "Many American doctors are unhappy with the quality of their professional lives," are frustrated in their "attempts to deliver ideal care," and at the same time to find personal restorative time, find it difficult to uphold "professional principles" under the "strain" of financial incentives, and detect irony in their efforts to practice as patient advocates in face of a "loss of control" in the clinical decision-making process.11

Echoing Kassirer's concerns, Franciscan physician and clinical bioethicist Daniel P. Sulmasy of New York Medical College confirms that physicians are "perplexed" by the changes in the American healthcare system, and are "searching for direction in the setting of mergers, lay-offs, pressures to control costs, managed care organizations, integrated delivery networks, the closing of public hospitals, and increasing


The terms "clinical physician," "clinical practitioner," and "clinician" are synonyms, and denote a physician "engaged in the [direct] care of patients" (William R. Hensyl, editor, Stedman's Medical Dictionary [Baltimore, Maryland: Williams and Wilkins, 1990], p. 317). Furthermore, the term "clinician" used here signals my intention to limit the scope of this essay to the "physician as clinician." I do not suggest by this limiting action that this essay has no relevance to those physicians who are not clinically engaged. However, the clinician's plight will be my primary concern, partly because, as a clinician myself, I understand it reasonably well, and partly because I judge that this cohort of physicians is likely the most vulnerable in the medical profession today. Henceforth, unless otherwise noted, the terms "doctor," "medical practitioner," "physician," and "practitioner" will be used to denote "clinical physician," "clinical practitioner," or "clinician.”

11Jerome P. Kassirer, "Doctor Discontent," New England Journal of Medicine 339, no. 21 (1998), pp. 1543-1545. Dr. Kassirer, now editor-in-chief emeritus, was the editor-in-chief of the New England Journal of Medicine at the time his editorial was published. Note, however, that Kassirer wisely uses the phrase "many American doctors," because not each and every physician practicing in the United States of America is unhappy. See also note 35.
numbers of uninsured and underinsured patients." In this contemporary milieu, the clinician increasingly faces demands to preserve sometimes conflicting, if not mutually exclusive, values. If I may be allowed to speak for myself, as a clinician responsible for providing care to uninsured and under-insured patients, I struggle to strike a balance between delivering appropriate medical care to my materially poor, self-paying patients, and keeping the cost of that care under control. I have, for example, to diagnose and treat an uninsured 29-year-old Native American woman with a six-month history of left supraclavicular lymphadenopathy and generalized pruritis, who is not in a position to pre-pay for her lymph node biopsy, but for whom a six-week wait for a general medical appointment at the local county hospital ambulatory medicine center would be completely unreasonable (following which she doubtlessly would need to wait another few weeks before receiving a referral to a specialist [in all likelihood, a general surgical resident] by who the biopsy work will be performed) — and all this in a city renowned for providing superior medical education and delivering (to those who have access to it) excellent health care. It is difficult, in face of the difficulty of discovering a substantive meaning in a practice that has come to be enmeshed in and diminished by a deeply

13 The phrase “left supraclavicular lymphadenopathy” denotes abnormal lymph node enlargement in the left supraclavicular region, the anatomical space immediately superior to, or above, the left clavicle (Hensyl, Stedman’s Medical Dictionary, p. 900).
14 The phrase “generalized pruritis” denotes a diffuse, or widespread, itching of the skin (Hensyl, Stedman’s Medical Dictionary, p. 1277).
15 The particular vignette presented here is drawn from my patient records at the American Indian Health Service of Chicago, Chicago, Illinois, 1999.
16 The term “practice” in this context, and unless otherwise noted, denotes “the exercise of the profession of medicine” (Hensyl, Stedman’s Medical Dictionary, p. 1249), or — as Alasdair MacIntyre more elegantly offers — the “coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity [this “exercise”] are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity [this “exercise”], with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended” (Alasdair MacIntyre, After Virtue: A Study in Moral Theory [Notre Dame, Indiana: University of Notre Dame, 1984], p. 187).
troubled, inequitable healthcare "system," to avoid intense feelings of frustration and perplexity, symptoms of the syndrome of physician dysphoria.

What exacerbates the problem of physician dysphoria is the growing uncertainty within the community of practitioners pertaining to the telos of medicine, a telos that in the Hippocratic tradition is understood to involve the "cure of illness" or the "promotion of health." Guided by this telos, the physician qua physician "is presumed to help and not to harm, and to advocate the 'good' of the patient at all times." But what is "the good of the patient"? What is the telos of medicine? Proponents of physician-assisted suicide, for example — such as the majority of residents in the State of Oregon, where provision for physician-assisted suicide has been made through the Oregon Death with Dignity Act — fold (wrongly, I think) this particular "practice" into their conception of "the good of the patient." Many others — physicians and patients alike — vigorously oppose (rightly, I think) this

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17 The term "system" appears in quotation marks in an effort to underscore the irony of the term used with respect to the delivery of healthcare in the United States of America. Here I follow social bioethicist Daniel Callahan of the Hastings Center, who observes that the American healthcare system is "not actually a system at all, but a collection of programs and disparate institutions, neither coherently conceived nor coherently operated" (Daniel Callahan, What Kind of Life: The Limits of Medical Progress [Washington, District of Columbia: Georgetown University Press, 1990], pp. 69-72).

18 The term telos in this context denotes "end" (Martin Ostwald, notes to Nicomachean Ethics, by Aristotle [Englewood Cliffs, New Jersey: Prentice Hall, 1962], p. 315).

19 From the Hippocratic Oath: "I will apply ... measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice" (Verhey, "The Doctor's Oath," p. 72).


21 Pellegrino and Thomasma, Philosophical Basis of Medical Practice, p. 24.

22 The term "practice" in this context, and wherever it appears in the text of this essay in quotation marks, denotes a "customary action."

controverted "practice," in the belief that it is inconsistent with "the good of the patient." It would seem that the "practice" of physician-assisted suicide is at one and the same time an instantiation of the telos of medicine, but also of its subversion. Yet, how can this be?

Another interesting example of the uncertainty among practitioners regarding the instantiation of the telos of medicine concerns the movement to introduce spirituality into medical education and practice. This movement — launched by patients and patient advocates, including a significant cohort of pastoral care workers and physicians — is gathering momentum in the direction of enjoining clinicians to greater attentiveness to their patients' spiritual needs. Some physicians have embraced this movement — in the belief that it is consistent with the traditional telos of medicine, and have sounded calls for significant changes in medical education to reflect society's desire for spiritually sensitive practitioners. Others, seeing both benefits and dangers in this "spirituality-in-medicine" movement, are urging a more cautious approach. For some physicians, however, this movement is anathema — clearly inconsistent with medicine's traditional telos. Most clinicians, however, are simply bewildered by the movement; they wonder if attentiveness to their patients' spirituality is part of their role as advocates for "the good of the patient." They cast about for some rudi-


mentary understanding of spirituality and how it might be applied in the clinical care setting — or even whether it should be.\textsuperscript{30}

This significant and confusing variance over what counts as "the good of the patient" — observed in connection with the physician-assisted suicide and the "spirituality-in-medicine" movements — contributes to the fact that many clinical physicians find themselves saddled with a syndrome marked by symptoms that issue from constantly having to negotiate the narrowed of a "fundamentally deranged" health care "system"\textsuperscript{31} in the absence of a firm, commonly-accepted interpretation of the telos of medicine.\textsuperscript{32} Physicians are unhappy with a practice they perceive is embedded in a dysfunctional and unjust delivery system, takes as its point of reference a confusingly fluid telos, and that appears to have stretched well beyond its capacity to provide care in its insistence that they need as well to address their patients' physical, emotional, and spiritual needs. Their pain feels uncontrollable, overwhelming, mysterious, threatening, chronic.\textsuperscript{33} Their unhappy plight validates — in a remarkably ironic way — the insight of physician Eric J. Cassell of Cornell University's Weill Medical College, who in 1982 wrote in the New England Journal of Medicine to physicians about the suffering of patients:


\textsuperscript{31}Callahan, What Kind of Life, pp. 69-72. Callahan characterizes the health care "system" in the United States of America as "fundamentally deranged" in that it provides technologically-advanced care to the insured at burgeoning costs, while largely ignoring the growing ranks of uninsured Americans — mostly the urban and rural materially poor (if not homeless) — and countless others who are underinsured (Callahan, What Kind of Life, pp. 69-72).

\textsuperscript{32}The term "commonly-accepted" refers to the acceptance of the telos of medicine by the community of practitioners.

\textsuperscript{33}The spouse of a physician wrote in a letter to the New England Journal of Medicine: "For the first time in our 40-year marriage ... I wish my husband were no longer practicing medicine. I, who have been an integral and enthusiastic part of his commitment to medicine and people since those early postgraduate days, wish he were out of the profession. He works longer days now and comes home physically and emotionally spent. We never talk about medical matters anymore. My anguish about his situation is as acute as his. We could deal with this ... if we believed he still had some control over his professional life" (Ruzha Cleaveland, "Doctor Discontent," letter in New England Journal of Medicine 340, no. 8 [1999], pp. 649-653).
People in pain frequently report suffering from the pain when they feel out of control, when the pain is overwhelming, when the source of the pain is unknown, when the meaning of the pain is dire, or when the pain is chronic.\textsuperscript{34}

It would be difficult to find a more accurate summary of contemporary physician suffering.\textsuperscript{35} Their dismay is substantial. Should the community of practitioners and the community of patients be concerned? Kassirer asks, "Are patients well served by unhappy physicians?"\textsuperscript{36} This unhappiness already has driven some physicians into the arms of unions.\textsuperscript{37} Even more strangely, some doctors are "supplementing their incomes" by distributing — from their offices — vitamins, herbs, food supplements, cosmetics, and household products.\textsuperscript{38} Says a disgruntled California clinician: "What really scares me the most is that as I get older, I will become a more and more frequent consumer of health care services delivered by disgruntled physicians ..."\textsuperscript{39} At stake here is the physician's ability to preserve and persevere in the covenantal relationship between the physician and the patient at a time when that relationship is buckling and yielding to contractual, if not frankly adversarial, vectors.\textsuperscript{40} At stake here is the physician's ability

\textsuperscript{34}"The Nature of Suffering," p. 16.

\textsuperscript{35}Many American physicians are unhappily suffering. I do not argue that all are so afflicted. Clearly, there is a "small but substantial fraction of practicing physicians who are content," but the stridency of current complaints and the manner in which physicians are responding to the contemporary practice environment suggest that this "small" fraction of satisfied physicians is contracting (Kassirer, "Doctor Discontent," pp. 1543-1545).

\textsuperscript{36}Kassirer, "Doctor Discontent," pp. 1543-1545.


\textsuperscript{38}"Doctor Discontent," pp. 1543-1545.

\textsuperscript{39}Kendrick, "Doctor Discontent," pp. 649-653.

\textsuperscript{40}Physician Walter J. McDonald, Executive Vice President of the American College of Physicians — American Society of Internal Medicine, echoing Sir William Osler observes, "What physicians love about practicing medicine is the time they spend with their patients... When they can't spend those extra five minutes to turn a business trans
to seek and “find” meaning that sustains her or his desire to care for patients when stung by the nettles of clinical practice. At stake here — in the words of quintessential physician Sir William Osler — is “the true light” of the physician’s life: the ability to continue to care with “self-sacrifice, devotion, love and tenderness.” Can contemporary American physicians seek and “find” substantive meaning, meaning that sustains them despite their suffering — even “finding” it (as I often struggle to do) in their inability to provide for their patients the kind of care they judge appropriate and adequate? For example, can a physician who draws his or her patients from among the under-served — uninsured and under-insured materially poor rural and urban Americans — continue to provide them with meaningful care if among the choices they must negotiate is that between paying for a prescription for the antihypertensive drug diltiazem or for lunch? Clinicians are mired in a crisis of meaning, one that is spilling over from the community of practitioners into the community of patients (ultimately every American), if only because, in Kassirer’s words, “disgruntled, cranky doctors are not likely to provide outstanding medical care.” Can clinical physicians “find” enough meaning to sustain their caring?

action into a personal encounter, that creates real concern and challenges physicians’ sense of themselves as professionals” (Edward Doyle, editor, “How Six Medical Trends Will Shape the New Millennium,” ACP – ASIM Observer 20, no. 1 [2000]: 4-7). See also William Osler, “The Reserves of Life,” St. Mary’s Hospital Gazette 13 (1907), pp. 95-98.

"The term “find” is in quotation marks to underscore my Christian spiritual theological conviction that it represents a misnomer: Rather than “find” meaning, human beings, I believe, “recognize and receive” it openly as a gift from the Spirit.


"The phrase “substantive meaning” in this context and throughout this essay connotes “meaning that sustains a person, even in the midst of crisis or suffering.” I maintain that only “transcendent meaning” can sustain a person even in the midst of suffering; therefore, “substantive meaning” and “transcendent meaning” are connotatively equivalent terms for my purposes.

"This vignette is drawn from my patient records at the American Indian Health Service of Chicago, Chicago, Illinois, 1999. My patient observed, “I can’t afford my medicine. I’ve got to eat.”

Physicians, like all human beings, are — I believe — essentially seek-ers and “finders” of meaning.\(^{46}\) Without it they wither. As much as we human beings might succeed in “finding” meaning in many things, substantive meaning — transcendent meaning — flows only from our relationships with self and others. For the Christian who, in the words of theologian Hans Küng, is committed to “a message, a truth, a way of life, a hope, ultimately quite personally to someone: I believe ‘in’ God and in him whom God sent,”\(^{47}\) transcendent meaning necessarily flows from a “decisive”\(^{48}\) relationship: that between self and “Other,” “the Transcendent,” “the Holy Spirit of the Father and the Son,” “the Spirit of God and God’s Christ,” “the Spirit.” This normative relationship with the Spirit informs, interprets, integrates our relationships with self and others, and takes root in,\(^{49}\) and brings itself to display in “our way of proceeding.”\(^{50}\) It is this dynamic, relational, interpretive, and integrative dimension of a human being’s life, springing from, coextensive with, and grounded in the relationship between self and the Spirit, is what I take to be the Christian’s “spirituality.”\(^{51}\)

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\(^{46}\)This belief statement reflects the influence of many, including physicians Eric J. Cassell and Viktor Frankl. See Cassell, “The Nature of Suffering and the Goals of Medicine.” See also Viktor Frankl, Man’s Search for Meaning (New York: Washington Square Press, 1984). The account of transcendent meaning and spirituality that follows this statement represents a personal, experiential synthesis, and I can no longer accurately attribute much of it to specific sources, except where noted. See notes 47 and 48.


\(^{49}\)In my understanding, as an individual’s spirituality matures it becomes progressively pervasive as the Spirit moves to possess utterly the Christian.

\(^{50}\)The phrase “our way of proceeding” in this context connotes “our way of living.” Familiar to members of the Society of Jesus, this phrase has another more specific historical meaning: it suggests for Jesuits the “ideals and attitudes that distinguished [and continue to distinguish] Jesuit life and ministry from that of others” (John W. O’Malley, The First Jesuits [Cambridge, Massachusetts: Harvard University Press, 1993], p. 8).

\(^{51}\)“Spirituality,” in my account, is the “dynamic, relational, interpretive, and integrative dimension of a human being’s life.” For Christians and other theists, this dimension springs from, is coextensive with, and is grounded in the relationship between a human being and “the Transcendent” (which is Trinitarian for Christians). For non-theists, this dimension springs from, is coextensive with, and is grounded in the relationship between a human being and “the transcendent,” however one conceives of “the transcendent.”
Spirituality allows the Christian to recognize and openly receive the transcendent meaning sought — the substantive meaning that sustains one, even in the face of adversity. Spirituality is dynamic: it moves to progressive maturity through a pervasiveness that marks the Spirit's movement to possess utterly the Christian. Spirituality is relational: it seeks relationship with "the Other" through proximate relationships with self and others. Spirituality is interpretive: it recognizes "the Transcendent" in the moment-by-moment substrate of relational experience. Spirituality is integrative: it receives openly the Spirit's gift of transcendent meaning in each of life's experiences. In the absence of spirituality, transcendent meaning becomes elusive. In consequence of an immature spirituality, transcendent meaning is at least partly elusive. In the throe of a maturing spirituality — with a progressive pervasiveness that marks the Spirit's movement to utterly possess the Christian — the Christian can more fully recognize and receive transcendent meaning as the gift of the Spirit who, in the words of Jesuit poet Gerard Manley Hopkins, "over the bent World broods with warm breast and ah! Bright wings." Transcendent meaning, then, is the gift of the Spirit — and the gift is a loving relationship of union with the Spirit's very Self experienced as wholeness.

For the physician who is also a Christian, the substrate of transcendent meaning is the experience of the imperiled healing relation-

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53This phrase signals my intention to limit the scope of this essay to "the [clinical] physician who is also a Christian." I do this because of my belief that a discussion of the physician as "a contemplative likewise in action" is best begun among those who share a common faith-tradition — whose spiritual language is likely to provide for substantial dialogue and agreement. While this is indeed a large cohort, I believe that certain Christian physicians, most notably those of the Roman Catholic faith-tradition, may find my words more resonant because of the sources and the approach that inform this essay. Be that as it may, another question could be asked here: Could it be that Christian physicians, or even Catholic Christian physicians, are completely or largely content with medical practice — that is, they inhabit Kassirer's "small but substantial fraction" of practitioners who describe themselves as "very satisfied"? There are no studies to suggest such an implausible situation. My personal anecdotal experience of speaking with Christian physicians, especially (though hardly exclusively) Catholic Christian physicians, in Arizona, Illinois, Michigan, Minnesota, Ohio, Pennsylvania, and South Dakota, suggests otherwise.
ship between physician and patient — the heart of clinical medical practice. Without that relationship, there is little, if any, transcendent meaning in practice; and without a maturing spirituality — without the cultivated ability to more fully recognize and openly receive the sought-after gift of transcendent meaning from this relationship, there is little, if any, transcendent meaning forthcoming. Without a maturing spirituality, the substantive meaning that can issue from the physician-patient relationship will seem largely buried, hidden, or locked away — inaccessible to the dispirited doctor. Why is that? The answer, I suggest, is that a maturing spirituality is progressively pervasive: it insinuates itself in a person’s life, reflecting the Spirit’s movement to possess the believer. It is not enough, then, to have an immature spirituality that remains isolated from medical practice, not fully integrated with it, and, therefore, incapable of dynamically informing it. An immature spirituality offers an experience of clinical practice that is spiritually desiccated.

It is my conviction, however, that despite their well-chronicled suffering, physicians who are engaged Christians may be gifted with, recognize, and openly receive the transcendent meaning and spiritual flourishing they seek as sustenance for their caring work by disposing — opening — themselves to a more thoroughgoing integration of their spirituality and their clinical practice: by allowing their spirituality to mature — by allowing the Spirit to possess them more fully and inform their practice as the Spirit desires and invites.\(^{54}\) I offer in this project an experiential understanding — informed principally by the spirituality of Basque mystic, saint, and spiritual director Ignatius Loyola and his interpreters — of how this spiritual integration unfolds as “the contemplative attitude,” which deepens through grace, opening the way to “finding God in all things,”\(^{55}\) as — in the words of Jesuit Father Jerónimo Nadal — *simul in actione contemplativus*, “a contemplative

\(^{54}\)A presupposition of my thesis is that Christian physicians possess a Christian spirituality that may or may not be maturing.


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likewise in action.”\textsuperscript{56} I invite physicians to dispose themselves to the emergence of the Spirit’s gift of “the contemplative attitude” in the clinical setting — to dispose themselves to becoming what they naturally\textsuperscript{57} are: contemplative physicians, or “contemplatives likewise in the practice of medicine,” more fully attentive to the sacredness of the present moment — to “the divine milieu.”\textsuperscript{58}

Does the Spirit invite physicians\textsuperscript{59} to dispose themselves to the integration of spirituality and clinical practice — to become “contemplatives in action”?\textsuperscript{60} Many messengers proclaim this invitation. Consider Ben Sira, the ancient author of the Book of Sirach,\textsuperscript{61} who in chapter 38 tells us, “God it was who established his [the physician’s] profession. From God the doctor has his wisdom.”\textsuperscript{62} For Ben Sira, the physician — through her or his practice — glorifies God, whose “creative work continues without cease.”\textsuperscript{63} Furthermore, the physician “be-seeches God [t]hat his diagnosis may be correct and his treatment bring about a cure.”\textsuperscript{64} These words of sacred scripture not only suggest, but also presuppose, a thorough integration of spirituality and medical practice. Ben Sira calls for a spirituality of the workplace — recognition that spirituality is inseparable from the rest of life. Nothing lies outside the encompassing sphere of spirituality’s integrative gaze.

\textsuperscript{56}\textit{Simul in actione contemplativus} in this context translated from Latin denotes “a contemplative likewise in action” (Joseph F. Conwell, \textit{Contemplation in Action: A Study in Ignatian Prayer} [Spokane, Washington: Gonzaga University, 1957], p. 25).


\textsuperscript{59}In this context and henceforth—unless otherwise noted, the term “physician” connotes “Christian clinical physician.”

\textsuperscript{60}.Classen, “Three Powers,” p. 265.

\textsuperscript{61}The \textit{Book of Sirach} (also known as the \textit{Wisdom of Sirach}, or \textit{Ecclesiasticus}) is for Roman Catholic and Orthodox Christians a canonical, or, more accurately, a “deuterocanonical,” text. Protestant Christians consider this book apocryphal, and, therefore, have traditionally excluded it from the Old Testament canon (Bernhard W. Anderson, \textit{Understanding the Old Testament} [Upper Saddle River, New Jersey: Prentice Hall, 1998], p. 4).

\textsuperscript{62}\textit{Sirach} 38,1-2 NAB.

\textsuperscript{63}\textit{Sirach} 38,6-8 NAB.

\textsuperscript{64}\textit{Sirach} 38,14 NAB.
The Spirit's "invitation" also resonates in the insights of various Christian spiritualities, Ignatius Loyola's among them.\textsuperscript{65} Consonant with the wisdom of Ben Sira, Ignatius Loyola writes in the "Principle and Foundation" of the \textit{Spiritual Exercises}, that "the end for which we [human beings, including, of course, physicians] are created" is "to praise, reverence, and serve God our Lord."\textsuperscript{66} Through his practice of medicine, the physician is presented with the opportunity to participate in the overarching \textit{telos} of relationship with God. To take advantage of this opportunity, the physician has to become "a seeker of God in all things," "a contemplative likewise in action," someone who has been able to integrate spirituality and medical practice. But how does this "integration" unfold for the clinician? I submit that it does so as the gift of "the contemplative attitude" — that "centered," immediate, relational disposition of attentiveness to the Spirit deriving from a proximate attentiveness to self and others, from that disposition that Walter J. Burghardt has described as "a long loving look at the real."\textsuperscript{67} Sir William Osler suggested as much in his address to American and Canadian medical students in 1905:

Nothing will sustain you more potently than the power to recognize in your humdrum routine, as perhaps it may be thought, the true poetry of life — the poetry of the commonplace, of the ordinary man, of the plain, toil worn woman, with their loves and their joys, their sorrows and their griefs.\textsuperscript{68}

The physician possessed of the "contemplative attitude" engages in a medical practice that moves him or her beyond \textit{techné} \textsuperscript{69} into the

\textsuperscript{65}Sixteenth-century Basque mystic, saint, spiritual director, and founder of the Society of Jesus.
\textsuperscript{69}\textit{Techné} in this context denotes "the skill, art, or craft and general know-how, the possession of which enables a person to produce a certain product. The term is used not only to describe ... the kind of knowledge a shoemaker needs to produce shoes,
purview of that "spiritual exercise" by which he or she seeks and finds God in the examination room:

For Christ plays in ten thousand places,
Lovely in limbs, and lovely in eyes not his
To the Father through the features of men's faces.\textsuperscript{70}

Such a "contemplative physician" is more "centered" upon the patient, more attentive, more affectively present, more instrumental, more capable of instantiating the telos of medicine in the patient's narrative, more likely to find God, than previously — all "for the benefit of the sick."\textsuperscript{71} Through "the contemplative attitude," the Spirit may come to wholly possess the physician.\textsuperscript{72} The physician, however, must first make himself available to the integration that the Spirit desires to bestow. He must allow the (re)joining of spirituality and medical practice — kept apart too long.\textsuperscript{73} It does not suffice that physicians practice their faith-tradition regularly though in a manner that prevents this faith from fully informing medical practice. I speak from my own experience as a practicing Christian who, for a great many years, was unable to meaningfully integrate spirituality and medical practice,\textsuperscript{74} I invite physicians to dispose themselves, in the clinical setting, to the emergence of the Spirit's gift of "the contemplative attitude" — to become "contemplatives likewise in the practice of medicine." Throughout this essay, I use illus-

but also to describe the art of a physician which produces health ... Thus technée as an applied science concerned with production is often contrasted with epistémé, which is pure scientific knowledge for its own sake" (Ostwald, notes to Nicomachean Ethics, p. 315).


\textsuperscript{71}The phrase "for the benefit of the sick" is drawn directly from the Hippocratic Oath (Verhey, "The Doctor's Oath," p. 72).

\textsuperscript{72}Here I reflect the influence of Carmelite Sister Ruth Burrows for whom "mystical" denotes "being wholly possessed by God" (Ruth Burrows, Guidelines for Mystical Prayer [Denville, New Jersey: Dimension Books, 1976], p. 10).

\textsuperscript{73}Cassell, "The Nature of Suffering," p. 15.

\textsuperscript{74}Physician, author, and spiritual director Gerald G. May of the Shalem Institute for Spiritual Formation, Mount Saint Alban, Washington, District of Columbia, has a moving account of his own dilemma along these very lines (May, The Awakened Heart, pp. 213-221).
trative vignettes drawn from my varied experience as a primary care internist: practicing at the Kettering Medical Center, Kettering, Ohio, in affiliation with the Wright State University School of Medicine, Dayton, Ohio; practicing with American Indian patients\textsuperscript{75} on one or another of four reservations or at the ambulatory medicine center of the American Indian Health Service of Chicago\textsuperscript{76} in affiliation with the

\textsuperscript{75}Although there have been significant improvements, the health of American Indians and Alaska Natives remains below that of the general population of the United States, because of the continued poor nutrition, the unsafe water supplies, the inadequate waste disposal facilities, and the physical isolation of reservations. Major health problems include poor prenatal care, aging, coronary artery disease, type 2 diabetes mellitus, alcoholism, mental illness, and accidents. While coronary artery disease is the most common cause of death in Native Americans, accidents rank number 2, with diabetes and chronic liver disease ranked 4 and 5, respectively. Causes 2, 4, and 5 do not rank in the top ten causes in the general population. The current age-adjusted alcoholism death rate for American Indians is 440 percent higher than that of the general population; the accident death rate is 165 percent higher; the diabetes-related death rate is 154 percent higher; the homicide rate is 50 percent higher; and suicide rate is 43 percent higher (Communications Office of the Indian Health Service, United States Department of Health and Human Services, \textit{Comprehensive Health Care Program for American Indians and Alaska Natives} [Washington, District of Columbia: United States Department of Health and Human Services, 1995], pp. 6-9).

\textsuperscript{76}The American Indian Health Service of Chicago, where I began work on 26 November 1997, is an urban health center for American Indians and Alaska Natives located in the uptown district of metropolitan Chicago at 838 West Irving Park Avenue within walking distance of the American Indian Center at 1630 West Wilson Avenue, and the American Indian Economic Development Association at 4753 North Broadway Avenue. The American Indian Health Service of Chicago, or the AIHS of Chicago, incorporated on 23 December 1974 by members of the Chicago Indian community for “the purpose of improving the availability and accessibility of health services for American Indians in the Chicago area” through a facility serving individuals on a non-profit basis, is affiliated with the Indian Health Service, or IHS, the University of Illinois at Chicago College of Medicine, and the Rush Presbyterian-St. Luke’s School of Nursing. The fundamental purpose of the AIHS of Chicago is to provide health care for urban Native Americans with a legitimate tribal affiliation based on criteria established by the federal government in conjunction with each of the federally-recognized tribes and bands. The ambulatory medicine center provides primary health care, counseling, support-groups, medication, and medical education for Native American patients, as well as clinical medical education for medical and nursing students. Approximately 50 percent of the patients who use the services of the AIHS of Chicago have no health insurance. Medicaid or Medicare covers the remaining 50 percent. The center is staffed by a receptionist, a clinical nurse, two community health nurses, two nurse practitioners, an executive administrator, three middle-level administrators, and two
University of Illinois at Chicago College of Medicine, Chicago, Illinois, and the Indian Health Service\textsuperscript{77}; practicing spiritual direction with physicians, one of whom — the author — is a volunteer. Current funding for the AIHS of Chicago is through the IHS, the March of Dimes, and the United Church of Christ (American Indian Health Care Association, \textit{The Urban Indian Health Program} [Saint Paul, Minnesota: American Indian Health Care Association, 1984], pp. 7-8).

\textsuperscript{77} The Indian Health Service of the United States Department of Health and Human Services is the major federal health care provider to Native Americans. The IHS provides a comprehensive health services delivery system for American Indians and Alaska Natives with the opportunity for maximum tribal involvement in developing and managing programs to meet health needs. The goal of the IHS is to raise the health status of the American Indian and Alaska Native people to the highest possible level. To carry out its mission, the IHS: (1) assists Indian tribes in developing their health programs through activities, such as health management training, technical assistance and human resource development; (2) facilitates and assists Indian tribes in coordinating health planning, in obtaining and utilizing health resources available through federal, state, and local programs, in operating comprehensive health care services, and in health program evaluation; (3) provides comprehensive health care services, including hospital and ambulatory medical care, preventive and rehabilitative services, and the development of community sanitation facilities; and (4) serves as the principal federal advocate for Indians in the health field to ensure comprehensive health services for American Indian and Alaska Native people. The relationship between the federal government and Native American tribes derives from 350 treaties signed by the federal government and by various Indian tribes, beginning in 1784, when the first treaty was signed with the Delaware Nation, and ending in the last half of the nineteenth century with the signing of a treaty between the federal government and the Nez Perce Tribe of Idaho. As a result of these treaties, the federal government guarantees certain rights for Native Americans by virtue of a "trust responsibility" that entitles Native peoples "to participate in federal financial programs and other services, such as education and health care. Some tribes declined to sign treaties with the United States, and, as a consequence, are not "federally recognized," and are, therefore, ineligible for participation in federal programs, such as the IHS. The IHS provides care for the 545 federally-recognized tribes and bands on Indian reservations in 34 states, and in urban centers in the contiguous 48 states. The Native American population, based on 1990 census figures, is estimated to exceed 2 million persons, of which 1.34 million qualify for federal services. Most tribes and bands have tribal governments and constitutions established under the Indian Reorganization Act, the Oklahoma Indian Welfare Act, and the Alaska Native Act. Consistent with tribal sovereignty, the Indian Self-Determination and Education Assistance Act of 1975 builds on the IHS policy of permitting tribes the option of "staffing and managing IHS programs in their communities, and provides for funding for the improvement of tribal capability" to administer local facilities. Increasing numbers of American Indian and Alaska Native governments are exercising operational control over the hospitals and the outpatient facilities on their reservations (Communications Office of the Indian Health Service, \textit{Comprehensive Health Care Program}, pp. 6-9).
clinical physicians; and conversing with them. These vignettes serve as tangible reminders that physicians confront a crisis of substantive meaning born of progressive diminution, confusion about the instantiation of the telos of medicine, and concurrent calls from patients and patient advocates to be more spiritually sensitive. As a fellow traveler, I draw the attention of my sister and brother physicians to the Spirit’s invitation for them to come closer — an invitation that can be accepted through the cultivation of openness to receiving “the contemplative attitude” as “contemplatives likewise in action,” from which they may recognize and openly receive the transcendent meaning that sustains them, even in the midst of their suffering.

The Clinicians’ Crisis of Meaning

Many physicians are dismayed. Some are frankly morose. Complaints come from academics and practitioners alike, from those who are heavily affected by managed care and those who are not. There has been an undercurrent of unhappiness among physicians for many years, but the complaints seem more widespread and more strident now. One thing we know: disgruntled, cranky doctors are not likely to provide outstanding medical care.

—Jerome P. Kassirer, “Doctor Discontent”

At the 2000 convocation of the fellows and the masters of the American College of Physicians—American Society of Internal Medicine, internist Whitney W. Addington (the College’s president), warned the assembled physicians that 25 percent of them would likely develop, during their practice years, a major affective disorder, namely, depression. Citing the toll of chronic and potentially debilitating stress factors on contemporary clinical practitioners, Addington recommended that his fellow internists “have a personal physician—an internist” for when that day finally comes. Alabama internist Mark A. Stafford, addressing clinicians suffering from “compassion fatigue,” or “burn out,”

79 Whitney D. Addington, “President’s Address” (presented at the annual convocation of the American College of Physicians – American Society of Internal Medicine, Philadelphia, Pennsylvania, 13 April 2000).
laments that the "ever-increasing pace" of clinical medicine "can wear down the most positive among us," ultimately forcing physicians to leave medical practice.\textsuperscript{80} Physician advocate William Bazan of the Wisconsin Health and Hospital Association writes in his book, \textit{Medicine in Search of Meaning: A Spiritual Journey for Physicians}, that clinical practitioners have lost a "sense of meaning and purpose."\textsuperscript{81} Depression, "burn out," and loss of "meaning and purpose" are only some of the words and phrases that physicians increasingly apply to themselves, as well to some of their patients. What is happening to America's physicians? While, as Kassirer points out, there has been "an undercurrent of unhappiness among physicians for many years,"\textsuperscript{82} the harsh and strident tone of contemporary expressions of unhappiness among physicians bodes ill for physicians and patients alike, because "cranky doctors are not likely to provide outstanding medical care."\textsuperscript{83}

Of course, not all physicians are suffering. At a recent meeting of clinicians in suburban Chicago — the theme of which was "medicine and spirituality" — a busy nephrologist confided in me that he was "quite happy" with the practice of medicine: "I love my work. It's interesting. I'm not starving. I'm well paid. My kids go to good schools. I don't understand what these guys [other physicians] are complaining about. They're not starving."\textsuperscript{84} This, unfortunately, seems to be the minority view: A 1995 survey of 1700 practicing physicians found that only 25 percent described themselves as "very satisfied with the practice of medicine."\textsuperscript{85} Many physicians find these statistics alarming, especially when coupled with "abundant anecdotal evidence" of physician discontentment.\textsuperscript{86}

\textsuperscript{80}Mark A. Stafford, "Burned Out? Ask Patients about Their Quality of Life," \textit{ACP Observer} 20, no. 2 (2000): p. 3.

\textsuperscript{81}William Bazan, \textit{Medicine in Search of Meaning: A Spiritual Journey for Physicians} (Mequon, Wisconsin: Caritas Communications, 1999), 15.

\textsuperscript{82}Kassirer, "Doctor Discontent," pp. 1543-1545.

\textsuperscript{83}\textit{Ibid.}

\textsuperscript{84}This vignette is drawn from a conversation with the nephrologist quoted in Barrington, Illinois, 11 February 2000.

\textsuperscript{85}Kassirer, "Doctor Discontent," pp. 1543-1545.

\textsuperscript{86}\textit{Ibid.}
How are physicians suffering? To enrich this discussion, I present an illustrative vignette drawn from my experience as the attending physician on an internal medicine inpatient teaching service in 1992:

I joined the team as we visited Mrs. Eveningstar [not her real name], a 55 year old Caucasian woman with no history of alcohol abuse who had been admitted the night before from the emergency room with acute pancreatitis, cause unknown (though later presumed to be secondary to severe hypertriglyceridemia). Mrs. Eveningstar’s disease was moderate in severity, and her course was one of measured improvement until about the third day of her hospitalization when she began to complain of vague left lower quadrant abdominal pain that gradually became bilateral. Because she had been progressing reasonably well, the inpatient service team had projected a discharge date on the fourth day of hospitalization. Unfortunately, the patient’s new symptoms demanded further evaluation, including, though not exclusively, a general surgery consultation. When the utilization review nurse confronted me in my capacity as the attending physician about why this patient was not ready for discharge, I carefully explained the need for further evaluation of the patient’s new symptoms prior to discharge. Shortly thereafter a representative of the patient’s insurance company, a local health maintenance organization of some reputation, telephoned to say that my residents’ care was inefficient, and that I was to exclude this patient from the teaching service and manage the care of the patient directly — in order to expedite discharge. Coming on the heels of other similar disputes with the same organization and its unitization review nurses, I grew frustrated and then very angry. A firestorm of controversy and indignation erupted within the inpatient service team and the teaching staff generally. At one point, I wondered, ‘How can medicine really be worth this kind of aggravation?’

This vignette illustrates some of the endemic problems afflicting clinical practitioners today. Confronted with various chronic stressors, which seem both more prevalent and more nettlesome than in the past, clinicians find their work less satisfying — less meaningful. Kassirer observes, “Abundant anecdotal evidence and several surveys identify

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67This vignette is drawn from my experience of practicing and teaching internal medicine at the Kettering Medical Center, Kettering, Ohio, and the Wright State University School of Medicine, Dayton, Ohio, 1992.
some of the factors that underlie their [physicians’] discontent,” and the “actions doctors are taking confirm that there is substantial dismay. What are they complaining about, and what are they doing about it?”

Physicians are frustrated, according to Kassirer, with “their attempts to deliver ideal care, restrictions on their personal time, financial incentives that strain their professional principles, and the loss of control over their clinical decisions.” He continues:

[Their time is] increasingly consumed by paperwork that they view as intrusive and valueless, by meetings devoted to expanding clinical-reporting requirements, by the need to seek permission to use resources, by telephone calls to patients as formularies change, and by the complex business activities forced on them by the fragmented health care system. To maintain their incomes, many not only work longer hours, but also fit many more patients into their already crowded schedules ... [that] leave little time for their families, for maintenance of physical fitness, for personal reflection, or for keeping up with the medical literature.

Putting an even finer point on the causes for physician discontent, Kassirer states that many physicians “are disturbed about the limitations on their capacity to make independent clinical decisions,” and about “incentive systems that reward them for spending less money on patient care,” engendering “wrenching ethical dilemmas” that “create an intolerable threat to physicians’ integrity if the incentives are strong enough to tempt doctors to shun sick patients.” He adds, “Physicians whose bonuses depended on ... measures of productivity had higher levels of anxiety and concern that they might be compromising patient care than physicians whose bonuses were indexed to the quality of care ...” In addition to these factors, the financing of a medical practi-
tice seems to be "a major source of frustration." As "a consequence of new technology, new drugs, and an aging population," insurers may without warning cut physicians' fees, which — when combined with "payment delays, denials of claims, and the expense of complying with ever more complex and demanding regulations" — adds greatly to the frustration felt by practitioners.

The degree and extent of physician discontent has not been exhaustively studied. In the previously cited 1995 survey of 1700 practicing physicians, results revealed that approximately 40 percent of physicians surveyed reported that "they were spending less time with patients than they had three years earlier," and that their capacity "to make good decisions for their patients had declined." Fully 60 percent of these physicians had serious problems with external reviews, and approximately one third were either "somewhat dissatisfied" or "very dissatisfied" with medical practice. As noted earlier, only 25 percent of these practitioners were "very satisfied with the practice of medicine." Indeed, the current trend favors "increasingly frustrated physicians." Many clinical physicians have sold their practices and joined multi-speciality groups, hospital networks, or physician management companies. Others "have simply given up," and "have retired early or have filed for disability insurance," with disability claims among physicians up dramatically in the last few years. Kassirer worries that many physicians in their forties and fifties "are searching for new, nonclinical careers in administration, communication, or education." Others have turned

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94 Ibid.
95 Ibid.
96 Ibid; See also K. S. Collins, C. Schoen, and D.R. Sandman, The Commonwealth Fund Survey of Physician Experiences with Managed Care (New York: Commonwealth Fund, 1997).
98 Ibid.
to unionization, with practitioners in California, Arizona, and New York — among others — affiliating with larger, well-established unions “with which they seem to have little in common,” such as, the American Federation of State, County, and Municipal Employees and the International Association of Machinists and Aerospace Workers.\textsuperscript{102}

There are observers who maintain that physicians will eventually adapt, and become more content. Some clinicians, for example, are meeting the challenges “head-on” by mastering bookkeeping, accounting, working in groups, aggressively negotiating with insurers, competing with local hospitals by setting up testing laboratories, and by selling products like “vitamins, herbs, food supplements, cosmetics, and household cleaners.”\textsuperscript{103} At the present time, however, many clinicians are “dismayed,” if not “frankly morose.” Kassirer warns: “Payers, insurers, and legislators must recognize this predicament and stop pretending that doctor discontent doesn’t matter.”\textsuperscript{104} Physician executive E. R. Washburn sees a “coming medical apocalypse,”\textsuperscript{105} citing “five ominous trends” that suggest an imminent “medical meltdown” — the first four\textsuperscript{106} of which contribute to the fifth: “Providers [are] losing faith in their future and becoming increasingly demoralized about practicing the healing arts.”\textsuperscript{107} Physician David C. Squillacote of the Multiple Sclerosis Foundation claims, “Words [used to describe physicians’ attitudes] such as ‘unhappy,’ ‘dismayed,’ and ‘frustrated’ could easily...[be] replaced with ‘angry,’ ‘dispirited,’ and ‘hostile.’ Many of us feel we were

\textsuperscript{102}Ibid; See also A. Adelson, “Physician, Unionize Thyself: Doctors Adapt to Life As HMO Employees,” \textit{New York Times}, 5 April 1997.


\textsuperscript{104}Kassirer, “Doctor Discontent,” pp. 1543-1545.


\textsuperscript{106}The first four “ominous trends” include “(1) The practice of providing medical care becoming too complex from both a business and a legal perspective; (2) Less money being spent on medical care without any corresponding reduction in services provided, creating long-term operating deficits; (3) Investor-owned, for-profit corporations changing the focus of medicine by putting shareholder concerns ahead of patient care; [and] (4) Employment-linked health care insurance creating a growing uninsured population, adding extra financial stress to our hospitals” (Washburn, “Coming Medical Apocalypse,” pp. 34-39).

sold a bill of goods,” accepting “years of long hours, low pay, and tremendous responsibility.”

Physician Richard A. Kendrick states soberly, “What really scares me the most is that as I get older, I will become a more and more frequent consumer of health care services delivered by disgruntled physicians who have incentives to give less and less care.”

The dismay — a symptom of the syndrome of physician dysphoria — underscored by Addington, Stafford, Bazan, Kassirer, Washburn, Squillacote, Kendrick, and many others, is further aggravated by the confusing fluidity of medicine’s traditional Hippocratically-informed telos: “to advocate [for] the ‘good’ of the patient at all times.” What now counts as “the good of the patient”? As I suggested earlier, physician-assisted suicide is an example of the fluidity of the instantiation of telos of medicine. Since the late fourth or early fifth century B. C. E., this “practice” has been proscribed by the medical profession — guided by the healing spirit of the reformers who promulgated the Hippocratic Oath: “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.” Yet, voters in the State of Oregon affirmed — and physicians there engage in — this “practice” now sanctioned by the Oregon Death with Dignity Act, Oregon Revised Statute §§ 127.88 – 127.995, which was implemented after a 4 November 1997 referendum decided against repeal. Almost two years later, however, on 27 October 1999, the United States House of Representatives, “alarmed” by the Oregon law, passed a bill that would make it a federal crime for physicians “to prescribe drugs to help terminally ill patients end their lives,” or any “intended” act of physician-

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110 From the Hippocratic Oath: “Whatever house I may visit, I shall come for the benefit of the sick…” (Verhey, “The Doctor’s Oath,” p. 72).
111 Pellegrino and Thomasma, Philosophical Basis of Medical Practice, p. 24.
assisted suicide.114 According to the bill, a physician who prescribes pharmacological agents “for the purpose of causing death” would be subject to substantial criminal penalties.115 Representative Henry J. Hyde of Illinois argued that the House was simply trying to protect “the sanctity of life by forbidding doctors to prescribe drugs for the purpose of hastening death.” He observed that Oregon “decided to change the time-honored professional purpose of medicine and give doctors the option to serve no longer as healing forces, but as social engineers, messengers of death. Doctors are authorized by the Oregon law to put down the stethoscope and pick up the poison pill and assist in the execution of their patients.”116 Representative Jim McDermott of Washington—who is a physician—countered that Congress “was arrogantly setting the standards for the practice of medicine.”117 The American Medical Association came out in support of the House bill, noting that the AMA has “long opposed assisted suicide” as being “antithetical to the role of physician as healer.”118 Abortion opponents at the national Right to Life Committee also offered support for the bill arguing that it was because of the “concern for the vulnerable and the powerless” that such a stand is needed.119 This apparent shifting toward and away from the “practice” of physician-assisted suicide underscores the lack of consensus within the community of practitioners and the community of patients in the United States of America regarding the instantiation of the telos of medicine. How can it be that physician assisted suicide is both consistent with and opposed to the telos of medicine?

Interestingly, the “spirituality-in-medicine” movement contributes to physician bewilderment and frustration vis-à-vis the fluidity of instantiations of the telos of medicine. With no clear understanding, or working definition, of the term “spirituality”120 among physicians, the

115Pear, “House Backs Ban.”
116Ibid.
117Ibid.
118Ibid.
119Ibid.
120Even among the advocates of a closer relationship between medicine and spirituality, it is difficult to detect a clear conception of the meaning of the term “spirituality.” Some physician-authors rather weakly describe spirituality as “[that] which
debate here is often confused — and sometimes heated. The prospects for clarity and consensus seem rather remote at present. Consequently, advocates are moving to embrace a closer relationship between medicine and spirituality, especially in the examination room where practitioners are encouraged to be more spiritually sensitive. At the same time, others are more cautious — and still others are openly hostile to any rapprochement of medicine and spirituality. For example, a California physician — angered by the suggestion of raising “spiritual issues” with patients — declares that such “recommendations are unacceptable because belief in ‘spirituality’ is incompatible with science,” adding:

It is axiomatic that only phenomena that are measurable can be investigated and until phenomena can be measured they must remain speculative or theoretical … spirituality is not quantifiable or provable. Therefore, spirituality has no place within science or scientific medicine. Furthermore, spiritual issues cannot be researched scientifically, so we cannot expect this subject to become part of science … Teaching the use of spirituality [in medical schools] would be similar to teaching the use of fortune-telling, parapsychology, and other nonscientific methodologies. Nor should the medical model be changed to include spirituality. The term scientific-spiritual to describe a medical model would be an oxymoron … Physicians that believe in science will need to resist such movement.122

For this physician, spirituality reduces the physician to “a shaman.”123 Of course, it can be argued here that this physician reveals his own spirituality, which emerges from his scientific “religion.” But, I digress. My point here is that the dialogue within the community of practitioners is a confused one in which many physicians do and do not see spirituality as participating in the instantiation of the telos of medicine

123Ibid.
123Ibid.
— as advancing "the good of the patient" through the medical "art, based on science."\textsuperscript{124}

Yet, it is increasingly clear that the community of patients desires, if not demands, physicians who are more spiritually sensitive: A 1999 study of 177 patients conducted at the University of Pennsylvania demonstrated that 94 percent of the patients who reported religious beliefs agreed that "physicians should ask gravely ill patients whether they have such beliefs." Furthermore, almost half of those patients who "denied having spiritual or religious beliefs that would influence medical decisions nevertheless agreed that physicians should ask about them."\textsuperscript{125}

How will physicians handle these findings?

All of this indicates how physicians are suffering. But why are they suffering? I argue that physician suffering is a crisis of meaning — a crisis of substantive, or transcendent meaning. Consider the following vignette drawn from a conversation I was privileged to have with a struggling, though very caring, young clinical pediatrician who practices in Chicago:

Having read about Dr. Tom Dooley "when I was 10 years old, I dreamed of going to medical school." Pediatric clerkship intensified "my desire to serve children and their parents." After completing a pediatric internship and residency, "I entered private practice as a member of a large group of pediatricians." At first, work was "very satisfying." Patients and their parents responded to her healing work, conferring on her a sense of satisfaction that diminished the discomfort of "the minor inconveniences of practice," such as, administrative paper work and telephone calls from insurance company representatives. Gradually, however, she noticed "fewer and fewer" of such satisfying moments. They seemed displaced by the lingering feelings of her fights with insurance company representatives, and even with the patients themselves — particularly over antibiotic usage for viral upper respiratory tract

\textsuperscript{124}William Osler, "Teacher and Student," \textit{Aequanimitas with Other Addresses to Medical Students, Nurses and Practitioners of Medicine} (New York: McGraw-Hill, 1932), p. 34.

\textsuperscript{125}Ehman, Ott, Short, Ciampa, and Hansen-Flaschen, "Do Patients Want Physicians to Inquire," pp. 1803–1806.

\textsuperscript{126}This vignette is drawn from a conversation with the pediatrician quoted in Barrington, Illinois, 11 February 2000.
infections. Now she voices mostly frustration. To the question, "Why do I keep going?" she answers, "Frankly, I need the money — I have bills to pay."\textsuperscript{126}

This vignette strengthens my belief that medicine’s stressors now dwarf whatever meaning physicians once derived from clinical practice. Indeed, I suspect that stressors are — in some instances — actually diminishing what were once sources of significant meaning, such as, the physician-patient relationship. At stake here is whether or not physicians can “find” the substantive meaning that sustains their care. As patients, we should all be concerned. And where does this leave physicians?

The chronic stressors of contemporary medical practice, I believe, carry an invitation to physicians regarding substantive meaning: to seek and “find” that meaning in their suffering — and in their joy. What will it take for practitioners — for Christian physicians — to move from anger, confusion, despair, dismay, dispiritedness, and frustration, and say with the Apostle Paul, “We are afflicted in every way, but not constrained; perplexed, but not driven to despair; persecuted, but not abandoned; struck down, but not destroyed; always carrying about in the body the dying of Jesus, so that the life of Jesus may also be manifested in our body”?\textsuperscript{127} It will take the substantive meaning that flows from a more thoroughgoing integration of personal spirituality and clinical practice — from an ever-maturing spirituality, from an ever-deepening relationship with the Spirit.

I was struck recently at a meeting of several thousand physicians at just how quiet the assembled were after a stirring invocation by a local rabbi. When the visiting rabbi uttered the word “Amen” to end his invocation, the assembled were absolutely silent. I like to believe that these physicians were simply speechless and prayerfully reflective. I suspect, however, that two very different worlds met, but remained separated by a wide gulf — a gulf that Cassell justifiably attributes to Cartesian dualism.\textsuperscript{128} The Spirit invites the Christian physician to cross that gulf. On the other side is the substantive meaning that sustains a caring physician.

\textsuperscript{127} Corinthians 4.8–11 NAB.
\textsuperscript{128} Cassell, “The Nature of Suffering,” p. 15.
The Spirit’s Invitation

Does the Spirit invite Christian physicians to “cross that gulf” to a more thoroughgoing integration of spirituality and clinical practice? I believe so. The invitation is explicitly extended — proclaimed — through the inspired writings of Yeshua ben Eleazar ben Sira, the author of the Book of Sirach, one of the few biblical authors who actually wrote the scriptural text ascribed to him. Ben Sira was a citizen of Jerusalem and a member of one of the city’s prominent families. As such, he was well

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129 The Judaic world of the author of the Book of Sirach, Yeshua ben Eleazar ben Sira, of the late second and early third centuries B.C.E. was a hellenized world, culturally transformed as a consequence of the conquests of Alexander the Great in the fourth century B.C.E. This transformation, which surged through the entire Near East, including Egypt, Palestine, Syria, Babylonia, and Persia, influenced many facets of life, including philosophy, literature, athletics, and religion (R. A. F. MacKenzie, Sirach, volume 19 of Old Testament Message: A Biblical-Theological Commentary, edited by Carroll Stuhlmueller and Martin McNamara [Wilmington, Delaware: Michael Glazier, 1983], 14; Victor Tcherikover, Hellenistic Civilization and the Jews, translated by S. Applebaum [Philadelphia: Jewish Publication Society of America, 1959], pp. 142-151). For the Israelites, there was a need to integrate these Hellenic, or Greek, cultural elements while preserving their traditional belief in Yahweh. This task was a less difficult one during the period of rule by the Egyptian monarchs, the Ptolemies, who ruled from Alexandria; but after Palestine was subjected to the rule of the Syrian monarchs, the Seleucids, who ruled from Antioch, a significant and progressive tension between the “Hellenizers” and the “Judaizers” developed, culminating in the Maccabean uprising in 166 B.C.E. (MacKenzie, Sirach, 14). Hellenism boasted many followers among the Israelites, and, ultimately, an internecine struggle erupted among Jews. The work of Yeshua ben Eleazar ben Sira, according to Professor R. A. F. MacKenzie, “reflects an early stage of the process, and though he bitterly reproaches the ‘apostates’...for the most part he takes for granted that his hearers are as loyal and faithful to ‘the tradition of the fathers’ as he is himself” (MacKenzie, Sirach, 14). From what we know of his dates, it is likely that Yeshua ben Eleazar ben Sira lived most of his life from birth until 198 B.C.E. under Ptolemaic rule, and, then, near the end of his life in 175 B.C.E., under Seleucid rule (Alexander A. Di Lella, "The Wisdom of Ben-Sira," volume 6 of The Anchor Bible Dictionary, edited by David Noel Freedman [New York: Doubleday, 1992], p. 933). “Yeshua,” or “Joshua,” is translated as “Jesus” in Greek, and “Sira” likewise is translated as “Sirach”; hence, the rendering of “Yeshua ben Sira” as “Jesus son of Sirach.” “Eleazar” denotes the name of the author’s father, and “Sira” denotes the name of the author’s grandfather (MacKenzie, Sirach, 15). I shall follow convention, and hereafter use the form “Ben Sira” to designate the author’s name, and “Sirach” to designate the Book of Sirach.

educated, widely traveled, and trilingual, conversant in Hebrew, Aramaic, and Greek. His work suggests that he “was devoted to the pursuit of wisdom” and to the reflective study of the sacred scrolls.\textsuperscript{131} The text of the \textit{Book of Sirach}, also known as the \textit{Wisdom of Ben-Sira}, the \textit{Proverbs of Ben Sira, Liber Ecclesiasticus},\textsuperscript{132} or simply \textit{Ecclesiasticus}, was originally written in Hebrew in Jerusalem around 180 B.C.E., and then translated into Greek for those Jews living outside Palestine who were no longer fluent in Hebrew.\textsuperscript{133} The purpose of Sirach was to respond to the Hellenization process begun under Alexander the Great and continued under the Ptolemies and the Seleucids. Ben Sira likely witnessed the effect of Hellenization on the faith and the practice of the Jews, and the publication of \textit{Sirach} was intended to buttress the faith of Israel. Ben Sira, however, did not seek to condemn Hellenism. Rather, he sought to demonstrate definitively that true wisdom resides in Jerusalem, not in Athens. Interestingly, Ben Sira incorporated a number of Hellenistic insights into his work — if they were reconcilable with the faith and the tradition of Israel.\textsuperscript{134} With respect to the text’s canonicity, the Roman Catholic and the Orthodox Churches, since the Patristic era, have regarded Sirach as canonical — specifically, deuterocanonical, in contradistinction to protocanonical — a status that was confirmed by the Council of Trent.\textsuperscript{135}

\textsuperscript{131}Sirach 34,11 NAB.

\textsuperscript{132}Liber Ecclesiasticus is rendered in English from Latin as “the Church book” (MacKenzie, \textit{Sirach}, 13). This title, which dates back to Cyprian (who regarded the text as canonical), probably reflects the use of this text in catechesis and liturgy (Bergant, \textit{Israel’s Wisdom Literature}, p. 166).

\textsuperscript{133}Bergant, \textit{Israel’s Wisdom Literature}, pp. 166-167. Ben Sira’s grandson notes in the foreword that he labored on the translation in “the thirty-eighth year of the reign of King Erugetes” (\textit{Sirach} Foreword NAB), which historians date at 132 B.C.E. (Bergant, \textit{Israel’s Wisdom Literature}, p. 168).


\textsuperscript{135}Alexander A. Di Lella, “Sirach,” chapter 32 of \textit{The New Jerome Biblical Commentary}, edited by Raymond E. Brown, Joseph A. Fitzmyer, and Roland E. Murphy (Englewood Cliffs, New Jersey, 1990), p. 497. The text, however, was excluded from the Hebrew canon during the second half of the first century C.E., when Pharisees in southern Palestine debated its canonicity within the context of closing the canon. Although the Hebrew canon was closed around 100 C.E., those books regarded as sacred and authoritative had been translated and gathered into the Septuagint. While Ben Sira was alive, the collection of sacred writings known as “the Writings,” or
With respect to composition, the text’s literary genre, structure, and content suggest that Proverbs heavily influenced Ben Sira,136 who moved beyond a simple proverbial citation, and developed the proverb by articulating its significance for his contemporary world, using a substantially longer instructional genre, rather than the basic proverbial sentence.137 The implicit theological purpose of the original text was to achieve a synthesis, for “those who love wisdom and desire to make even greater progress in living in conformity with divine law.”138

Kethubim, remained “open” (MacKenzie, Sirach, p. 20). The precise reason behind the book’s exclusion by the Pharisees remains unclear, although MacKenzie suggests that it may have been the result of the book’s relative newness, or, perhaps, because it disputed the pharisaic doctrines of resurrection and retribution (MacKenzie, Sirach, p. 20). The Septuagint, the Greek translation of the Hebrew sacred writings later canonized by the Catholic Church, included Sirach, which continues to be used extensively in Roman Catholic catechesis and liturgies. After having been written in Hebrew, the book’s prologue was written in Greek in three paragraphs by the author’s grandson, and was not constitutive of the original work of Ben Sira; hence it is not regarded as inspired or canonical (MacKenzie, Sirach, p. 20). Sirach was published in 117 B.C.E. (Di Lella, “Sirach,” pp. 496-497). It was this Greek translation, crafted by Ben Sira’s grandson, that enjoyed a wide circulation, and was eventually accepted into the Septuagint — and from there into the Latin Vulgate. When the Protestant reformers elected to appropriate the Hebrew canon, Sirach was relegated to a separate noncanonical category, the Apocrypha, in contradistinction to the Catholic deuterocanonical. (MacKenzie, Sirach, 17-18, 20). Once it was excluded from the Hebrew canon, the Hebrew text of the book ceased to be reproduced, and was lost until the nineteenth century. In 1896, four manuscripts—approximately two thirds of the text—were recovered in Cairo in the Ezra Synagogue’s genizah, a storage cubicle for discarded sacred manuscripts (Bergant, Israel’s Wisdom Literature, p. 166). These manuscript fragments were subsequently published in 1930 and in 1957. In the twentieth century, additional fragments were recovered from archeological sites at Qumran (1948) and Masada (1964). Both sets of manuscript fragments authenticate the Cairo document. Today, two thirds of the Hebrew text of Sirach has been recovered (Bergant, Israel’s Wisdom Literature, p. 166; Patrick W. Skehan and Alexander A. Di Lella, “The Wisdom of Ben Sira,” in The Anchor Bible [New York: Doubleday, 1987], pp. 51 – 62), and has been used extensively in contemporary biblical translations, including those that I use in this essay. Christians, of course, have preserved the Greek translation of the Hebrew text, which has been augmented considerably over two millennia, with verse enumeration added during the sixteenth century (MacKenzie, Sirach, p. 18).

137Bergant, Israel’s Wisdom Literature, p. 167.
138Sirach: Foreword NAB.
of an abundance of traditional material from two distinct traditions: Ben Sira sought to weave a tapestry using threads taken from the “Mo-
osaic tradition of salvation-history and covenant-theology” and from the
wisdom tradition of the Near East with its emphasis on creation in the
absence of any understanding of Yahweh.”139 In Sirach, Yahweh is clearly
identified as the Creator from whom divine “Wisdom” emanates to of-
fer herself to humankind;140 but more must be said of “wisdom” be-
fore I specifically return to the Spirit’s invitation to physicians.141 Scrip-
ture scholar R. A. F. MacKenzie observes that “wisdom” for the Hebrews
on one level meant

‘skill,’ technology, the ability to adapt or control sectors of ma-
terial reality, of the physical world, for the advantage of human-
kind. Thus, the hunter, the trapper, the farmer ... would each have
his or her proper ‘wisdom,’ to be established by trial and error, then
to be transmitted partly by example partly by verbalization to the
next generation.142

“Wisdom” at a deeper level referred to social relationality, specifi-
cally to diplomatic relations, as the older parts of Proverbs evinces. At
a deeper level still, “wisdom” was a word that applied directly to the
Creator as “Wisdom”:

Since Wisdom is so precious a thing, it follows that God must
have his own, which will naturally be infinitely superior to any
human wisdom and quite inaccessible to humankind unless ... 
God in his goodness chooses to communicate it, by revelation, to
... his creatures.143

In Sirach, Ben Sira boldly personifies “Wisdom” as emanating “from
the mouth of the Most High,” closely identified with God, and mani-
festing in the Sinaitic covenant: “Wisdom” is in the “Law of Moses.”144

139 Di Lella, “Sirach,” p. 496.
140 MacKenzie, Sirach, p. 15.
141 The term “Wisdom” in this context and throughout this essay denotes “divine
wisdom.”
142 MacKenzie, Sirach, p. 16.
143 Ibid.
144 Sirach 24.1-31 NAB; Bruce Vawter, The Book of Sirach (New York: Paulist Press,
Of particular interest to contemporary clinical practitioners—who may question whether the Spirit invites them to accept the integration of their spirituality and medical practice—is the text of Sirach 38,1-15, which treats the subject of the physician with particular reference to the practice of medicine. There are a number of references to the physician in the Old Testament (and the New Testament), but few of these references pertain directly to the physician qua physician and the practice of the medicine. Consider the text of Sirach 38,1-15 NAB:

1Hold the physician in honor, for he is essential to you, and God it was who established his profession.
2From God the doctor has his wisdom, and the king provides for his sustenance.
3His knowledge makes the doctor distinguished, and gives him access to those in authority.
4God makes the earth yield healing herbs which the prudent man should not neglect;
5Was not the water sweetened by a twig that men might learn his power?
6He endows men with the knowledge to glory in his mighty works,
7Through which the doctor eases pain and the druggist prepares his medicines;
8Thus God’s creative work continues without cease in its efficacy on the surface of the earth.
9My son, when you are ill, delay not, but pray to God, who will heal you:
10Flee wickedness; let you hands be just, cleanse your heart of every sin;
11Offer your sweet-smelling oblation and petition, a rich offering according to your means.
12Then give the doctor his place lest he leave; for you need him too.
13There are times that give him an advantage, and he too beseeches God
14That his diagnosis may be correct and his treatment bring about a cure.

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145 Other references to physicians in the Old Testament can be found in 2 Chronicles 16.12, Genesis 50.2, Jeremiah 8.22, Job 13.4, Sirach 10.10, and Tobit 2.10.
15He who is a sinner toward his Maker
will be defiant toward the doctor.

This text rests in the second major division of *Sirach* (24,1–43,33 NAB), where its purpose is to reconcile the tension between the conflicting Jewish and Greek perspectives regarding the physician and the practice of medicine by articulating Ben Sira’s canonical synthesis—a synthesis that focuses on the person of the physician and the relationship between the physician and God, a relationship in which the physician and the practice of medicine are taken to be a part of God’s creation. Like the preceding and succeeding literary units, *Sirach* 38,1–15 is a two-stanza didactic poem with instructional verses arranged in a verse-couplet model. Of these 15 verses, I consider only those of import to the integration of the physician’s spirituality and clinical practice, beginning with verse 1: “Hold the physician in honor, for he is essential to you, and God it was who established (ḥalaq) his profession. The phrase “for he is essential to you,” underscores the significant role of the physician in society. The author, however, quickly adds that it was God “who established” the practice of medicine. That is, the healing effected by the physician is carried out in accord with the divine will, and, for that reason, the physician is to be honored, or respected. These are the words of “a practical man of faith,” who regards physicians and the practice of the medical arts as “God’s gifts.” The wise man, “seeking to understand God’s creation, will acknowledge and use the doctor as part of God’s provision for man.” Ben Sira’s view of the human physician, reflects a “Hellenized outlook on medicine and doctors, in which the doctor is God’s agent for healing.”

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148 The “physician,” or “healer,” wore a leather apron and used a bandage box that contained a writing stylus, a scissors, and a knife. The “physician” healed the wounded using various herbs produced by God, and was called upon to suck out snake venom, prescribe dietary regulations, and apply plaster to injured areas of the body (Julius Preuss, *Biblical and Talmudic Medicine*, edited and translated by Fred Rosner [New York: Sanhedrin Press, 1978], p. 11).
halaq is, according to Professor Gerhard von Rad, another significant word in verse 1, specifically in verse 1b.\footnote{Gerhard von Rad, *Wisdom in Israel* (Nashville, Tennessee: Abingdon, 1972), p. 134.} This word is sometime translated from the Greek text as “create” or “created,” in the sense that “the Lord created them [the physicians],” a translation that is reproduced in both the NRSV and the NEB versions of *Sirach* 38,1b. The NAB version of the verse, however, relying more heavily on the Hebrew text, translates halaq as “established his profession,” which is closer to the sense of “allot” or “allotted” advocated by von Rad, who translates verse 1b as “and God has given to him, too, his lot.”\footnote{von Rad, *Wisdom in Israel*, p. 134.} All told, I contend that verse 1 makes a bold statement by acknowledging that God sanctions the physician, rather than competes against her or him — also evident in verse 2a: “From God the doctor has his wisdom.” Here the NAB version speaks of the doctor’s “wisdom,” whereas the NRSV speaks of the doctor’s “gift of healing,” and the NEB speaks of the doctor’s “skill.” This seems to confirm that “wisdom” is being used in verse 2a to mean “skill,” which seems consistent with the subject of the remainder of the chapter.

According to the verse 1, God has established the practice of medicine, and the doctor, therefore, heals. Does this not create a difficulty for Ben Sira with respect to divine causality? In other words, who is healing, God or the physician, or both? If the physician heals, does this not create a problem for the traditional faith of Israel? Ben Sira here suggests that the physician and those who rely on the physician are not impious for valuing the medical arts — they do not lack faith in God to heal — for, in accord with verse 2, the wisdom of the physician comes from God.\footnote{MacKenzie, *Sirach*, p. 143.} Verse 4 further enmeshes the healing power of God with the physician’s practice of medicine: “God makes the earth yield healing herbs, which the prudent man should not neglect.” Not only does the physician’s “wisdom,” or “skill,” come from God, but also “healing herbs” on which the physician relies.\footnote{Ibid.} It would be impious not to use that which God has provided.\footnote{Ibid.}
Verse 5 asks: "Was not the water sweetened by a twig that men might learn his power?" Here, Ben Sira refers to an ancient incident recorded in Exodus 15,23–25 NAB, wherein the Hebrew refugees, having reached Mara in the Sinai, found the water too bitter to drink, at which point, Moses — at God's command — threw a wooden log into the water, which (the water) was then made sweet. Professor Snaith suggests that Ben Sira is re-interpreting the sweetening of the water in the Sinai as the result of the natural properties in the wood — indirect, rather than direct, divine action: "As God healed the water through the wood, so he heals humans through the doctor and his medicines." 158 Verse 6 affirms: "He endows men with the knowledge to glory in his mighty works." This verse suggests, when considered with verses 1–5, that the physician's "wisdom" and his "healing herbs" are the means through which the Most High may choose to heal a person, 159 and, thereby manifest divine glory. Although physicians and medicine are to be respected as "God's gifts," one must ultimately rely on God. 160 The doctor is God's way of curing illness. 161

Verse 8 rejoices: "Thus God's creative work continues without cease in its efficacy on the surface of the earth." This verse anticipates the words of the Irish Jesuit poet, Gerard Manley Hopkins, who wrote, "the world is charged with the grandeur of God." 162 Physicians are cast as God's intermediaries, and continue the work of creation. 163 Verse 14 makes even more explicit the relationship between God and the physician: "and he too beseeches God, That his diagnosis may be correct and his treatment bring about a cure." With this verse Ben Sira suggests a relationship between God and the physician born of a thoroughgoing integration of spirituality and medical practice. These words anticipate those of the Apostle Paul in 1 Corinthians 10,31–11,1 NAB: "Brothers and sisters, whether you eat or drink, or whatever you do, do everything for the glory of God." And Paul's words anticipate those of Ignatius

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158 Snaith, Ecclesiasticus, p. 185.
159 MacKenzie, Sirach, p. 143.
161 Snaith, Ecclesiasticus, p. 184.
163 Snaith, Ecclesiasticus, p. 184.
Loyola who, in the “Contemplation to Attain Love” that concludes his *Spiritual Exercises*, invites the exercitant “to ask for interior knowledge of all the great good I have received, in order that, stirred to profound gratitude, I may become able to love and serve the Divine Majesty in all things.” For Ignatius Loyola, this great desire is archived in the phrase (and its variations) “finding God in all things.” In words transcribed by Jesuit Father Luis Gonçalves da Camara in what is commonly known as Ignatius’s *Autobiography*, Ignatius reveals that since his conversion “he had always grown in devotion, that is, ease in finding God … Every time, any hour, that he wished to find God, he found him.” Jesuit spiritual director and close associate of Ignatius Loyola, Father Jerónimo Nadal describes this disposition to which Ignatius refers, as that of *simul in actione contemplativus*, “a contemplative likewise in action,” of one who “contemplated the presence of God” so that “God must be found in everything.” This is the Spirit’s invitation to physicians transmitted down through the ages: to be disposed to receive the gift of the integration of spirituality and medical practice from which flows the meaning that sustains — transcendent meaning.

But even if this invitation is recognized and accepted through an engagement with one’s faith-tradition, or religion, there are barri-

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164 Ignatius Loyola, *Spiritual Exercises*, 94 (233.1).
168 Many physicians (and indeed others as well) conflate the terms “religion” and “spirituality.” I have already defined spirituality for the Christian as the “dynamic, relational, interpretive, and integrative dimension of a human being’s life, springing from, coextensive with, and grounded in the relationship between self and the Spirit.” Making allowances for the controversy surrounding the definition of religion, which is well beyond the scope of this essay, I take as a general definition of a religion or faith-tradition, “a form of life which may or may not be expressed in systems of belief and practice” (Rosemary Goring, editor, *Larousse Dictionary of Beliefs and Religions* [Edinburgh: Larousse, 1994], p. 434). The key is the phrase “systems of belief and practice.” “Religion” and “spirituality” for the Christian are not synonymous, but they are, nevertheless, related. Indeed, they are interrelated. Spirituality is an expression of a faith-tra-
ers to its incarnation. There are barriers to opening oneself to the on-going — and always (in this life) incomplete — process of spiritual maturation that brings one slowly to a sense that her or his spirituality is “the filter for all … experiences,” and “inspires actions through decisions and makes possible our individual discoveries about the mystery of life.” For the person with a maturing spirituality, every decision is, ultimately, a spiritual one — one seen through the lens of spirituality, and reflective of the relationship between the self and the Spirit. The greatest barrier for the physician who has engaged her or his faith-tradition — and seeks a more thoroughgoing integration of her or his spiritual and professional lives — is, I believe, understanding how the Spirit desires to unfold within her or him the meaningful integration sought. How does such integration unfold? Surely, it is through the grace of “the contemplative attitude,” the disposition of “a contemplative likewise in action.” It is the practice of opening to this “attitude” that leads to “finding God in all things” as “a contemplative likewise in action,” as “the contemplative physician.” But what is this “attitude” physicians prepare to receive, and how can they open themselves to it in order to “find” sustaining meaning?

The Clinician As Simul in actione contemplativus

It becomes every man who purposes [sic] to give himself to the care of others, seriously to consider…that all his skill, and knowledge and energy as they have been given him by God, so they should be exercised for His glory and the good of mankind, and not for mere gain or ambition.

—Thomas Sydenham, “The Doctor”

A spirituality without a faith-tradition, while I suspect it is possible, is one that I do not believe can withstand much suffering. Its resources are too limited. It is like a plant growing on shallow ground. The winds of suffering easily shear it from its mooring. The spirituality of the Christian must be rooted in her or his faith-tradition — an engagement must be there at least on some level — if it is to continue maturing.


What is “the contemplative attitude”? How does it unfold in the life of the clinician? How can physicians — despite substantial resistant, if not antagonistic, forces — dispose themselves to its emergence? These are the three questions I now address.

What is “the contemplative attitude”? “Natural,” according to physician and spiritual director Gerald G. May of Washington’s Shalem Institute for Spiritual Formation. He convincingly adds, “We were all natural contemplatives as children” with “[a] first sense of life” marked by an “all-encompassing presence.” In May’s view, “[m]ost of us have lost the naturalness because we have been so strongly conditioned to pay attention to this thing, to concentrate on that thing.” Yet, despite this loss of “naturalness,” “the contemplative attitude” still emerges in the lives of most human beings: “It happens in moments when we are open, undefended, and immediately present. People who are called contemplatives [emphasis added] are simply those who seek the expansion of the moments [of immediate presence], who desire to live in that quality of presence more fully and continually.” “The contemplative attitude,” then, is “natural.” Physicians, like all human beings, are naturally contemplative.

“The contemplative attitude” is also a gift. “It is a gift, like life itself,” affirms Jesuit paleontologist and mystic Father Pierre Teilhard de Chardin. The emergence of “the contemplative attitude” is pure gift from the Giver who gives — loves — unconditionally. It cannot be “autonomously achieved.” The practice of “the contemplative attitude,” therefore, is — again in May’s words — “the practice of opening one’s hands to receive the gift.” It is the disposing of oneself to the emergence in one’s life of “the contemplative attitude.” And what emerges is an “attitude” of attentiveness (“presence” in May’s terminology) to the Spirit through the proximate attentiveness to everyone — self and other(s) — and everything, captured in Merton’s sense of awakening.

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171May, The Awakened Heart, p. 192.
172Ibid, pp. 180, 192.
176May, The Awakened Heart, p. 192.
177Ibid, 192.
"to oneness with God."\(^{178}\) What emerges is a mindfulness of the present moment, "a pure intuition of being...[an] experiential awareness of reality and a way of entering into immediate communion with reality," captured in Burghardt's "long loving look at the real," at "fire and ice... the sun setting over the Swiss Alps, a gentle doe streaking through the forest... a ruddy glass of Burgundy, Beethoven's Mass in D, a child lapping a chocolate ice-cream cone... a striding woman with windblown hair... the risen Christ."\(^ {179} \) What emerges is Hopkins's world "charged with the grandeur of God."\(^ {180} \) What emerges is Osler's "poetry of the commonplace, of the ordinary man, of the plain toil worn woman."\(^ {181} \) What emerges is Teilhard de Chardin's "diaphany of God," that "particular perception of the divine spread everywhere."\(^ {182} \) What emerges is — in the words of Jesuit theologian Father Karl Rahner — the "Ignatian mysticism of joy in the world," which describes how Ignatius Loyola "approaches the world from God" through "the maxims of 'indifferencia' and of 'finding God in all things,' where '[t]he first ['indifferencia'] is the presupposition of the second ['finding God in all things']."\(^ {183} \)

In the "Principle and Foundation" of the *Spiritual Exercises*, Ignatius enjoins us "to make ourselves indifferent to all created things" so that we may "desire and choose only that which is more conducive to the end for which we are created," namely, "to praise, reverence, and serve God our Lord"\(^ {184} \) (to be in loving relationship with God). For Ignatius, *indifferencia*, or "indifference," is "the calm readiness for every command of God, the equanimity which ... continually detaches itself from every determinate thing which man is tempted to regard as the point in which alone God meets him." For Ignatius, "the contemplative attitude" comprises "an ultimate attitude towards all thought, practices, and ways ... [of] reserve ... because all possession of God must leave God greater

\(^ {178} \) Conn, *Spirituality*, 33.
\(^ {180} \) Hopkins, "God's Grandeur," p. 66.
\(^ {182} \) Teilhard de Chardin, *The Divine Milieu*, pp. 218-129.
\(^ {184} \) Ignatius Loyola, *Spiritual Exercises*, 32 (23.1-23.7).
beyond all possession of him.”185 Further explicating Ignatian “indifference,” Rahner observes:

Out of such an attitude of indifferencia there springs of itself the perpetual readiness to hear a new call from God to tasks other than those previously engaged in, continually to decamp from those fields where one wanted to find God and to serve him; there springs the will to be at hand like a servant always ready for new assignments; the courage to accept ... having nowhere a permanent resting-place as in a restless wandering towards the restful God ... Filled with such indifferencia, Ignatius can even forgo manifestations of mystical graces — after all God is beyond even the world of experience of the mystic.186

Ignatian “indifference,” in Rahner’s view, “becomes a seeking of God in all things. Because God is greater than everything, he can be found if one flees away from the world, but he can come to meet one on the streets in the midst of the world.”187 For Ignatius, there is only one principle in the “restless search for God: to seek him in all things,” that is, “to seek him in that spot where at any particular time he wants to be found.”188 Ignatius thus “seeks only the God of Jesus Christ, the free, personal Absolute: contemplativus.” But Ignatius “knows that he can seek and find him [God] also in the world, if this should please him: in actione.” Ignatius, therefore, “is prepared in indifferencia to seek him and him alone [God], always him alone but also him everywhere, also in the world: in actione contemplativus”189 — or, in Nadal’s construal, simul in actione contemplativus, “a contemplative likewise in action,” who “contemplated the presence of God ... in everything.”190 “The contemplative attitude,” then, in my understanding, is an attitude of attentiveness to the Spirit — oriented to, or seeking, oneness with the Spirit — through the proximate attentiveness to everyone and everything, “in all things.” It is an “attitude” that manifests as an affective “centeredness” that comprises Ignatian “indifference.”

186 Ibid, 291.
187 Ibid.
188 Ibid.
189 Ibid.
190 Conwell, Contemplation in Action, p. 25.
How does “the contemplative attitude” unfold in the life and the practice of the clinician? Through the action of the Spirit, it unfolds as an affective “centeredness,” or “equipoise,” from which it becomes apparent that there exists — to use Ignatius’s terminology — a “diversity of spirit[s]” moving within the physician’s heart, “one from the devil, the other from God.” Consider the following vignette offered by an interventional cardiologist:

I was in the cath [cardiac catheterization] lab working [performing a cardiac catheterization] on a patient when a visiting interventional [cardiologist] — who was interviewing for a position in our [medical] group — walked into the room to observe the procedure. The patient had a tight stenosis of the right coronary [artery] that was very distal — difficult to reach. I remember thinking and feeling two very different things: that I could do what was in the patient’s best interests and treat the patient medically or I could demonstrate my expertise and attempt the angioplasty at greater risk to the patient. Each option felt very different.

This vignette demonstrates the “diversity of spirit” or “the various motions which are caused in the soul,” which Ignatius, drawing from Christian tradition, describes in a systematic way that can be communicated to and understood by spiritual pilgrims, especially those beginning their journey.

For Ignatius, these “motions,” such as the cardiologist’s competing thoughts and their attendant feelings, refer to “the flux of thoughts (such as judgments about God, self, the world, plans, lines of reasoning, lines of association, or imaginings), and of affective acts (such as peace, warmth, coldness, sweetness, bitterness, buoyancy, or depression).” Ignatius observes about these “various motions” that “in every instance”

191Ignatius Loyola, A Pilgrim’s Testament, p. 147.
192Ibid, 9-10.
193This vignette is drawn from a private conversation with the cardiologist quoted, Chicago, Illinois, 28 January 2000.
194Ignatius Loyola, Spiritual Exercises, 121 (313.1-313.2).
these “motions” either “build up or tear down the Christ-life in us.”

Spiritual director and author Jules J. Toner confirms that the “unvarying thrust [of the “motions”] is toward having a beneficial or harmful influence on faith, hope, charity, prayer, personal relationships, apostolic work, decisions that give direction to our life as Christians ...”

For Ignatius, then, some of “the various motions” are “prompted by God,” and others are “prompted by the evil spirit,” and the difference between them can be recognized, or “discerned,” as such in that “these motions tend, of themselves, to have good or evil effects on our faith life,” if they are “accepted and allowed to work.” This suggests, of course, that in the absence of such acceptance, or cooperation, the “motions” have neither a constructive nor a destructive effect. Toner notes:

Those which of themselves tend to a destructive effect can be resisted and become the occasion of actual spiritual growth. Those which of themselves tend to a constructive effect can be ignored, resisted, or even misused, and so be the occasion for sin and regression in Christian life. What effect they actually have depends on what we do with them.

Given the effects of “the various motions,” Ignatius systematically articulates “rules to aid us toward perceiving and then understanding, at least to some extent, the various motions which are caused in the soul: the good motions [“consolation”] that they may be received, and the bad [“desolation”] that they may be rejected.” These “rules,” widely known as “rules for the discernment of spirits,” convey to the individual the means for recognizing the “motions” of “consolation” and “desolation” so as to cooperate with the former and resist the latter, and in so doing to dispose oneself to the removal of “disordered affections” that impede “seeking and finding God’s will,” and becoming “a contemplative likewise in action.”

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197 Toner, A Commentary, p. 37.
198 Ibid.
199 Ibid, 38.
200 Toner, A Commentary, p. 38.
201 Ibid.
202 Ignatius Loyola, Spiritual Exercises, 121 (313.1-313.2).
203 Ibid, 21 (1.3-1.4).
The "contemplative attitude," then, is an affectively "centered" attitude of attentiveness that comprises Ignatian "indifference," and from which "the various motions" within the physician's heart become more obvious — the practitioner is more attentive to the "motions," and is better equipped to cooperate with "the good motions" and to resist "the bad [motions]." This is the attentive "equipoise" of the interventional cardiologist in the vignette: he sees and feels what his choices are, and knows how they will effect or orient him in his relationship with God.

My primary concern here is not to provide another exhaustive treatment of the "discernment of spirits." That is well beyond the scope of this essay. Rather, I am concerned with offering a description of "the contemplative attitude" within which one recognizes the presence of "motions," which can be cooperated with or resisted in the examination room by the "centered" physician who is at once attentive to the patient through active listening, attentive to the "motions" within her or his heart, and — through the attentiveness to both — attentive to the Spirit. Such a physician is "seeking and finding God" in the experience of the physician-patient relationship. Such a physician is aware of the divine presence. Such a physician seeks — as Nadal urges — God "in the inmost movements of ... [her or his] heart, where he [God] is found in serene quiet and sweet intimacy along with an unfathomable sense of his infinite energy."204 Such a physician is simul in actione contemplativus, "a contemplative likewise in action."205

What does this mean concretely? It means that a clinician sits with a patient in the examination room or at the bedside, in a "centered" stance, that is attentive (actively, empathically listening) to the patient, and at the same time attentive to her or his interior "motions," cooperating with "the good" and resisting "the bad" (discerning). What happens when a physician does this? She or he becomes aware of just how many "motions" are stirring within her or his heart. She or he becomes aware of the "motion" of urgency that propels a clinician quickly from the examination room while a patient is in mid-sentence. She or he becomes aware of the "motion" of compassion that prompts the physi-

205 Conwell, Contemplation in Action, p. 25.
As I sat down in the examination room across from my patient, I noticed that she had with her — for her reading while she waited for me to see her — a book about “self-discovery.” After discussing the problem that she had identified as the reason for her visit — foot and ankle pain — I became aware of an strong “motion” [from a “spirit”] stirring within me: it manifested as an “urgency,” repeatedly pointing me toward concluding the encounter and walking quickly out the door to keep on schedule. With this awareness — attentiveness — I began to consciously “center” myself much like I do when I practice spiritual direction: I move to an affective equipoise within which I become acutely aware of — attentive to — my own interior movements, trusting that the Spirit leading me by placing before me in those movements invitations for me to draw near. Through this “centering,” I became aware of the “urgency” waxing and waning, but was able to resist it, and instead embrace another “motion” of compassion: I simply asked my patient how she liked the book she had with her. Gradually, she started to unpack a very painful story of spousal abandonment and poor self-esteem sliding into depression. As I struggled to be attentive and empathically respond to her narrative, I was aware repeatedly of my “urgency” to cut things short and move on to my next patient. Each time the “urgency” would return, I would recognize it, and it would subside. The compassionate “motion” coupled with the thought that “my place is here right now” gradually came to supplant the “urgency.” I left that exam room with a sense of being in God’s presence, with a sense of being God’s instrument, with a sense of having loved and been loved.  

Here is an example of “the contemplative attitude,” of attentiveness to the patient (the other) and to self — and through that attentiveness — to (oneness with) the Spirit, as it unfolded in the present moment in a clinical setting in such a way as to effect a clinical decision to inquire or not, to end the encounter or extend it. This is not three separate forms of attentiveness, but one — it is attentiveness that is coex-

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206 This vignette is drawn from my patient records and experiences at the American Indian Health Service of Chicago, Chicago, Illinois, 1999.
tensive with an affectively "centered" and "indifferent" position of equi-
poise from which the physician listens actively to her or his patients,
while at the same time "listening" to her or his own internal movements —
trusting that those internal movements, or "motions," derive from
diverse "spirits," which can distinguished, or discerned, and can be co-
operated with or resisted. And one of those "spirits" is the Spirit that
dwells within the human heart, about whom sixteenth century Span-
ish mystic and saint Teresa of Avila rejoices, "How wonderful it is that
He Whose greatness could fill a thousand worlds, and very many more,
should confine Himself within so small a space [as the soul]....

This is "finding God" in the examination room. This is medical prac-
tice as "a means of preparing and disposing our soul to rid itself of all
its disordered affections and then, after their removal, of seeking and
finding God's will." This is medicine beyond techné to "spiritual ex-
cise." Much more can be said here about "the discernment of spirits"
and about making choices, or "elections," but that is not my purpose.
Rather, I seek here to articulate an understanding of "the contempla-
tive attitude" within which that "discernment" and "election" unfold.
Make no mistake: disposing (or opening) oneself to an always-in-pro-
cess, thoroughgoing integration of spirituality and clinical practice, such
as, "the contemplative attitude," is not easy — the path may be simple,
perhaps, but not easy. The progressive, ongoing, process of spiritually
maturing — the continual, attentive "yes" to the Spirit's invitations —
that brings "expanded perception, enhanced responsiveness, and greater
self-knowledge" does not for most of us emerge effortlessly. I do not
suggest that it is not a gift, but rather a gift that is given with the under-

207Teresa of Avila, The Way of Perfection (Nashville, Tennessee: Thomas Nelson Pub-
lishers, 1999), p. 213.

208Ignatius Loyola, Spiritual Exercises, 21 (1.3-1.4).

209In the Spiritual Exercises, Ignatius articulates three ways, or "times," for mak-
ing "a sound and good election." While this indeed refers to choosing a state in life, it
can be applied as well to less momentous decisions, such as, every choice, everyday.
The choices made in the preceding vignette are consistent with "the second time,"
wherein there is "sufficient clarity and knowledge...received...from experience in the
discernment of various spirits" (Ignatius Loyola, Spiritual Exercises, 76 [175.1-177.3]).
A thoroughgoing treatment of "the methods of election" is beyond the scope of this
essay.

standing that practiced openness to it must precede its coming to fruition. It is not unlike other gifts. For example, a gifted cardiologist must still hone her or his capacity to perform angioplasties. Aristotle observed as much with respect to virtue. 211 This integration holds out the possibility of transcendent meaning and spiritual flourishing (a sense of giftedness centered on wholeness derived from relationship with the Spirit) that is capable of sustaining the physician’s caring work. Yet, many forces work against the movement to integrate (unfolding as “the contemplative attitude,” which deepens to “finding God in all things”).

What are these forces? Physician and spiritual director Gerald May suggests some significant barriers to the emergence of “the contemplative attitude” with his personal testimony:

I worked as a psychiatrist in public institutions (military and state hospitals and prisons) for nearly twenty years. During the last twelve of those years, I was consciously trying to be mindful of love, to practice the presence of God [to practice opening himself to “the contemplative attitude”]. It was the most frustrating thing I ever tried to do. I was very diligent; I prayed and meditated in the morning, and I reminded myself while driving to work [to be attentive]. I could be conscious, consecrated, and grounded in the present moment all the way there, but as soon as I entered the ward everything changed. I was immediately kidnapped. I was gone: away form the present, away from any sense of love or its source … It was not a gradual transition … One moment I was there; the next I was gone. Where did I go? I didn’t even know at the time. Looking back, it seems clear that I went into my sense of responsibility for the diagnosis and care of the patients…The stresses on the staff were incredible … There would have been time and space for a little remembrance [of the divine presence], but I kept forgetting…Most days I would remain forgetful until my work was done … Then I would remember, and such sadness would fill me … I tried everything … [a] spiritual director … people praying for me…and still it did not “work.” 212

For May, this was "a long time of spiritual suffering" as he sought the integration of spirituality and medical practice. Despite his efforts to engage his faith-tradition, to pray, to mediate, to stay in spiritual direction, and to be self-reflective — all very helpful to opening oneself to the Spirit, "the contemplative attitude" did not emerge: "Nothing helped; nothing made it better. I couldn't understand it. And it went on for twelve years." May's suffering — his frustration at not being attentive to the Spirit in his clinical practice — ceased when, after taking a position as a full-time spiritual director, he began to notice that as a psychiatrist when he got up each morning, he would dress himself with "a kind of psychological armor before going to work." He explains:

I knew that everyday people would be screaming at me, threatening me, making urgent demands. I knew that each day I would be afraid — not so much of being hurt but of making a mistake that might ruin or destroy someone's life. I could not enter that kind of day undefended, and so I established a kind of feeling-barrier against the stresses I would meet.

May suspects that most physicians have such an unconscious "barrier" that — while it does not preclude a physician from being compassionate, or at least perceived that way — resists the openness necessary for "the contemplative attitude" to emerge in the midst of clinical practice. Furthermore, he contends that this defended stance may be accompanied by a decreased "receptivity" to the gift of "the contemplative attitude" and a tendency to grasp at it as if we could "engineer" "the contemplative attitude."

Like May, for years I practiced medicine without a deep experience of the awareness of the Spirit in my work. Unlike May, however, I did not reflect on how my spirituality could inform my practice — how medical practice might be a "spiritual exercise" I practiced medicine in a way that kept the two apart, despite faithful service to both my patients and my church. The change for me evolved slowly, assisted by my making the Spiritual Exercises and by my prayer. The Spiritual Exercises provided me a dynamic means of "the day by day living out of discerned

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214 Ibid, p. 216.

responses to the actual Word of God here and now — finding God in all things.”216 My prayer — an awareness meditation of “just sitting” with the Spirit of God and God’s Christ — deepened “the contemplative attitude” within which I became aware of or attentive to the “motions” of the “spirits,” which I sought to discern and elect. Of this form of prayer, James W. Skehan observes, “I believe that awareness discipline is not only basic to, but presupposed in the Ignatian method [of the Spiritual Exercises] … it is an important path to contemplation …”217 For Skehan, the imagelessness of contemplative prayer — of contemplation — causes to emerge a “faculty” of “the heart” for communicating with God. This kind of communication demands a “silencing the mind.”218

Additionally, in retrospect, I see some other barriers to the emergence of “the contemplative attitude” in my life and clinical practice — the “institutional” barriers. I appreciate now what Sulmasy calls “the present economic reconstruction of medicine,” which resists the introduction of the traditional virtues of medicine in favor of “efficiency.”219 With this comes the displacement of the covenantal physician-patient relationship by the more contractual — and adversarial — provider-consumer relationship. Clearly, our institutions contribute to physicians’ difficulty in opening themselves to the emergence of “the contemplative attitude.”

How can physicians — despite substantial resistant, if not antagonistic, forces — dispose themselves to the emergence of “the contemplative attitude”? I believe that it is very helpful to engage one’s faith-tradition, to pray, to meditate using a “centering” awareness exercise, to have a spiritual director, to make retreats, to develop habits of self-reflectiveness, to practice discernment using a consciousness examen, to make the Spiritual Exercises, and to practice active listening with one’s patients—not all of which are, of course, appropriate or even possible for some. May’s example, however, suggests that these efforts at dispo-

218Ibid.
sition must be supplemented: physicians, because of their tendency to wear "psychological armor," must also attend, in an intentional way, to their "defended" stance that seems to get them through the day — at some cost. He asks of the "defended," "Can you risk being a little less defended, a little more vulnerable to what you meet every day?" 220

One way to follow May's advice, less "defended" and more "receptive," is provided by the example of internist Mark Stafford, who offers a compelling account of his own suffering from "compassion fatigue." 221 Worn down by a "busy practice," Stafford left his position "to seek relief." He searched for that relief first by changing specialties, and then by moving into academic medicine. Each time he found that his duties would "siphon off" his energy. This left him to reflect on "why I had gone into medicine in the first place." As he reflected, he came to see that what had brought him to medicine was his desire to impact his patients' "quality of life." 222 He resolved to begin asking his patients about their lives:

At the end of one patient visit ... I put down my chart and looked my patient right in the eye. Then I leaned forward and said, 'Robert ... I want to know how you feel about the quality of your life ... physical health, emotional well-being, relationships, finances and spirituality ... Patient after patient, I asked the same question, and I was dumbstruck by the information revealed to me. Again and again, I heard deeply personal disclosures about emotional issues that caused real pain to my patients but had been completely unknown to me ... In the days that followed, my original question continued to be a gold mine of intimacy and revelation. I learned much about feelings of pain and shame that hid just beneath the surface, aching to be uncovered ... [and] I experienced a deep oneness with my patients. Often, we sat in silence. I didn't have answers, but I let patients know that I had heard them. I was changed by the experience ... In the objective, scientific, sterile medical world, we had experienced intimacy. Today I look forward to clinic in anticipation of what I am going to learn about my patients' lives. I take myself a little less seriously ... [knowing] my patients' qual-

221 Stafford, "Burned Out," 3.
222 Ibid.
ity of life often has little to do with massaging hemoglobin A1C’s ... I am still a conscientious internist trying to deliver high quality care. But I try never to forget my patients’ stories and what matters most to them ... I am happier ... [and] have confirmed that the secret to enjoying medicine lies in caring for you patient.223

This vignette underscores many things. It demonstrates how the absence or deficiency of meaning (relative to stressors) forces clinicians out of practice. It demonstrates how the substantive, sustaining meaning of medical practice is present all along, despite the difficulties of the current practice environment. It demonstrates how meaning in medicine is derived ultimately from the physician-patient relationship, and how it must be tapped through practice, through attentiveness to the patient (the other) and to self — attentiveness that for the Christian is attentiveness to the Spirit. It demonstrates how active listening on the physician’s part penetrates the “psychological armor” that defends her or him, permitting “receptivity” and opening the door to the emergence of “the contemplative attitude.”

Is “the contemplative attitude” for every physician? “Yes” is my emphatic answer. Spiritual masters, grounded in scripture and tradition, have for centuries rightly affirmed that the Spirit, as understood within the Christian faith-tradition, invites every (human being) physician to open herself or himself to the emergence — in her or his life and practice — of “the contemplative attitude.” Merton, for example, observes that contemplation “fulfills our deepest human capacities,” but its emergence requires affective and intellectual development of the gift.224 He asks, “Why do we think of the gift of contemplation ... as something essentially strange and esoteric reserved for a small class of almost unnatural beings and prohibited to everyone else?” He answers, “It is perhaps because we have forgotten that contemplation is the work of the Holy Ghost acting on our souls through His gifts,” which are “part of the normal equipment” of a human being. He adds that if this gift is given by God, then “presumably” God wants it cultivated.”225 Consonant with Merton’s perspective is that of May who — as I noted earlier

223 Ibid.

224 Conn, Spirituality, p. 33.

— observes that “contemplation [an attitude of “presence”] happens to everyone,” because we human beings are “all natural contemplatives.”

226 I do not hesitate to agree, although I add here that while all physicians have the gift (the capacity) of “the contemplative attitude,” it will necessarily, like all of the Spirit’s gifts, emerge more fully in some and less fully in others — again as spiritual masters have known for centuries.

Conclusion

By the term Spiritual Exercises we mean every method of examination of conscience, meditation, contemplation, vocal or mental prayer, and other spiritual activities... For, just as taking a walk, traveling on foot, and running are physical exercises, so is the name of spiritual exercises given to any means of preparing and disposing our soul to rid itself of all its disordered affections and then, after their removal, of seeking and finding God’s will in the ordering of our life for the salvation of our soul.

—Ignatius Loyola, Spiritual Exercises 227

I would like in conclusion to address the question: “What are the implications for physicians and their patients if physicians adopt and cultivate openness to what I understand as “the contemplative attitude”? It is, I believe, artificial to consider the implications of “the contemplative attitude” for the physician apart from the implications for the patient. For the physician who adopts and cultivates openness to the emergence of “the contemplative attitude,” an inner movement to a greater general attentiveness to self and others manifests itself, from which arises a greater attentiveness to “the Other.” With this greater attentiveness to self, others, and “the Other” comes a “centeredness” from which the physician listens more carefully and clearly, and is better able than otherwise to instantiate holistically the telos of medicine in the life of a particular patient. With this movement in attentiveness to self, others, and “the Other” comes a sense of the practice of medicine beyond techné to “spiritual exercise” as Ignatius Loyola understands that term. This

227 Ignatius Loyola, Spiritual Exercises, 21 (1.2-1.4).
understanding of medical practice as “spiritual exercise” underscores the spiritual nature of the physician’s caring: by her or his attentiveness to the Spirit within, the physician comes to see her or his “disordered affections” in the very act of listening simultaneously to herself or himself and her or his patient — and through this seeks and finds “God’s will in the ordering of ... life.”228 In “seeking and finding God’s will” in the examination room in the midst of the physician-patient encounter, the physician opens herself or himself to recognizing and receiving the loving gift of the Spirit’s very self — and this relationship which subsumes all others brings the substantive, transcendent, meaning that sustains the physician’s caring, even in the trying milieu of contemporary medical practice. Having moved beyond techné to “spiritual exercise,” the physician has said “yes” to the Spirit’s invitation to be disposed to the integration of spirituality and clinical practice, has said “yes” to being simul in actione contemplativus, has said “yes” to being “a contemplative physician,” and has said “yes” to an ever-deepening relationship with the Spirit of God and God’s Christ — a relationship that may manifest over time as utter possession of the physician by the Spirit (oneness).

For the patient of “the contemplative physician,” there manifests a meaningful covenantal physician-patient relationship that stands in sharp contrast to the increasingly common “ordinary” contractual arrangement of “provider” and “consumer.” For this reason, I contend that “the contemplative attitude” is in the service of “the good of the patient.” If medicine’s telos of serving “the good of the patient seeking help” is further specified — in what I regard as a compelling and plausible construal—in terms of meaning, then the physician is a practitioner, who supports, through the medical “art, based on science,”229 the patient’s search for substantive meaning. Such support demands a physician who is aware of her or his patient’s values and spirituality — both are inextricably linked to a patient’s search for substantive meaning. The more spiritually attentive the physician, the greater will be her or his facility at instantiating the telos of medicine — relative to the same physician in a less spiritually attentive attitude. The more contemplative the physician, the more self-aware, the more perceptive, the more dis-

228Ibid.
229Osler, “Teacher and Student,” p. 34.
cerning — the more attentive she or he will be,\(^\text{230}\) and the better served will be her or his patient. A physician who is unaware of her or his own spirituality, or who seeks to incarcerate it, will not likely inquire after her or his patient’s spiritual well-being — and will miss an opportunity to know her or his patient more completely, quite possibly leading to clinical decisions that are not well-situated in the context of the patient’s life narrative. Furthermore, such a physician will be ill-prepared to advocate for physicians and patients vis-à-vis the current debate challenging “the biomedical model” of disease in favor of “the biopsychosocialspiritual model.”

Beyond these implications for physicians and their patients, I cannot fail to emphasize my conviction that the integration that flows from the emergence of “the contemplative attitude” is an invitation to physicians (and for their patients) from the Spirit, proclaimed through scripture and carried forth in Christian spiritual traditions, notably — though not exclusively — the Ignatian tradition. The Spirit invites physicians to this integration, and seeks for them a deeper loving relationship that may lead (for it is beyond our power) to a contemplative relationship of utter possession (or oneness) and wholeness — to a mystical relationship that Carmelite author and spiritual director Ruth Burrows regards as “the essence of Christianity, not the privileged way of the few.”\(^\text{231}\) Gradually, the physician may become, in ongoing fashion, whom she or he contemplates — the Christ\(^\text{232}\) as suggested by a vignette drawn from the experience of a physician working among the poor:

One of my patients, living on the street day in and day out, eventually developed AIDS, tuberculosis, chronic pyelonephritis, hepatitis C, chronic alcoholism, and chronic hypertension — all by age 40. I knew that my clinic was his only hope of solid and ongoing care — he had been in and out of just about every emergency room in the city. Looking at him lying flat on my exam table — dirty and smelling real bad, a physical and a psychological wreck, whom I feared would likely soon be dead — I saw the poor Christ: “I was hungry


and you gave me food, I was thirsty and you gave me something to
drink, I was a stranger and you welcomed me, I was naked and you
gave me clothing, I was sick and you took care of me.\textsuperscript{233}

About “the contemplative physician,” it can be said, “You are the light
of the world. A city built on a hill cannot be hid. No one after lighting a
lamp puts it under the bushel basket, but on the lamp stand, and it gives
light to all in the house. In the same way, let your light shine before oth-
ers, so that they may see your good works and give glory to your Father
in heaven.”\textsuperscript{234} Indeed, with respect to the gift of integration of spiritu-
ality and clinical practice, the words of Jesus’ disciple James ring out:
“What good is it, my brothers and sisters, if you say you have faith but
do not have works? Can faith save you? If a brother or sister is naked
and lacks daily food, and one of you says to them, ‘Go in peace; keep
warm and eat your fill,’ and yet you do not supply their bodily needs,
what is the good of that? So faith by itself, if it has no works, is dead.”\textsuperscript{235}
The Spirit desires and invites the acceptance of this kind of integration.

It is clear, then, that the acceptance by and emergence in physicians
of “the contemplative attitude” has implications for physicians and pa-
tients alike. The problems that afflict physicians will endure, but their
suffering can be an opportunity to “find” substantive, sustaining mean-
ing that ameliorates this suffering and supports physicians’ caring to
the benefit of their patients. This “attitude” may allay some of Kassirer’s
concerns. For example, despite shortened office visits, “the contempla-
tive attitude” may reduce the erosion of the covenantal physician-pa-
tient relationship. This “attitude” may prevent “the general quality of
health care” from dropping by reducing the likelihood of “gifted stu-
dents” not entering medicine “because of the faltering enthusiasm of
their physician role models …”\textsuperscript{236} This “attitude” may reduce the like-
lihood that the medical profession itself will suffer “if physicians gain a
reputation for serving only the rich, for hawking wares in their offices,
for skimping on care to enrich themselves, [or] for bargaining collec-
tively with commercially oriented unions ….”\textsuperscript{237}

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\textsuperscript{233}Matthew 25,35-36 NAB.
\textsuperscript{234}Matthew 5,14-16 NAB.
\textsuperscript{235}James 2,14-17 NAB.
\textsuperscript{236}Kassirer, “Doctor Discontent,” pp. 1543-1545.
\textsuperscript{237}Ibid.
\end{flushright}
Having now examined in some depth the suffering among physicians, I submit that it is clear that American physicians are unhappy. Many are struggling to find substantive meaning in a diminished practice that is enmeshed in and burdened by a troubled healthcare "system," a telos of medicine that is increasingly fluid, and a growing and bewildering demand from patients and patient advocates for a greater attentiveness to patients' spirituality. In this project, I argue that, despite their crisis of meaning and the suffering it engenders in this challenging medical milieu, Christian clinicians may be gifted with the transcendent meaning and spiritual flourishing they seek as sustenance for their caring work by disposing themselves to a more thoroughgoing integration of spirituality and clinical practice — something that the Spirit desires and invites. I offer an experiential understanding — informed principally, though not exclusively, by Ignatian spirituality — of how such an integration unfolds in the clinical setting as "the contemplative attitude," which deepens through grace, opening the way to "finding God in all things" as simul in actione contemplativus, "a contemplative likewise in action." I invite physicians to open themselves to the emergence of the Spirit's gift of "the contemplative attitude" in clinical practice — in the examination room, at the bedside. While there are undoubtedly some objections — and, at least, one common objection — to my account, I believe that the salutary implications of "the contemplative attitude" are far more substantial than detrimental in their impact on the traditionally covenantal physician-patient relationship.

I close this essay with a reflection on the prescient words of Sir William Osler — words that transcend the decades since 1906 to again stir physicians' hearts:

I have an enduring faith in the men who do the routine work of our profession. Hard though the conditions may be, approached in the right spirit — the spirit which has animated us from the days of Hippocrates — the practice of medicine affords scope for the exercise of the best faculties of the mind and heart. That the yoke of the general practitioner is often galling cannot be denied, but he has not a monopoly of the worries and trials in the meeting and conquering of which he fights his life battle; and it is a source of
inexpressible gratification to me to feel that I may perhaps have helped to make his yoke easier and his burden lighter.\[238\]

The disposition I call "the contemplative attitude" is a way for physicians to incarnate Osler's "right spirit," which, for the physician who is an engaged Christian, is truly — as I suspect Osler himself recognized — "the right Spirit," or "the Holy Spirit." May this insight make the physician's yoke easier to bear. 