Medicine and Religion

Doctor as prophet

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Introduction

There are three basic meanings of the word "prophet." The first refers to the person who speaks for God, the second to the prophetic writings of the Old Testament, and the third to one who is a visionary or prognosticator.

One who speaks for God

To start with the concept of the person who speaks for God, in some ways this is the most difficult dilemma for the contemporary physician, living as he does in a period of religious indifference when both doctor and patients are unlikely to have overt religion as a prominent feature in their lives. It may be said that in that case there is no problem: the doctor can get on with his work and omit God from his function. In fact, that is what many doctors do, but the problem is not solved so easily. Doctors have to deal with illness, suffering, and death. In these circumstances they encounter human beings who are at a point in their life when uncertainty, doubt, and fear about the meaning and purpose of life all make their entry and pose questions when human mastery of the environment is most inadequate and incomplete.

The doctor may choose to ignore them but these pressing questions do not go away and they are part of everyday life. So, whether he likes it or not, the doctor is made into one of the persons who is expected to refer to ultimate values and God. In the past, when society was steeped in the Christian faith, the issues of pain, suffering, and death had recognisable answers. Today we have no such agreed basis, and the task of the doctor is that much more difficult.

What are the human characteristics that convey the presence of God when that name is never mentioned, when formal religion is not acknowledged? What are the natural means which are the signposts to the supernatural? I want to emphasise first and foremost that to function as a doctor one has to enter into a relationship with another human being, the patient. The moment we enter into relationship with another human being we step into divine characteristics. Human beings in relationship call for an order of existence with such high demands that they clearly exceed the life of animals. They have a past and present and a future. They live with the knowledge of life and death, and both of these pose questions about the origin and purpose of humanity.

At the heart of any relationship, but particularly between

doctor and patient, is required the presence of trust. Trust is in fact another word for faith, and the patient divinises the doctor by virtue of the power, authority, and healing capacity he possesses. The ingredients of faith are many, but for the doctor they include reliable availability, conscientious listening, careful examination, accurate diagnosis, and skilled management. Skilled management means more than knowledge: ultimately it means that the patient feels he can be known as a person.

The presence of mutual trust paves the way for the next human vital experience—namely, the presence of hope. A doctor has to inspire hope. In the midst of suffering it is the doctor's responsibility to include in his management hope and to reinforce it whenever it is present.

Beyond trust and hope every patient longs for a response of love. Each patient will interpret love differently, but all are looking for patience, understanding, empathy, concern, and tolerance in the doctor's dealings with them. Patients are in fact extremely tolerant people provided they recognise in their doctor the characteristics of trust, hope, and love. For the Christian these human characteristics have been transformed by St Paul into faith, hope, and love as the ingredients of Christian life. This is what I mean by transforming the ordinary into the extraordinary, the human into the divine.

Many people will challenge this transformation. Trust, hope, and love, they will say, are ordinary experiences and do not in themselves call for a divine origin. My answer is very simple. Those who try to live by these principles know just what a nightmare it is actually to practise them. They are certainly human in their origin, but to translate them into action requires a degree of persistent motivation that calls for a power beyond us, a source that possesses these qualities in full and to which we can turn to sustain us. That source is what Christians call their God, but a power beyond us is what all human beings experience when they put into practice these characteristics. Ultimately the universal language of all humanity is love, and I believe that wherever love is God is. But neither the doctor nor his patient needs to acknowledge God overtly to show love, and love is the bridge between the God that we overtly acknowledge and the God we experience without realising it.

Prophet of the Old Testament

The second meaning of the word "prophet" is in the sense of prophet of the Old Testament. These were often reluctant men and women who felt compelled to speak in the name of God. They were often aware of the presence of doom and gloom as a result of the hardness of people's hearts, their evil ways, and the need for repentance. It is a picture that one does not easily recognise in a doctor. Doctors are not likely to seek repentance in their patients except when someone is obstinate and refuses to cooperate with an obvious treatment. When one thinks of the series of bizarre treatments that doctors have advocated in the past I am not sure who should be repenting,

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the doctor or the patient. But in fact the doctor does act as a prophet of the Old Testament variety. He has to convert his patients away from smoking, obesity, stress, alcohol, and most commonly all the legion of tablets for anxiety and insomnia. Often the underlying problem is a trait of the personality such as anxiety, and it is much easier to drink or take tranquillisers than to face the stress at work, in the marriage, or in one's own make up. The psychiatrist who has to deal with many of these human problems knows that the motivation to change is the key to effective alteration. In the absence of the fear of divine wrath and displeasure what is left is the doctor's personality and capacity to persuade. This capacity is most effective when he conveys authentically that he genuinely cares what happens to the patient and longs for a conversion that will rescue him from his plight.

There is another way of dealing with the problem. We can put the facts before the patient and then leave him free to choose his course of action. Of course, this is essential. We must not coerce patients, and people resent the feeling that we are trying to convert them to our way of thinking. But we all know how difficult it is for people to change habits which are deeply rooted in the personality. Real loving implies that we respect people's freedom and yet help them to overcome their fears, apathy, anxiety, inertia, and, when they have taken the plunge, to maintain their motivation by encouragement and affirmation.

A prognosticator

Thirdly, a prophet is one who foretells what is going to happen. It is in this capacity as a prognosticator that the word "prophet" is most likely to be recognised in medical circles. Let us see how he can convey the voice of God in this very specific role.

Basic to the doctor's work is history taking, examination, diagnosis, treatment, and prognosis. If all this is to be effective it is necessary for the doctor to enter into a relationship with the patient in which a form of covenant is enacted, in which the doctor gives and receives. What he gives depends on his knowledge, skills, and, of course, keeping up to date. Having given his treatment, he then monitors the progress of change, supports, encourages, and admonishes.

But to do all this effectively he has to receive. He has to receive the patient's story and this means discerning listening. He has to receive and appreciate the inner world of the patient which has coloured the account of his illness. He has to distinguish between the subjective and the objective, and in the process of listening has to respect the fact that the patients know themselves much better than we do. Psychiatrists have to do a lot of listening, and also a lot of interpretation. In fact most doctors have to do the same. There is a constant danger that the patient will tell us what we want to hear but equally there is a great risk that we will hear what we are conditioned to and reach a hasty or prejudiced conclusion. Despite my experience, I still fall into the trap of placing people into pigeon holes and sometimes they resent this immensely and tell me so later. All patients are unique and if we can transmit this personal recognition we convey to them an element of love as God loves us each uniquely.

The outcome of this mutual exchange is the first step of prognosis. If the doctor is competent, has made the right diagnosis, and has assessed the strengths and weaknesses of the patient correctly his diagnosis will have some degree of accuracy. We all know that most prognoses are based on statistical probabilities. No diagnosis has the certainty of divine knowledge, and even when the outcome is almost certain patients with fatal diseases have lived for years beyond their allotted span of time to confound medical predictions. One of the fascinating aspects of medical prophecy is the element of uncertainty, which often reveals the mystery of human nature and personality. We are constantly made to think again as patients defeat

the laws of probability, which reminds us that doctors have to be extremely humble prophets.

Part of this confounding is the healing process. Clearly if the doctor wants to be an efficacious healer he has to go beyond medicine and surgery; he has to be a healer himself. We know something of the placebo effect, but we know too little of the power that a doctor carries when he really believes in what he does, acts as if he believes it, acts in a caring way by encouraging, sustaining, injecting hope, and being part of the healing process. In this sense the doctor acts as a "grace," in which his presence is a freely given gift of the commitment to life.

Healing entails physical, emotional, and spiritual integrity. Physically we bring changes in the body by surgery or therapeutic agents. Emotionally we change the psyche by transforming it, and finally we change the spirit by bringing the person in touch with ultimate values. Ultimate values are about the purpose of living, and illness may be a powerful source of changing direction in life. It can be an occasion of crisis which asks new questions and in doing so may lead to a sense of God or the absolute or a power beyond ourselves, but in any case so far as men and women struggle for life because they value it as something unique and precious beyond mere self preservation they also enter into the world of becoming fuller persons, answering some of the questions of the being beyond.

In this exchange the doctor has to recognise the spiritual resources of the patient. One of these may be an overt faith in God. This may be absent but may take the form of persistence, perseverance, determination, inner peace, faith in life, endurance, hope, optimism, and certainty that death is not the end. It is never sufficient to base prognosis on scientific knowledge alone without taking into account the response of the individual. The medical prognosis must be guided by the current medical knowledge and the determination of the patient to overcome the obstacles of illness. What has to be sustained is hope in the worth of life. But in the process of healing suffering has to be encountered.

The encounter with suffering

The encounter with suffering is a complex process. For many it is the stumbling block to the presence of a loving God. For some fundamentalist Christians it is an expression of God's punishment. That is not a satisfactory response to me. Suffering has two possibilities. It is either a creative experience or it is an incomprehensible tragedy. It is creative insofar as pain and suffering are a warning to correct whatever has gone wrong with the body or mind. As a warning signal it is of value. As a means of acquiring patience, tolerance, understanding of other people's suffering, control, and even displaying heroic qualities of defeating the destructiveness of suffering, it has obvious possibilities which can transform it into human triumph. On the other hand, pain and suffering restrict freedom and can destroy hope and plunge people into despair and isolation, and when these afflict the young and vulnerable there is a sense of profound injustice. Clearly the task of the doctor is to help the patient conquer suffering by alleviating it physically, transforming it psychologically, and wherever possible using it as an occasion when the patient can grow through the experience. In overcoming the evil of suffering by the goodness of remaining whole and intact we share in an experience which takes us into a different plane of being and gives us a task of resurrection.

Much suffering nowadays is associated with the confusion and uncertainty about the meaning of life. We can try to share with our patients our faith, if we have one. But whether we have one or not, whether they have one or not, what we can all do is to sustain their dignity and self esteem. In the presence of suffering, human beings lose their sense of value, worth, purpose, and meaning. Often they feel useless and redundant and in these circumstances we have to offer them the unequivocal dignity and self esteem of their humanity. We have to love their existence, however incapacitated in mind or body they may be.

Doctor and death

Ultimately the doctor has to face the reality of death with his patient. The death of human beings is not the perishing of animals. Clearly one answer is belief in life after death, and, in its authentic presence, death assumes a different meaning. But for all of us, believers or not, death has universal threats. It is not death we are afraid of. We have no knowledge of what death is. But we do have knowledge of the fear of non-being. The terror that some patients have of going to sleep is exactly that. It is the terror of ceasing to be. There is the pain of the loss of those we love and who love us. There is the fear of becoming helpless, impotent, and redundant in life.

Very often the debate around death is whether the patient should be told or not. Clearly some patients would be devastated and overcome by the knowledge. But, whether we inform or not, the task of the doctor is to make the life of the patient as full as possible until the last moment. The challenge of death is to face it and live fully until the end.

Faith and practice

In conclusion, we have to recognise that there is a small band of believing doctors who attend church and practise their faith. There is a larger number of doctors for whom religious life and practice are unacceptable, but God remains to a variable

degree a reality, an ultimate power, latent and hidden. There is a much higher proportion for whom God is a shrouded mystery, clothed in agnosticism, neither denied nor confirmed, nor totally rejected. Finally there is a small minority who are committed atheists but for whom pain, suffering, and death have no satisfactory answers. Our patients also share this multiple confusion.

Instead of our all going our separate ways we have to converge. Those of us who are practising our faith actively must recognise that our faith is respected but the practice of it in church is of no interest to others. Those of us who neither practise nor overtly believe but have a sense of the holy and the infinite have to recognise that the practice of medicine demands recognition of this; and those who have made up their minds through atheism and agnosticism have also to recognise that this is their right and it works for them but not for everyone else.

Just as there is an effort to unite in ecumenism, both believers and unbelievers must recognise the common predicament, and the confusion of the way ahead in our society. We need to work through those aspects of human experience which can transform the ordinary into the extraordinary and can help discern the mystery of the beyond, because the art of healing demands this ultimate value of the transcendental, which means going beyond. In this paper I have tried to indicate how the doctor, acting in the triple capacity of prophet, uses ordinary experiences where the human meets the beyond in an encounter of love.

Miracles of healing in Anglo-Celtic Northumbria as recorded by the Venerable Bede and his contemporaries: a reappraisal in the light of twentieth century experience

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The vigorous hybrid culture of Briton and Angle^{1 2} blossomed in the seventh century into the amazing Northumbrian golden age whose artefacts still astonish and delight us.³ Its stimulus was the reintroduction of dynamic Christian faith by dedicated Celtic missionaries.⁴ Despite its defeat in 664 by the Roman party, the Celtic faith long remained pervasive,⁵ completely shaping the life of Cuthbert and determining the private spirituality even of its arch opponent Wilfrid.⁶

We know that Celtic monks supplied medicines⁷ and that surgery was practised, perhaps by clerics⁸ as well as laymen.⁹ Miraculous healings, however, loom largest in contemporary records. They have been conveniently catalogued by Highfield.¹⁰ In later centuries "miracles" were to degenerate into "wonders"¹¹ and to become as important for the curriculum vitae of the potential saint as are publications for the aspiring senior registrar in modern medicine. In this springtime of the faith, however, miracles were not wonders but "signs" of the power of God.¹²

Some writers have laughed at miracle. A nineteenth century churchman wrote "If Bede may be credited Cuthbert's only amusement (on the Farne Islands) must have been the performance of miracles . . . which notwithstanding their absurdity were duly credited and implicitly believed for centuries."¹³ A more recent historian has written of "benevolent magic."¹⁴

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The denial of miracle, however, poses three problems. Firstly, Bede tells us in the introduction to his *Vita S Cuthberti*, in which so many of these accounts appear, that it was read aloud to, and approved by, Cuthbert's community at Lindisfarne¹⁵ at a time when at least five of those he named therein as first hand witnesses of the miracles were still alive.¹⁶

The second difficulty is of accounting for the stature of Cuthbert, who has dominated our northern traditions for 1200 years. Three centuries after his brief bishopric King Athelstan of Wessex made pilgrimage to his shrine at Chester-le-Street to present rich treasures. If we exclude the miraculous from his story, of the 46 chapters in his biography we are left with only six (chapters 9, 16, 26, 37, 39, 40).

The greatest difficulty, however, is Bede's stature as a historian, a reputation which continues to be enhanced,¹⁷ yet in whose works miraculous healings are inextricably interwoven.

Bede's stories of miracles are seen by some as the chief obstacle to sympathy and rapport with him.⁶ Attempts are therefore made to explain them away as due to his different interpretation of history¹⁸ or his view of the function of facts.¹⁹ As well as his need to show Christ to be as powerful as the old pagan lords, it is suggested that we should recognise three men in Bede: the historian, the hagiographer, and the theologian.²⁰ These are distinctions he would surely not have allowed in view of his claim in the preface to his *Historiam Ecclesiasticum Gentis Anglorum* to have written "in accordance with the principles of true history."²¹⁻²³

The dilemma has been critically summarised by Meyveart. The modern scholar is above believing in miracles, in fact from