

Second Annual Thelma Shobe Lecture  
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## **“Rediscovering the Joy of Practice”**

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I am profoundly honored to have been asked to give the Thelma Shobe Lecture, and I am grateful for the opportunity to meet Dr. Patricia Benner and the other members of the committee. While I am disappointed that Ms. Thelma Shobe Cooke could not join us, I understand this lecture is being taped and that she will see us at a later time. As a Franciscan friar I must also mention that I am always happy to visit the city named for the founder of my order.

That there is a Thelma Shobe Lecture is a very good thing, and deserves special mention. It is a sign of the vitality of a new and exciting movement in health care regarding which I have been both an enthusiastic witness and eager participant. By being here, you too are part of it—the growing awareness of the need for the healing professions to re-engage the spiritual dimensions of practice.

Let me start by saying, briefly, that I take spirituality to be about the transcendent dimensions of life—not an other-worldly sense of transcendence—but a view of transcendence as immanent—transcendence as rooted in reality.

Spirituality is a habitual way of seeing the universe and our humanity that is rooted in reality, yet understands reality to include far more than merely that which can be seen under a microscope or measured. Gerard Manley Hopkins expressed this view succinctly when he wrote:

The world is charged with the grandeur of God.

It will flame out, like shining, from shook foil;

It gathers to greatness like the ooze of oil

Crushed.

This is the spirituality of transcendence as really in the world, neither something unreal, nor an experience of some other, parallel reality.

If spirituality is truly immanent, the primary spiritual questions will, accordingly, at first appear mundane and pedestrian. If spirituality concerns concrete human experience, common to us all, then the questions of concern to spirituality will not be some secret, Gnostic set of magical inquiries. The primary spiritual questions are these—questions of meaning, questions of value, and questions of relationship. These questions arise only for persons, yet they arise in *all* aspects of the lives of *all* persons. This is why authentic spirituality, at first, seems so innocuous and mundane. Yet, if it is true that we can experience the transcendent in and through the mundane, then spirituality can never be merely mundane.

Importantly, the work we do as health care professionals raises these fundamental spiritual questions in an especially salient way. These are the questions—of meaning, value, and relationship—that are whispered with every last gasping pant of dyspnea; that ride the crest of every wave of nausea; that bubble up from the depths of depression; that pain brings into sharp, agonizing focus.

I think you know what I am describing. Whether overtly or not, patients ask these questions all the time. What does this all mean? Can I find meaning in my suffering? Am I of any value at all, now that I can no longer work and must depend upon others, even for toileting? Does anyone care? Will I be abandoned?

Meaning...value...and relationship...

At long last, we are beginning again to become aware of how important it is for us to attend to these questions as they arise for our patients. This is the spring from which the spirituality and medicine movement flows.

But I want to turn our attention today in a slightly different direction. It is revolutionary enough to begin talking about the spirituality of patients. I want to move us one step further and ask us to begin to address a few questions about our own spirituality as health care professionals.

The theme for today's talk is joy. I want to convince you that true joy is a spiritual experience. Joy is genuinely transcendent. For example, there is no "UCSF Scale of Practitioner Joy."

We can't see joy under a microscope. Even though I firmly believe we are made for joy, I am just as certain that there is no gene for joy. Joy is not in our DNA, but arises out of our DNA—an emergent property that cannot be reduced to biochemistry even if it is inseparable from our neurophysiology.

Would that we all were joyful—here and everywhere in health care. Sadly, many of us are not. According to my informal Pub Med search, over 450 articles have been published in the last year alone regarding nurse satisfaction. So much would not have been written if there was not a problem. For physicians too (although the denial is greater and the volume of literature not so large), dissatisfaction is approaching crisis levels.

Anecdotally, we all know this is true. Listen to your colleagues in the doctors' dining room or the nursing staff lounge. "It's not like it used to be." "We see more patients and spend less time with each: sicker and quicker." "Our patients no longer respect us. Instead, they sue

us.” We work harder just to maintain income.” The Alphabet Soup Gestapo is out to get us—the IRS, OMB, OSHA, the RRC, CMS, HIPAA, and the IRB...just for starters.

The quest for joy in health care cannot, of course, divorced from the general social context. It has been said that we live in a culture of complaint. We all consider ourselves victims in one sense or another. No nation in the history of the planet has ever been as privileged as our own, yet no nation’s citizens complain as loudly about how difficult life is. Healthcare occupies a particularly prominent place in the culture of complaint.

Who could blame us for not having joyful lives? We are surrounded by suffering. Outside of obstetrics, the best it gets in most parts of the hospital is relief, not joy—relief that the tumor was benign; relief that one’s spouse did not have a heart attack. Hey, it was only pericarditis!) Relief hardly amounts to joy. Suffice it to say, there is no joy in Med-ville.

How could we be joyful dealing with sickness and death, beset by bureaucrats, and making less money than people who have had half our education? Accordingly, the question, “Where’s the joy in health care?” seems perfectly legitimate.

#### WHAT IS JOY?

To answer this question, we need a better sense of what we mean by the word ‘joy.’

Joy seems to spring, says Sidney Callahan, from a “heightened psychological self-awareness” and an affirmation one’s whole person. Joy is not a synonym for pleasure. Joy, like pleasant feelings or sensations, is immensely desirable.

But the pleasures of sex, or a delicious meal, or a wonderful symphony, are ephemeral. They come and go, lasting moments or hours. Joy, by contrast, is a sustained state. Certainly we can become joyful persons, and we may lose our sense of joy, but joy is state that endures over long

periods of time. Some spiritual traditions even go so far as to posit that joy can be eternal. If so, joy is transcendent.

Pleasure, by contrast, is never eternal. There are, to be sure, passing moments that we can describe as moments of joy. But momentary experiences of joy are not the same as joy itself. We can experience joyful moments, but these are only possible if they well-up from a deep and abiding sense of joy. These experiences are but fleeting flashes of recognition of an ongoing sense of joy that is already given. Pleasure is also something that is often within our control. Joy is not. We can choose to have sex, choose to eat a delicious meal, or choose to listen to fine music. Joy, by contrast, is not a choice. One cannot choose to experience joy. Joy cannot be controlled. Joy simply happens. One can predispose oneself to joy, but one cannot go to a store and buy something that will make one joyful. One cannot choose either to be joyful or joyless. Joy and pleasure are not the same.

Think, for example, of the trumpet voluntary at the beginning of Bach's Christmas Oratorio, or the final movement of Beethoven's Ninth Symphony. These are wonderful artistic expressions of joy. They are extremely pleasurable to hear. But I suspect most people hear these as merely pleasurable. To experience the joy the composers are trying to communicate through these pieces one must be able to connect with the underlying source of abiding joy that the composers are attempting to express, one Christian, one humanist, both supremely human. Joy is not the same as pleasure.

Neither is joy a synonym for happiness. Although they are related, and both happiness and joy are pleasant and desirable, joy is more intense than happiness. Joy is more than contentment. Joy borders on bliss. Happiness can be private, but joy is meant to be shared. In fact, there is a positive feedback loop. When joy is shared it leads to more. In this sense, joy is

transcendent. It points beyond itself and beyond those who experience it. Happiness also seems to depend upon a minimum amount of pleasure and freedom from pain. In this sense, happiness is susceptible to the vagaries of fortune. Joy, by contrast, seems to be something independent of fortune. Joy can be found, remarkably, in the midst of great suffering and material want. For example, the poor of the developing world sometimes seem extremely joyful. And we have all known patients who are suffering enormously from their illnesses but are extremely joyful in the face of it, even if we would hesitate to say that they are in a happy state.

Joy is not a simple state of affairs, like happiness, or a habitual predisposition, like a virtue. In traditional Catholic theology, joy is classified as a “fruit” of life in the spirit. Joy happens, even (or especially), to those who least expect it. It is this stuff, joy that seems so lacking in health care today.

### THE ROOTS OF JOY

From whence, then, might the joy of practice arise for those of us in health care? Where is joy to be found? Before answering these questions, I want to offer a warning. This is not a lecture in feel-good religion and will not be a shallow, self-help talk masquerading as genuine spirituality. I will not give you a formula for joy, a lantern to rub, a secret prayer to recite, or a mantra to chant. Joy can be provoked, but it cannot be conjured. Joy supervenes upon a life of authentic spirituality. There is no cheap joy. Too much of what passes for spirituality in our contemporary culture is a vain search for cheap joy. My motto is different, “Ask not what your spirituality can do for you. Ask what you can do for your spirituality.” This is the only way to discover true joy. It will pass through your fingers if you try to grasp it.

I want to argue that joy flourishes in a life that is nourished by three great roots: gratitude, love, and hope. I want to demonstrate that we can re-discover the joy of practice by cultivating these three attitudes.

## 1. Gratitude

Gratitude is the antidote for the culture of complaint. Please do not misunderstand me. I hate bureaucracy more than most. I become very frustrated having spent ten minutes on hold on the telephone only to find myself begging an 18-year old automaton in Omaha to authorize a drug I think is indicated for my patient. I'll confess that I do my share of contributing to the culture of complaint. But haven't clinicians put up with far worse for the sake of their patients? After all, I'm not practicing in downtown Baghdad. I'm not risking my life in a 14th century epidemic of plague without recourse to any effective treatment. When I calm down enough to think about it, I have a great deal for which to be grateful. So do us all.

The culture of complaint is like a frosted contact lens.

It blurs our ability to see the transcendence that is present in our own reality. Gratitude, by contrast, is the heart of prayer. Gratitude moves us to authentic prayer. And authentic prayer enables us to remove those frosted contact lenses.

I live in Harlem. I have learned a great deal from the spirituality of the African-American community. Now this is a group of people that certainly has a lot more to complain about than do I. I am reminded of this weekly at mass. The people's hand-written petitions for the prayer of the faithful are always sobering, often heart-wrenching. Their prayers include, "Please God let my son get out on early parole." "I pray that my husband finds a job." "Let us pray for all our brothers and sisters who are struggling with HIV/AIDS." But what do they sing immediately after reciting these petitions? I sing Hallelujah! Hallelujah! (Why?) Because I'm grateful.

Hallelujah! Because I'm grateful. Gratitude rises up out of poverty, injustice, addiction, and plague. Hallelujah! Because I'm grateful. Such expressions help keep me grounded in reality whenever I think I'm having a bad day. The frosted contact lenses of the culture of complaint can't help but pop out of my eyes. Gratitude leads us to sing songs of joy.

For what might we, as health care professionals be grateful? First, we might consider the generally privileged lives most of us have led. We have won what the philosopher John Rawls calls the social lottery. Very few of us were born in abject poverty, bereft of opportunities for education, looking forward only to very short life expectancies due to the disease and violence of our environments. This is not the case for most human beings born in this world. We have had the opportunity to become nurses, physicians, or other health care professionals because we happened to be born in circumstances that made that possible. We should be very grateful.

Second, we have been privileged to be practicing the healing arts at a time when medical science has revealed more about the wonders of human biology and has provided more opportunities for diagnostic and therapeutic intervention than at any time before. We have sequenced the human genome. We bombard people with radio waves inside huge magnets and generate images of their internal anatomy. New infectious diseases arise and we now consider it routine that we discover their causes and develop effective treatments within just a few years. All of this is amazing; fantastic; wonderful. We should be very grateful.

Third, we have all had wonderful teachers. I'm sure there were some forgettable teachers along the way, but I'm also sure that there have been some unforgettable ones for all of us. The healing arts are not passed on genetically, but by teachers. There have been the role models; those who have challenged us; those who have given us extra help when we needed it. Nursing

and medicine are not self-taught. We have learned these arts from our teachers. We should be very grateful.

Fourth, and most importantly, we have all had the incredible privilege of being true healers—of being present to fellow human beings at a time of desperate need and of having been able to use our knowledge and skills to make their situations better. We are privileged to touch people in remarkable ways—

With skillful fingers plying their flesh, mediating the healing that culminates when we release them from our grasp and disappear as they are restored. We are privileged to enter into the secret places of their life-histories, to be considered worthy of the trust they place in us. We have all had the experience of being healers. We should be very grateful. Such gratitude nourishes an authentic spirit of joy.

## 2. Love

There is no use in being overly subtle, so let me state it baldly and boldly. You will never find joy in health care unless you love your patients. And if you don't love them now you can learn to love them. The English word 'love' has several meanings. The Ancient Greeks had at least three words for love. Understanding these Greek words can help us to understand a bit better what kind of love I am suggesting. Those three Greek words for love are: *eros*, *philia*, and *agape*.

Eros is a passionate, intense desire for something. It is often associated with sexual love, but need not be. When we say that a colleague is passionate about her research project, for instance, we are speaking about *eros*. At its root, *eros* is attraction to beauty. That beauty may be an elegant experiment, the beauty of someone we find sexually attractive, or the beauty of a work of

art. We do want health care professionals to have *eros* in the sense of wanting them to be passionate about their work. But it is not *eros* I have in mind in talking about love for patients. For example, we need to be able to work with those who are unattractive. And sexual passion is rightly forbidden within the relationship between a health care professional and a patient. *Philia* denotes the love of friendship. It entails a fondness and an appreciation for another person. From the ancient Greco-Roman era to our own era, many have suggested that *philia* is the ideal relationship between a health care professional and a patient.

I am not sure, however, that this is quite the proper way to think about the love between practitioners and patients. Aristotle, for instance, thinks that friendship is really only possible among equals. But the patient lying on the stretcher is never the equal of his nurse or physician. He is in a position of inequality, dependence, and vulnerability. Friendship also involves a mutuality that is not part of the relationship between practitioners and patients. I have no basis for expecting that my patient will wake up for me at three o'clock in the morning if I need her. She, however, has the right to expect such behavior from me.

Third, as Dan Davis points out, friendships are not usually specific to institutional contexts. One might meet a new friend at a golf course, but if one never does anything together with that person anywhere outside the golf course, it is probably not a true friendship.

Likewise, unless the relationship becomes atypical and one begins to golf with one's patient, or go to the opera together, or have dinner together, one's relationship is probably not best described as friendship. Fourth, if one's relationship does begin to look like a friendship, including meeting frequently in social contexts outside the institutionally medical context, there

are serious reasons to wonder whether one ought to sever the relationship as practitioner and patient. This is because one's objectivity can be compromised in such circumstances.

Finally, there is a sense of partiality implied in *philia* that seems at odds with requirement health care professionals have to serve all who come to them in need. Thus, I do not think that *philia* (friendship) is the proper love between physicians and patients. *Agape*, by contrast, denotes an unselfish love for all persons; the kind of love we can have for all humanity. *Agape* carries a sense of appreciation of the individual person, yet without the partiality of *philia*. *Agape* has the outward and other-directedness of *eros*, but its attraction is diffused among the many and more subdued in tone. *Agape* seems like the kind of love we can truly and properly have for our patients.

It is *agape*, I would suggest, that drives some of our colleagues to join Doctors without Borders and serve in Somalia. It is also *agape* that drives the rest of us to do things such as staying later in the office to be sure that the patient fully understands our recommendation when we could have just settled for a signature on the consent form. It is *agape* that drives us, in simple but concrete ways, to attend to the personhood of each patient; to be truly present; to listen attentively. It is *agape* that makes us get out of bed at 3am to answer a page. If we think hard enough, it is probably *agape* that gets us out of bed every day just to show up and serve the sick.

Unless you're in it for the people, you will not find joy in healthcare. Fidelity to the call of *agape* is the wellspring of joy in practice.

### 3. Hope

It is impossible to be joyful if one has no hope. Hope is a desire for something in the future that is good, difficult to attain, but possible. Our culture in general and medicine in particular, has

become very constrained in its hopes. What passes for realism is often just cynicism and nihilism. There is nothing to which to look forward.

With our patients, we are even urged by well-meaning people to help them “re-frame” their hopes. As the biomedical outlook looks bleaker, we are urged to help them transition from hope for a cure, to hope for remission, to hope for survival until an anniversary or other some landmark event, to hope for symptom control. But being sick or terminally ill does not render a person stupid. Somehow we don’t seem to think that they are smart enough to realize that if hope is something that sequentially grows narrower in scope, it will eventually be the case that all hope finally evaporates. This is not the kind of hope that leads to joy.

We ourselves can fall victim to the same sorts of traps. We might hope for the right residency, fellowship, or faculty position. We might hope for a better balance between work and home life.

We might hope to cure all our patients, or to find a cure for one or another disease. We might be reduced just to hoping for Friday night. But all of this is ephemeral at best, and never guaranteed. All our patients will die. If we cure cancer they’ll just die of Alzheimer’s disease. Monday follows every Friday.

Real hope is not a prediction, but a form of faith in an immanent spiritual reality. The object of ultimate hope must be transcendent.

As Vaclav Havel has written,

The kind of hope I often think about (especially in situations that are particularly hopeless, such as prison) I understand above all as a state of mind, not a state of the world. Either we have hope within us or we don’t;

It is a dimension of the soul, and it's not essentially dependent on some particular observation of the world or estimate of the situation. Hope is not prognostication.

Nor is ultimate hope a cheap, naively cheery disposition. Hope is not a psychological state—a hippomaniac condition of perpetual optimism. Hope is a desire for an object that is always before us, never easy to attain, but always possible to attain. Ultimate hope must be both immanent and transcendent.

Again, as Havel has written:

Hope is definitely not the same thing as optimism. It is not the conviction that something will turn out well, but the certainty that something makes sense, no matter how it turns out.

Transcendent hope is found in immanent meaning. Meaning is the ultimate object of our deep desire to know and understand, a desire that is both immanent and transcendent, difficult to attain but always possible to attain. It is in making sense of what we do and in all that is around us that we find ultimate hope. Without meaning there is no hope, and without hope there is no joy. If this is what hope ultimately means, then the sick and the dying can find hope even in the throes of death, because, as human beings, they have the possibility of finding a way to make sense of it. They can be certain that they will be shown a way out of no way.

Sharing as we do in the humanity of our patients, we can be certain that it is only through re-discovering the meaning of our own work as healers that we will find hope. What does it mean to be a healer? It means being one whose efforts restore right relationship; one who brings together the ragged edges of disrupted tissues or frayed familial relations in such a way that they anneal, regenerate, and renew themselves.

Consider the following analogy: In my religious tradition, properly speaking, the priest does not marry a couple. Literally, they marry themselves while the priest witnesses their marriage on behalf of the community. Health care is similar. We are privileged witnesses to the ceremony of healing. If the body had no regenerative powers of its own, there would be no health care. Surgery would simply be impossible if tissues could not heal themselves. No patient survives long with only antibiotics in place of an immune system. Like the priest at a wedding, we set the conditions, perform the rituals, mumble a few words, and line everything up. But in the end, primarily, we are witnesses to the great mystery of healing. And that mystery is interpersonal as well. Our presence is part of that healing.

A society that does not set aside and authorize a group of its members as healers, and assure everyone else access to them, is a sick society, in need of restoring right relationship within itself. The sick come to us because they cannot mobilize their own self-healing and need our assistance. We are witnesses to the mystery of healing and servants of the mystery of the human person. We heal as much by relating to our patients as whole persons as we do by restoring physiological harmony. In fact, it is the former that animates and justifies the latter. If that were the case, we would be veterinarians and *Homo sapiens* would be just another species in the barn.

To appreciate these mysteries is to find the meaning present in our daily work. And who would not be a joyful as a servant of such a rich and meaningful mystery?

#### WEDNESDAY MORNING

Well, I can assure you that if I were giving this talk on the East Coast, they'd be certain by now that I was from California, and that if I were giving it anywhere else in California, they'd say I must be from San Francisco, and since I am giving it in San Francisco you probably believe

I must have spent the 1960s in Haight-Ashbury. Isn't this just unrealistic drivel? Is it actually possible for 21st century US practitioners to cultivate grateful attitudes, love their patients, and find meaning in healthcare? Well, let me tell you about last Wednesday morning in the faculty practice. I saw Ms. Berger. She's just turned 65. Her diabetes and also, mysteriously, her COPD, were both cured by bariatric surgery five years ago, which resulted in a 100 pound weight loss down to a trim 250. She has just developed an ulcer at the gastric anastomosis. She told me that she was not so much concerned about the ulcer or her pain as the fact that the gastroenterologist told her that her stomach is very small. "That's why I'm always hungry," she said. "Can't we get a surgeon to make it a little bigger?" She was dead serious, apparently not fully accepting, five years out, that this is exactly the point of bariatric surgery. She also still smokes. She's been on Chantix for her cigarette addiction since it came on the market. We've been through several bouts of cellulitis, pneumonia, a subclavian DVT after the bariatric surgery, and more. She's a non-practicing Jew, lives alone, wears big hats like the old Congresswoman Bella Abzug, takes more pills than any other patient I have ever treated, and drives a motorized red scooter upon which I think she is psychologically, rather than physically, dependent.

What can I say? She is not my friend, but I really do love her. *Agape*, after all, is not abstract love for humanity, but a concrete love for the humanity in those we meet. Even if it does not share all the particularity of *philia*, still *agape* is concrete. As Aristotle once wrote, "The doctor does not treat humankind in general, but Callius or Socrates or some other individual who is sick." I am grateful for all the technology from which Ms. Berger benefits, grateful for what she taught me as my first patient to go through bariatric surgery, and grateful for the opportunity to get to know such a colorful character. Being present to her and for her is meaningful for both of us. I stand in awe of the mystery of her unkillable constitution,

disobeying all the rules, going through crisis after crisis, hospitalization after hospitalization, all with a breezy sense of aplomb. It is a joy to be her doc.

I also saw Mr. Hernandez. He's 42 years old and works as a building "super." He's had pneumonia once, and he has hyperlipidemia for which he refuses treatment, saying that he'll handle it by diet even as his weight increases with every passing year. Mostly, he struggles with recurrent depression. He's been divorced three times. He is currently unmarried but has his share of girlfriends. He knows he drinks too much. He tells me stories about the arrogance of the rich people in his building and about investigations by the district attorney for corruption among building supers, and audits by the IRS. I really don't understand much of it, but I suspect that I'm not hearing the whole truth, and I worry that he's as careless about his financial affairs as he is about his health. For the last few weeks, he's been having much more trouble sleeping, decreased libido, and feels tired all the time. I think I convinced him to re-start paoxetine and finally to start atorvastatin for the first time. We'll see if he's actually taking these drugs when he comes back in a few weeks.

He feels free to tell me incredible details about his life—about how he messed up and had sex with his second wife, about how he doesn't like the way the first wife is raising his daughter. There is something about him that is very real—very flawed and very real. It is his reality that I love—strong and brown and proud and handsome and sad. He has given me the privilege of sharing his journey to discern the meaning of all this—the meaning of his very life. He lays bare the brutal honesty of it. The meaning is in the *pathos*. Abraham Heschel once wrote that the prophets were able to feel the passion of the Most High—that this was true *pathos*. Their sole task, as prophets, was to communicate that Divine *pathos* to the people. One need only believe that the *pathos* of the Divine is inside each and every person to understand our prophetic role as

health care professionals. Because if this is true, then we actually come to understand the *pathos* of the Divine through understanding our patients. What else could make a job more meaningful? Who would not sing for joy?

I also saw Ms. Gupta. She is a 35 year old chronic schizophrenic. She was first referred to me eight years ago when a friar said she needed an understanding doctor. The friar did not understand that she really needed a good psychiatrist more than an understanding internist. At the time she was being hospitalized for psychosis four to five times a year. I was eventually able to convince her to be hospitalized at St. Vincent's, and they enrolled her in a day program, which worked well for her. For five years she avoided hospitalization before becoming more paranoid about the staff and more resistant to taking her medications. She eventually stopped all her meds, was even lost to follow-up for nearly a year, punctuated, we later learned, by hospitalizations at other institutions. Now she is back, taking a different anti-psychotic and being treated as an outpatient, but still refuses to participate in the day hospital or group sessions.

My medical role has been to try to manage her weight, her lipids, and her constipation; to listen to her without allowing her to split between me and the psychiatric staff; and to provide preventive care. Some of that has been difficult. She is intelligent and can appear at times much less ill than she is. But she is really very sick. For example, the first (and only) time I attempted a pelvic exam she actually became sexually aroused. She now gets her PAP smears from a woman colleague in OB-GYN. She is Indian-born but an intensely religious Episcopalian. She frequently wants to talk to me about priests we both know or about matters of her personal prayer and piety. She often reverts to saying that she can just pray and get off her medicines.

I can't say that I like her. But I can say that I love her. I don't simply feel pity for her. My love is for her as a person. I try hard to imagine what it is like to be in her condition, living

alone in some sort of structured housing unit in Manhattan that seems more like a dormitory; to imagine what it is like to be really friendless, largely abandoned by one's family, beset by delusions that are imperfectly controlled only by drugs that make one fat and less attractive and have other serious side-effects. I do hope someone will find a cure for schizophrenia, but my hopes for Ms. Gupta are deeper than that.

In the end, a hope based on pharmaceutical agents is itself a delusion. I find hope in the meaning of our relationship, a meaning that transcends the sum of every encounter in the hospital or the office. I find hope in the meaning of being a healer for her—even in its radical incompleteness—because I have faith in a day of universal reconciliation that subsumes all my paltry efforts to set in motion the conditions for her healing. I am grateful for what she teaches me about my own limitations and finitude; my constant struggle to recognize that some things are out of my control and improperly addressed by my incessant tendency to assume the role of “fixer”. I'll be blunt. There are times I positively dread seeing her—when she is off her medications and trying to convince me that the psychiatrists are conspiring against her and that niacin makes her hallucinate. But real joy supervenes upon our dread. This is the joy that Tagore understood so well when he wrote of “the joy that sits still with its tears on the open red lotus of pain...and knows not a word.” Ms. Gupta teaches me about that kind of joy.

#### CONCLUSION

That was just Wednesday morning—or part of Wednesday morning. I saw six other patients and could have told similar tales about each. I do not think my Wednesdays are different from your Wednesdays, or that Monday and Thursday are any different either.

Is this a spirituality of joy in practice? Well, if the fundamental spiritual questions are about meaning, value, and relationship, then I think it is spirituality.

If hope is the meaning we find in our work; if love is the ground of our relationships with our patients; if gratitude is the posture we assume towards the priceless value we find in our patients and in our healing crafts, then we are living an authentic spirituality. And the fruit of such spirituality is joy. This joy does not eliminate or deny the troubles we face in our healing professions. But true joy is something that no managed care company, government bureaucrat, lawyer, or nasty colleague can ever take away. It is a joy that is meant to be shared—with our patients, and with each other. It is immanent and transcendent; present and eternal. It is my faith that such joy is our destiny.