Discerning the Spirit in the Double Life of Christian Vocation:

Health Care for the Dying: Reflections/Examples of the Meaning and Challenge of Being a Christian and a Doctor Today

I want to begin by thanking you for the invitation to return to this gathering which I attended so many years ago, sometime in the early '90s. I believe they were called SALT Conferences at that time. I can't tell you what an honor, what a joy it is to meet in a place where the name and the memory of Bob Bertram is invoked and in the presence of Ed Schroeder. How fortunate, how blessed we are indeed to meet in this place. Like Peter of old I'm tempted at this point to ask, "Should we build a booth here, or maybe three?" I think, I hope, that both Bob and Ed would recognize their own hands in the writing on this human heart at least one of their many letters of recommendation. Any errors of omission and commission, of course are my own in what follows and what has preceded this day.

The broader theme which I have been asked to address is this: *Discerning the Spirit in the Double Life of Christian Vocation.* It's a lovely theme, really. There aren't many other groups that use language like this in my experience. Maybe I'm just hanging out with the wrong crowd. It brings back fond memories of Bob and Ed reflecting out loud with us about the gospel in <u>this</u> world, the one in which we live, and not some religious imaginary world that nobody really inhabits. Many of our callings are in the secular world and I can remember as if it were yesterday, Ed and Bob teaching us that secular does not mean bereft of God, a kind of *sturmfreies Gebiet*, unreachable by the Spirit of God. Rather it comes from the Latin root *saecula,* meaning of this age, also Gods age, but an age in which the law predominates. (Pregnant pause). Inviting, of course the question which will not let us go… so how and when do we, in the power of the Spirit, speak about and speak into this world the *saecula saeculorum* the ages of ages, the gospel, of course, which brings life, and hope and peace, on earth now, to those under the law, and in heaven forever.

The specific focus I have been given is "*Health Care for the Dying: Reflections/Examples of the Meaning and Challenge of Being a Christian and a Doctor Today"*

I have to confess that I have taken liberties with the focal point of "health care for the dying." I have taken the dying to mean all those who have been born… the young, and the very old, and everyone in between. It's not that relating anecdotes about the last precious hours of those *in extremis* is not vitally important and, even more so, finding ways to be with them, ministering to them, and speaking to them words of comfort, crying to them that their warfare is ended, that their iniquity is pardoned.

While this topic alone could easily and worthily occupy our entire 45 minutes together, I resist, perhaps reflexively, the notion that matters of faith are really only sensible when we are *in extremis*, when the only thing that makes sense, after all of our efforts have failed, is a hail Mary pass. When the doctors have all left the room, and for once, and only in this one instance, does the physician find relief in her or his ability to call for the chaplain. Yep, it's a chaplain's case now.

Having been in so many congregations in so many different parts of this country, and having seen such a predominance of gray and silver hair at every quarter (my own hairs now included) I have begun to wonder if we ourselves don't bear some responsibility for this misunderstanding, that faith is for the old. To be fair, there are some notable congregational exceptions, also in this land, where a new generation of believers is being created. But I think it reasonable to say that these congregations are still all-too-often the exception.

So I have been stubborn and decided to speak about working as a physician and a Christian in, and among, the dying of all ages. This is my occupation and preoccupation night and day, as I seek to live out the calling that I have been given not only as a physician but as a father of four children, 9 to almost 14 years of age, as I seek to pass onto them the power of the life-giving word, the *viva vox Evangelii,* that I too have received. Unwilling, am I, to simply send them away, patients and

children alike, telling them to go live their lives and come back when they are old and dying, and then we'll talk faith.

So what does the double life of a Christian and a physician look like? What is the nature of the "Life" that the Holy Spirit "gives" in the secular world of the physician, as Pastor Kuhl has described in his proposal for this gathering? In part that depends on whom you talk to. In answering this question my physician friends in the Catholic Medical Association, with whom I have discussed this issue, will move quickly to relate their experiences of living out and maintaining a "pro-life" stance among its detractors. This is at least part of their witness.

I thought about reflecting on being a Christian and a physician in a world where the Minnesota legislature is currently staging hearings around the state for what has been called The Minnesota Compassionate Care Act. This act entails, in the words of the legislation: "…the medical practice of a physician prescribing medication to a qualified patient who is terminally ill, which medication a qualified patient may self-administer to bring about the patient's own death."

I must admit that the first time I heard about this bill and saw its nomenclature, I was transported in my mind back to a time before the *Wende* in the mid '80s in the GDR, East Germany, when the *Bundesrepulik* released a postage stamp commemorating the fortieth anniversary of the *Aufbau* of the Berlin Wall and all that it represented. Within less than a week the East Germans had printed their own stamp with the moniker: *Anti-faschistischer Schutzwall* (Anti-fascist protective wall). That small stamp serves as a reminder to me that even in the land of the free (and I don't intend that phrase in a sarcastic way) we too have to be vigilant for the abuse of language for political ends. So that what is termed "Compassionate Care" is more accurately named "Physician Assisted Suicide".

Now, I don't mean to suggest that there are not worthy issues to explore here. And if in the desire to come to the defense of received doctrine, I miss the opportunity to engage with others, who see it differently than me, in a meaningful discussion of what it means to be "compassionate", not in a philosophical way, but at the bedside of one who is suffering, then I have certainly missed a golden, and perhaps God-given

opportunity. Incidentally, the best book I have read on this subject to date was written by Allen Verhey, *Reading the Bible in the Strange World of Medicine,* published by Eerdmans in 2003.

Some of you may have known Allen. I had the good fortune to meet with him in his office at The Duke University Divinity School in 2013, for over an hour-long private conversation, just months before he died in Christ… following a long and slowly progressive chronic illness. I shall not soon forget.

But I will not linger here on this issue, important as it is.

More closely approaching our theme, however, I thought about the topic of chronic pain, particularly in light of the national recognition of late that we are "confronting an epidemic of overuse and abuse of painkillers." "Opioids kill more people than homicide, state records show," says the subtitle of a recent article in the Minneapolis Star Tribune. Did you know "that the United States represents just 5 percent of the world population but consumes 80 percent of the prescription opioids"? Did you know that "in 2012 enough opioid prescriptions were filled such that every single American could take Vicodin, one 5mg tab, every four hours, for one month"? Staggering! Literally! I suspect that you have heard this and many other statistics like it on national news and talk show outlets.

"We here in Minnesota treat pain aggressively," my wife and I were told in our face-to-face interview with the Minnesota Board of Medical Practice, when we first moved there in 2003. Not a bad goal. But apparently, and we are learning the hard way, aggressive treatment of pain is only one horn of the dilemma.

The health system for which I work in northern Minnesota and northwest Wisconsin and most other health systems in the land are now back-peddling furiously, trying to discern which patients should appropriately receive narcotic pain management and which patients should be tapered off and offered alternative treatments for their experience of pain and their dependence.

Interestingly, for the past two and one-half years I have been intermittently approaching the administration of my health system with a proposal to start and develop a practice that would allow me to focus my work on patients who self-select and who want to understand both their health and their illness in light of the resources of Christian faith: the Word, the community of believers, pastors, parish nurses, and services for healing. "Wow, that's a lot of health you've got there!" So might one spiritual conversation begin. "What are you going to do with all that health?" Or, "I see, that you are suffering. " And thus another conversation might begin.

Initially, my reception among the hospital and clinic administration could be described as polite, if not cool. There was some interest. I was told that at a meeting of all the regional division heads, including: cardiology, neurosurgery, trauma, gastroenterology, obstetrics and gynecology, primary care, and the like, my written proposal was discussed for an entire half hour. Very gratifying! Their conclusion?: "Well, yes, we think that faith has something to do with health…. But no, we don't want to get into that sort of thing."

With persistent effort, their reception over the past couple years has slowly been warming, I think. Of note, with the current crisis over the epidemic of the overuse of prescription opioids, I have seen a light go on in the eyes of some of the administration as well as other physicians. I can see the wheels turning: "Perhaps Braaten could take over the care of some (if not many) of the chronic pain patients who need to be weaned off." (The doctors thereby relieving themselves of some of the most notoriously difficult patients). Again, a hail Mary pass, late in the fourth quarter, as the doctors leave the room. Another chaplain's case. I see many of these chronic pain patients in my ER—some for overdoses and some with refill requests: seeing in their eyes, if not hearing from their mouths, "But doctor, isn't it your job to relieve pain?" I try to imagine how those in the administration anticipate that my conversations with those patients might go, if they were to approve my proposal. "You know," they might imagine me to say, "if you just had a little faith, perhaps you wouldn't need all those narcotics, to which you have become accustomed."

Alas, they have not yet given me the green light to proceed with the project, but I can see the workings of the mind in process. "We could call it 'alternative' or 'complementary' medicine. Or perhaps 'integrative medicine'?" And, not uncommonly, I hear spoken aloud even from friends who are physicians (though not necessarily Christians) that, after all, there is the placebo effect. (Subtext: "So if Braaten wants to talk about God, Jesus, the Spirit, and the disciples, so what! As long as it makes someone feel better, or gets them through the night, why not!")

Well, I'm not going to linger on this thorny set of issues either.

I realize that I am dropping incendiaries, as it were, only to walk away. It's kind of fun, actually, to have that freedom. I suspect that some of you are beginning to wonder though, "So where is this social, if not theological, butterfly, going to alight? What topic is he finally going to address, in trying to fulfill the task he has been given: to talk about the double life, the meaning and challenge of being a Christian and a doctor today. What does that look like?

The issue on which I wish to dwell is the *Sine qua non*, the "without which is not". Without this topic there is no double life. No Christian. No gospel. No healing or life in any sense approaching *Zoe.* Only *bios*, biological function. The topic I wish to address is the one thing needful, the eternal issue in the midst of all the other topical relevancies, the *saecula saeculorum* in the midst of the *saecula*, the secular world in which we live.

I am aware of this double life every time that I attend a meeting with the administration and department heads of primary care. How do I make the best case to them? What kind of arguments would win the day so that they would let me do this little thing that I want to do. I must confess that I feel something like I imagine the supplicants used to feel kneeling on the stones outside the gate week after week, hoping to be let into the temple of American healthcare.

Sometimes, I imagine, if only I could raise the dead. That would get someone's attention! Or perhaps that is asking too much. If only through a word I could make one person who is lame to walk. That might advance my purpose.

Before you dismiss those arguments to quickly, I think that Jesus understood them and was willing to meet that longing and that question in the public square. "*But that you may know that the Son of Man has authority on earth to forgive sins," he then said to the paralytic, "Rise. Pick up your bed and go home." And he arose and went home* (Matthew 9:6). Notice that Jesus didn't give the people gathered and the disciples a lecture on how true faith wouldn't require that anyone walk, let alone go home.

Sometimes I wonder if it is only nihilists, hiding behind the cloak of the theology of the cross, that want to pooh-pooh the force of that argument which Jesus acknowledges (in order that you too may know), that our deepest need is met, also on that level, of rising from our bed and going home.

Well, to date, I have not demonstrated that authority, as far as I know. But that does not mean that I am without *exousia,* the power of the Holying Spirit (see another Bob and Ed-ism!). The authority given to me in the gospel and which gives me no end of lightness and hope and joy and even a sense of triumph as I enter into those conversations with administration, is the authority of which the apostle Paul reminds me and to which I repeatedly turn:

> *For we are the aroma of Christ to God among those who are being saved and among those who are perishing, to one a fragrance from death to death, to the other a fragrance from life to life. Who is sufficient for these things?* (II Cornithians 2:15-16)

The weakness with which I enter the room in those public conversations is my "*aromata*", and is precisely the tool that the Spirit will use to make its case, *ubi et quando (visum est Deo)* "wherever and whenever God wills". And in that I can relax, and enjoy the encounter.

What I would like to do, then, is to share with you just a couple of the arguments that I have used in that setting, the setting of the secular, the *saecula*, or age in which the law predominates. If you can, imagine one or two administrators and a couple of physicians listening to and

considering this proposal: a clinical practice, extending to communities of faith and beyond, with faith in Christ, the word of the cross, the community and healing at its center.

After articulating a couple of the arguments I use in that setting, I would like to share with you just two vignettes of encounters that I have had as a physician where I could hear the proclamation, just begging to be made…to remind us to press the eternal issue, in season and out of season.

My purpose here is not a travelogue, a walk through Braaten's life as a physician, a physician who also happens to be a Christian. My purpose through these arguments and vignettes is to marshal a larger argument, to make a proposal to the The Crossings Community, or some part thereof, if anyone is interested, for a possible collaborative effort that I think has a chance to significantly advance the cause that has brought us together for these days. Let me say in advance that you won't hurt my feelings if you return blank stares. This is just a trial balloon, a thought experiment. If you are interested, let me know and we can discuss it further.

So, to a couple of the arguments that I use in the secular world in which I live and work:

1)There are arguments which appeal to the biological life that we all share, as Steve Kuhl wrote, "…the life that God the Creator has given us in creation." When I argue that congregations could serve as a mechanism to help older citizens remain longer in independent living and could help break some of the silence and the loneliness they feel, I have their attention. When I argue that congregations could serve as rallying points where people in the neighborhoods, who know they need to exercise, or who suffer from chronic pain or fatigue, could meet and gather support, then I have their attention. When I argue that congregations could monthly, or from time to time, offer a new take on the old pot-luck, search the pages of *Cooking Light* (for example) and bring something lite and tasty to share with the neighborhood, together with the recipes and nutritional information written on a card for take-home, I have their attention. When I speak of congregations offering respite for children and households that have only one parent, so that

there are fewer latch-key situations (yes, that's still a problem), I know that I have their attention. And then there is the obvious need for shelter for the homeless and food for the hungry. Not hard to make the case for congregational support there. All of these interventions fit under the current buzz-word: social capital. And the health-care sector is interested.

An article in the January 24, 2011 issue of the *New Yorker* by Atul Gawande entitled "The Hot Spotters" brought to our attention a new breed of health care provider (though very few in number) that is focusing its attention on the large number of patients who return to the ER over and again to receive care, and the disproportionate number of patients who are re-admitted to the hospital 30 days after a discharge for the same or similar complaint that brought them in the first time. With the horizon of skyrocketing medical costs and the growing proportion of GDP that we spend on health care in this country, these numbers represent the loss and waste of billions of dollars each year. For our purposes in the Church, the numbers of excess ER visits and re-admission rates reflects the number of people in our communities that are inadequately connected to resources at home and who are lost in the shuffle. If we work together in congregations, with pastors, parish nurses, and social workers to organize our efforts around these figures, we could get a sense of the scope of the problem, design an intervention and use subsequent rounds of data for quality improvement to measure our effect and alter our course accordingly. If you consider that Medicare reimbursement rates are now tied, at least in part, to reducing these re-admission rates, you can understand that when I discuss the prospects of congregational involvement with the administration, I'm certain I have their attention.

For these and a myriad of other ways that faith, or in the language of the trade: *religion, spirituality and health* can effect the biological, emotional and spiritual health of individuals and communities, I refer you to the work of Dr. Harold Koenig and others at Duke University, particularly succinct is his *Spirituality and Health Research: Methods, Measurement, Statistics and Resources*, Templeton Press, 2011.

Many congregations seem to understand these principles already and are well-engaged. It is truly exciting! Unfortunately, there appear to be all-too many congregations that seem to think that is their only purpose, as if the greatest problem we have as a species and the greatest need we share, the deepest level of diagnosis, has to do with the food that goes in our bellies, the shelters over our heads, and the need for community, of any kind. Vladimir Lenin thought that and wrote about it in his tract *On Religion*. Once all of these problems are solved and the workers have the respect they deserve and their proper position in society the need for religion will fade. From where I sit, that has just not been borne out, at least not in the world I inhabit.

2) The next argument that I use to help move the conversation away from a simple biological understanding of health follows: Most understand by intuition that there is more to human health than the gall bladder and an LDL level. Few would argue that those are unimportant to one's health, but most understand that there is a larger context in which our lives and our health have meaning and purpose. Witness the proliferation of alternative medicines and reference to natural remedies. These, as opposed to synthetic medications fabricated and swallowed in pill form, give some a sense of connection to nature, to the earth, and to the larger world in which we live.

Many others understand their lives in the context of hope and courage, of purpose and of faith. Great traditions have developed over the course of millennia, which have given insight to millions concerning the nature of human existence. These traditions have offered, in a sense, a diagnosis of problems that people encounter on a daily basis. Likewise, they suggest a prognosis or way through to a future that gives meaning, hope or understanding to those who follow their precepts. Among these include Buddhism, Islam, Hinduism, Christianity, Judaism and many others. One might also include, for some, atheism or affiliation with a particular political persuasion as grounding both meaning and purpose in life.

3)At about this point in the discussion the issues get even more interesting. One of the doctors will inevitably say, "Well, we have a number of chaplains, and some of the doctors even pray with their patients. So, we've got that covered. It's already happening.

At this I need to gingerly suggest that there are a variety of counsels, some more helpful than others. I usually paint the following scenario: Let's say that one of our fellow passengers aboard this ship we call life, or healthcare, falls over board. We quickly look over the rail and try to study the situation. We see our fellow shipmate struggling to keep her or his head above water, with the waves threatening to overwhelm. And we reflexively shout out: "I think I can see your problem! You're drowning!"

Okay. So far so good. We have a working diagnosis. An impression. All we need now is a plan. "All you need to do now," we shout… "is swim!" "That's great," says the one in the water, scarcely managing to stay afloat. "But would you mind throwing me a life-ring?"

The analogy is perhaps somewhat comical. But in essence isn't that what we are doing when we shout out to the drowning person that all they need is a little faith? "Hey, that's great. But could you throw me a life-line, something I can hold onto? "What is it," I ask my audience, "that actually creates faith, a faith that does not disappoint?" It is not enough to simply assert that faith is what is required. Like telling a drowning person that all they need to do is swim.

And then there are countless other words and images that proliferate and are recommended and touted as solutions: "Mindfulness! You just need to be mindful!" "Great! Mindful of what?"

And then there is another personal favorite: "Resilience". I hear it everywhere, mentioned in hushed tones as if the one speaking the word has delivered himself of some new and creative insight. "Ah, yes, resilience. If only I had some." "But could you throw me a lifeline, something I can hold onto? I'm drowning here!"

That is our focus. That is what we should practice, time and again, to throw the lifeline. *Was Christum treibt. Unam praedicam*, Luther wrote more than once, *sapientia crucis.* Preach one thing, the wisdom of the cross. Why does it so often seem that what we hear, even from our pulpits, is everything but.

Usually, at this point in the conversation someone will say something about diversity. "Well, you know there are many people of many different beliefs, who come from many different traditions. And we need to honor them, and consider them all."

I usually try to pre-empt that argument early by acknowledging, as I did above, that our work as Christians, everywhere, but also in health care, is set against the backdrop of many great traditions. We are one among many, and we stand on no higher ground. These great traditions, as essentially healing traditions have offered, in a sense, a diagnosis of problems that people encounter on a daily basis. Likewise, they suggest a prognosis or way through to a future that gives meaning, hope or understanding to those who follow their precepts. Among these include Buddhism, Islam, Hinduism, Christianity, Judaism and many others. Even the Anishinabe, the Ojibwa who live in northern Minnesota and Wisconsin: the Leech Lake, the White Earth, and Cass Lake Bands, *Lac Courte Oreilles*. All have their great tradition. And our message is one among them.

Wouldn't it be great, if the word "diversity," rather than being a threat rendering us mute in the public square gave us all, each of the traditions, a chance to speak and be heard? Sometimes I think that ever since Lessing and his essay *Die Erziehung des Menschengeschlechts (On the Education of the Human Race),* there has been a powerful push to homogenize the religions, causing them to lose all their idiosyncrasies and rendering them either into a lifeless abstraction, or a gushing gnostic sentimentality.

I can't tell you how often I run into the assumption that really all religions are saying essentially the same thing. Never mind that the same thing that they say turns out to be the position of the one holding that opinion. The idea that all religions have the same message reminds me of Hegel's dictum about romanticism: "that night in which all cows look black."

I feel sometimes, that those who crow the loudest about "diversity," those who are the most strident, and who repeat it the most often, actually like it the least. The suspicion is forming itself in my mind that

the word “diversity” is often used as a club, to bludgeon all who disagree with the wielder of it.

So what if, and this gets at the heart of my proposal to The Crossings Community, what if we work alongside others, to gather as publicly as possible a few representatives from a couple of the worlds great traditions, the most articulate representatives that we can find to bring their healing traditions to bear on a few good cases, people in struggles of one kind and another (medical, social, spiritual, relational, financial, or otherwise). How does each tradition interpret the problem? What is their proposed diagnosis? And if that is the level of the diagnosis, if that is the depth of the problem, what is the treatment? What is the prognosis? Sound familiar? Perhaps some of you have already done things like this and are tired of the project. To me it is exciting and could model a breach of the impasse which exists when trying to get at the issues of faith, which have such an enormous and even determinative influence on health and well-being in ourselves and in our communities.

In closing, I would like to turn our attention to a couple of cases, two of many that I carry with me in my heart, my mind and my experience.

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NB: Steve. I need to pare this down some. I was initially planning to include a couple of cases or vignettes which illustrate a few guidelines for spiritual counsel that I use when working with and thinking about patients that I have seen over the years. Since many in the Crossings Community already do this on a routine basis, I wasn’t sure that I could add much to their base of understanding by doing this. I therefore have chosen to try to depict the double life of a Christian and doctor, as I experience it. As I edit this down, I may still include an anecdote or two, but this should suffice for a respondent to prepare a comment or two.

Thanks again for involving me in this conference. I look forward to seeing you there. --Arndt