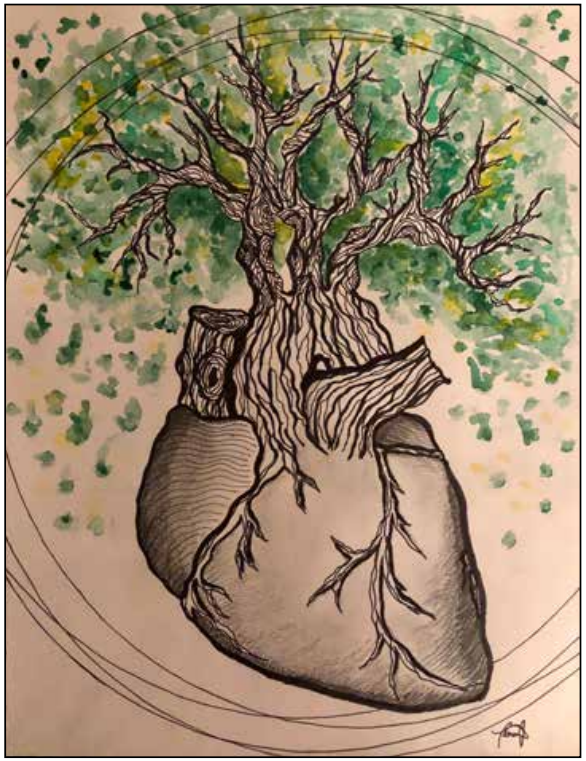

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ART & LITERARY REVIEW

ISSUE EIGHT 2019

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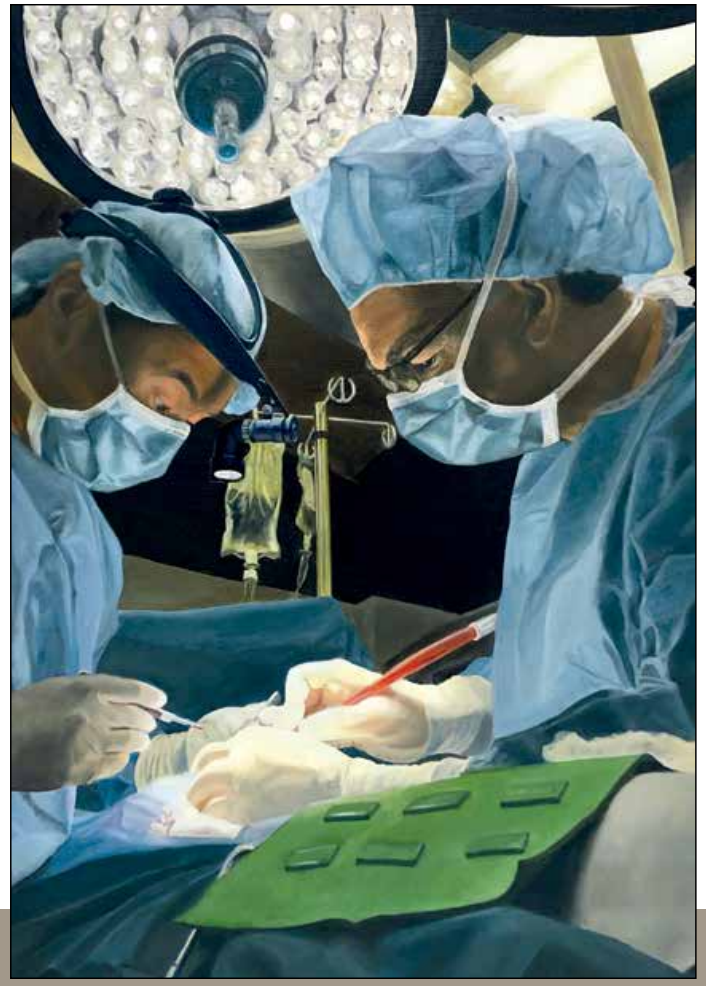

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The Chaplains at Lenox Hill

Last fall, during my third-year medicine rotation, I met a patient I'll call Ms. Arthur, a Jamaican woman in her early eighties with a self-deprecating sense of humor and a shock of bright white hair.

In the days before her admission to the inpatient wards, she had noticed her stool had become darker, and one day she felt tired, a little short of breath. She took a shower, hoping to refresh herself, but soon felt even weaker. She started sweating and sank to floor. That was when she decided to go to the hospital. In the emergency room, as a doctor was taking her history, she vomited a liter of blood and clots into a disposable pink bin.

Nothing like this had ever happened to her before, and there was no obvious cause. She didn't have a history of stomach ulcers, drink coffee or alcohol or take painkillers. She hadn't changed her diet or started any new medications. Two endoscopies and a colonoscopy found nothing remarkable, and there seemed to be nothing she could do to prevent another episode.

Over the course of the next few days, and after a few transfusions, she began to feel stronger, and she never vomited blood again. But the lack of a diagnosis still troubled her. What if it was the first sign of something more serious? What if one day, without warning, she passed out in the grocery store or in the street?

Without a physiological explanation, she turned inward for religious clues. Was she being punished? What was God trying to tell her?

The office of Lenox Hill's Pastoral Care Services is in one of the oldest wings of the hospital compound, and on an afternoon in February, I sat down with Rabbi Simcha Silverman, Father Anthony and Diane Dreher, a student chaplain, to hear about the kinds of conversations they have with patients. I was surprised to learn how much overlap exists between our roles as medical providers and their roles as spiritual counselors.

As Rabbi Silverman explained, the hospital identifies twenty-one religions in its census — a reflection of New York City's own diversity — but most patients still check the boxes for "unknown,"

"none," or "other." So while much of the work of the chaplains involves meeting religious needs like prayer or rituals, a large part of what they do is simply talking to patients using the same tools of empathy that medical students learn: reflection, legitimization and exploration.

"Illness strikes a chord with people. When you're hospitalized, you're in a moment of transition," Diane explained. "You're out of your regular life, whatever that is, and stuff bubbles up." Listening sounds like an easy task, but it can be hard to resist the temptation to fix a patient's problems, especially in a hospital setting.

Among the stories we shared that afternoon, Rabbi Silverman told me about a man in his mid-seventies with advanced COPD who felt that he was being punished. The rabbi asked him what he felt he was being punished for, and the man recounted something he did in high school against his parents. "This man had been walking around with this burden for over fifty years. If I had tried to reassure him and said, 'No, God doesn't punish like that,' it could have ended the conversation, but he might have carried this burden on his shoulders for the rest of his life." Instead, what they do as chaplains is to unpack it all and ask: What do you feel you're being punished for? What was your relationship like with your parents afterward? Do you think they held this against you until the end of their lives? What can we do to help you reconcile yourself with what you did?

Pain and suffering are often lumped together. In my time on the wards, I have seen that they are different, though they can coexist. During my OB/gyn clerkship, I witnessed extreme pain as women labored — at times, I could hear it all the way down the hallway. But these patients expected the pain, knew it would be temporary and accepted the reason for it, so there was very little suffering. In contrast, some of the psychiatric patients I've met express no pain at all but experience intense suffering.

Often as physicians we treat only the pain, but any caregiver can mitigate suffering. Rabbi Silverman shared another story of a nurse administering a medication to a patient who asked, "Will I survive this?" It was a vague question, and the nurse could easily

have answered it in its narrowest sense, “Will I survive this drug?” Instead, she interpreted the patient’s question in its deepest implication, “Will I survive this disease?” The nurse responded, “We’re trying everything we can for you. You’re getting the best possible care.” They talked a little while longer, and the following morning the patient passed away. She was awake almost until her final moments, and as the rabbi reflected, “It’s very possible that the last person to have given her some sort of emotional support was this nurse who almost chanced on it.”

In Islam, as in some other faiths, one of the requirements for conversion is a verbal profession of faith. In both marriage and legal testimony, we say out loud, “I do.” What is the power of speech beyond the meanings of the words themselves? Where does it come from?

The well-known Christian pastor Joel Osteen, who starts every sermon by inviting his audience to recite a short mantra, says, “Words have creative power. When you speak something out, you give life to what you’re saying. When God created the worlds, he didn’t just think them into being. He said, ‘Let there be light,’ and light came. His words set it into motion.”

We may not have answers to all of our patients’ questions. We may not even be able to diagnose every problem. Sometimes the best we can do for our patients is to explore. As with the therapy that comes from journaling, when patients speak aloud, they externalize their thoughts, hear the transformative power of their own words and encounter themselves in a different way. By turning patients’ internal monologues into dialogues, we allow them to draw upon their own spiritual strengths.

“It’s sometimes easy to tap somebody on the shoulder and say, ‘It’s going to be okay.’” Rabbi Silverman added. For many patients, it won’t be okay, so those words sound shallow. “We’re not there to give them a quick fix. Instead, we want to journey with our patients through their suffering or through their experience, even to celebrate with them when things go well.”

A few months later, I called Ms. Arthur at home, and we talked for a while. She told me that photographs downloaded from the tiny capsule she swallowed just before discharge later showed

no signs of the source of bleeding, and she hasn't had any more episodes of vomiting. She still worries about what happened to her last autumn and waits to see if it will recur. She prays that it won't. Otherwise, she says she is doing well. It was great to hear her voice on the phone. We promised to talk again.

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Arcadia

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