

Thelma Shobe Lecture
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Spirituality, Ethics, Medicine: Uneasy Partners
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Mrs. Cook, Professor Benner, colleagues: It is a distinct honor for me to be here as the inaugural Thelma Shobe Lecturer. That this Lectureship in this subject area exists is wonderful testimony both to the enduring commitments of Thelma Shobe and to her family's fidelity to those commitments. And it is important, here at the beginning—not only of my talk, but of all the lectures to come in this series—to be quite clear about the significance of this Endowment and Lectureship.

The amorphous field of thought and teaching and practice most often labeled “spirituality and medicine” has long been in need of a serious, lasting, and nontendentious platform, a forum in which the real issues—for healthcare, for bioethics, for all of us, practitioners and patients alike—the real issues at stake in that ill-defined field can be displayed fully and explored thoroughly in an on-going and public conversation. Thank you, Mrs. Cook, for providing precisely that forum, this platform.

As the inaugural Lecturer, I am keenly aware of both the opportunity and the challenge to start things off well—with a bang, if you will, at least the sort of small and sedate bang one wants of a lecturer—in order to set the stage, to frame the topic in ways that future lecturers may build on, if they so choose. Thus my title, which indicates that I am presenting the three elements brought together in this forum—spirituality, ethics, clinical medicine—as “uneasy partners.” The partnership of these three needs explanation

and justification, and their manifest and persistent uneasiness with each other needs unpacking—tasks that I can only initiate, gesture towards today.

It is usually a good idea, for credibility if nothing else, that one presume to lecture only about what one knows. So, I shall assert, here at the beginning, that as someone who is, at the same time, a physician and an ethicist and a scholar of religion, I know something about uneasy partnerships. Working at the intersection of these three disciplines, I have been necessarily interested in their relationship, and perhaps especially, as you will hear, interested in the effort to find a common language, a mode of discourse through which each voice in the triad can be heard and understood, without being distorted or muted.

So, I am taking this most welcome opportunity to think again about what I have learned over my years at the intersection, in order both to describe the terrain and to speculate about what kind of shelter might be constructed there in order to house all the inhabitants of that place where medicine and ethics and spirituality meet. Part of my underlying claim and assumption is that this is a place we all, as workers or as patients, occupy at some point, whether as temporary visitors or as more permanent residents.

I shall start where I intend to finish, by stating my firm conviction that the partnership of these three is vital to—in fact, it may well define—good nursing and medical practice and, beyond that, the well being of us all as persons of integrity, whether we are providers or recipients of medical care. But between this start and the finish, here is a brief guide to the route we shall take over the next 35-40 minutes, so that you'll be able to see the overall trajectory despite all the detours along the way. After defining my terms—always, for this subject, an essential preface—I'm first going to consider that idea

of integrity in order to create an analogical way of thinking about the partnership of spirituality, ethics, and medicine; and I shall then delve into their uneasiness with each other. That exploration will lead us to focus on the problem of uncertainty, that continuing plague of clinical practice, which will then take us, via a critique of clinical studies of prayer, to the search for that common language I mentioned, a language that will, in the end, bring us back to a reconsideration of integrity and its descriptors.

First, let me clarify the core words for this lecture—medicine, ethics, and spirituality—and the meanings I intend for them to convey.

I have chosen to use the word “medicine” instead of “healthcare” because it seems to me that what we do in hospitals and clinics is mostly not healthcare; it is care for persons—with illnesses, injuries, dysfunctions, disorders. Healthcare is undeniably important and it is the main focus for some clinicians—but, for most of us most of the time, even if health is what we’re trying to help our patients regain, it is not primarily what we’re caring for, what we’re attending to. Now, it is surely also the case that my use of the word “medicine” reflects the fact that I am a doctor, that I work in a medical school, teaching medical students; this is what I know and the way I talk. Nevertheless, I do intend that the word “medicine” in this lecture be understood as something like “clinical medical practice,” a term deliberately inclusive of nursing as well as doctoring, and of other professional activities, like physical therapy, that are also directly related to patient care, part of clinical encounters.

So, then what about the word “ethics”: as you may expect, I am referring primarily to clinical bioethics, and also to professional ethics in some ways, but I do want to make explicit one particularly enduring conception of the ethical enterprise, more

broadly understood, a conception that underlies almost everything else we may think or say about ethics. In ancient thought, philosophy was commonly depicted as having three main branches: One was metaphysics, contemplation about how and why things are as they are, about the nature of the universe and of human beings and of any gods there might be. Another was logic, the study of human reason, how we think; and the third was ethics. Ethics' task in this triad was to answer one question: Given our metaphysics—what we believe to be true about the cosmos and about life—and given the requirements of human reason, how then shall we live? It was sometimes put in other words: What is the good life? How is it attained? What kind of person should we be? How are we to flourish humanly? When you hear me use the word “ethics” today, let that basic question echo in your mind: How then shall we live?

And now I must turn to the word “spirituality,” having saved the hardest for last. This is a term notoriously resistant to fixed definition and, therefore, notoriously open to misuse and misunderstanding. So, transparency is necessary. “Spirituality” includes but is in no way synonymous with religion, at least as we generally use that term to stand for organized religious traditions. One can say that religious traditions form a subset, even a rather large subset, within spirituality, and that they may serve as the source or the expression of the spiritual beliefs and practices of some people. But, it is a mistake, sometimes a very bad one, simply to equate spirituality with organized religious tradition.

Spirituality then, broadly conceived, encompasses at least two major and related human activities: First, our spirituality holds our theories about the way things are—our metaphysics, if you will—our beliefs about how the world works, where human beings fit into it, whether there's anything else out there, and the practices we engage in to

acknowledge and honor those beliefs. Second, spirituality is the locus and expression of our valuing, what Augustine called our *ordo amoris*, the ordering of our loves. Now, Augustine, of course, had very particular ideas about what the order of our loves should be but, even without bringing those along, his concept of an *ordo amoris* is useful because, regardless of whether we accept any notion of God, whether we're the least bit Augustinian, we human beings do order, we do rank our loves, the things that matter to us—which is to say, we value things and we value them differently. That act of valuing, of setting priorities, is a spiritual activity; it directly reflects our basic spiritual beliefs about how things are and should be with the world and with us—whether we are deciding how to distribute our time and energy and money, or deciding how to vote, or—more directly relevant to this discussion—deciding how to manage risk, how to attend to our health, or how to choose between more chemotherapy or one more month to live. These examples do point out how difficult it is to separate spirituality from ethics and its defining question, how then shall we live—an observation that leads us to the subject of integrity.

Over the past few years, I have done a fairly thorough examination of the roots of the word “integrity” to clarify the definition and draw out some implications for ethics and for medicine. One of the interesting findings from that study is how fundamental the concept of wholeness, of oneness is to the meaning of integrity. The notion of consistent goodness also tracks prominently through the evolution of the word, but this idea of an intact oneness persists.

So, part of a basic definition of the integrity of a human being is that persons have integrity in the sense that they comprise one being, a single unity. The Latin root word for

integrity, after all, is *integer*, a word we now use in English to denote a single whole number, not multiple and not fractionated, a single unity. For rhetorical convenience, for ease of discussion, we talk about persons as though we are divisible into “parts”—into body, mind, spirit, and perhaps soul. There can be very good reasons for doing that; the convention is often quite useful for thinking and talking about human beings, but we are not really a conglomerate of parts. It’s much like our division of time into hours and minutes and seconds: a very useful convention, hard to imagine living without it, but time is not literally segmented—and neither are persons. We are not body and mind and spirit, somehow cobbled together to form something that only looks like one thing. We are essentially one thing, single unities, *integer*.

There is a lot more that could be said about this point—about, for example, the risks incurred when we believe our rhetoric, believe that we are composed of separable components—but I suspect that clinical experience helps keep many healthcare professionals away from that particular peril. Even the most inattentive practitioner can scarcely avoid learning that there is no patient whose disease process involves only the body, or only the mind, or only the spirit; one always entails the others because they are not separable. Body, mind, and spirit are not three parts of something; they are three ways of talking and thinking about something, and that something is a whole person.

I am belaboring this understanding of human integrity, because I want to draw an analogy between the three inseparable parts of a person and these three elements we’re talking about today. My claim is that spirituality, ethics, and medicine are not three parts of something, but are three ways of talking and thinking about something. Depending on the situation or on the inclination of the speaker, that something can be called healing, or

illness, or caring; it can be called nursing or doctoring. By this analogy then, the integrity of the clinical encounter depends upon a unity, an unfractionated association of medicine and ethics and spirituality. That most inattentive practitioner can also scarcely avoid noticing that there is no clinical encounter that does not engage, even if to varying degrees, medical knowledge, spiritual understandings and valuing, and ethical deliberation; one always entails the others because they are not separable. Thus, the partnership—essential, permanent, indissoluble.

None of which, whether you accept my analogy or not, dispels or, for that matter, explains the uneasiness that persists in the necessary and inevitable relation of these three to each other. Of course, that is also true of the body/mind/spirit formulation of individual human beings. I don't know about you, but my mind and body and spirit can be quite uneasy with each other, rather more often than I'd like. They tend to have somewhat different interests and goals and methods—and it is often the case that one of the three has to correct or restrain or submit to or encourage the others. And so it is with spirituality, ethics, and medicine in clinical practice. They can and probably should be uneasy with each other with some frequency. They, too, have rather different interests and goals and methods, and the perspectives of one may at times be required to teach or constrain or support the others. As is the case for personal integrity, if our professional work is to have integrity, if this clinical partnership is to be a good one, then we have to pay attention to these points of discomfort so that the potentially creative tension among them can in fact generate effective and integrated acts of care and healing.

As we turn now to pay more attention to this uneasiness, it would perhaps be good to note at least two of the, shall we say, elephants that seem often to be in the room when

the topic of spirituality and medicine is on the table. One of them—arguably the more obvious one, although it is rarely brought into formal discussions—is what we might summarize as assertively evangelical forms of religion. Some nurses and doctors—regardless of their own faith commitments and often with good reason, based on direct experience—fear that burgeoning interest in the spiritual aspects of medicine and the spirituality of patients and practitioners may be little more than a thin disguise for a mission that seeks the conversion of souls and identifies illness encounters as fertile ground for that work. While this is an important issue, one that needs to be talked about openly and wrestled with seriously by both professional ethics and theological ethics, nevertheless it is, as I have said, a mistake for medicine or ethics simply to equate spirituality with religion, much less with one aspect of particular traditions, and then, because of that erroneous equation, to reject any attention to spirituality in clinical practice and education as only and inevitably tendentious and intrusive.

The other unspoken issue—somewhat less obvious, but present even so and contributing to the discomfort—is the equation of spirituality with goodness and healing. It is not easy to find literature on the subject of spirituality and medicine that discusses spirituality in any but positive terms. I have colleagues seriously engaged in this work who vehemently resist the notion that the word “spirituality” can apply to anything negative or destructive. But clinical experience, not to mention the daily news, teaches us otherwise. Spirituality determines the work of the Dalai Lama and the work of Osama bin Laden; spirituality determined the actions of Martin Luther King, Jr., and his followers and those of Jim Jones and his followers. Spirituality is still spirituality, even when the

understanding of the world or the order of values being expressed is violent and destructive or suicidal.

Many of us have known patients whose spiritual beliefs and priorities have led them into practices and decisions that were severely damaging to their lives and to others around them, from those who refuse treatments likely to be successful in the belief that their disease is a justified punishment that must not be avoided, to those who directly injure themselves or their children in order to realign with the structure of the universe as they believe it to be. Medicine and ethics are right to be skeptical about and troubled by any blanket endorsement of spirituality as an unequivocal agent of healing. For those of us who are interested in exploring and promoting attention to spiritual matters in clinical encounters, it is a serious error to deny or ignore that spirituality, like every other dimension of our humanness, can at times be very bad for us and may require determined, compassionate resistance.

There are any number of other factors contributing to the uneasiness within this partnership. I am, as may be clear, focusing primarily on medicine's discomfort with spirituality and with ethics. There is plenty to be said about the reciprocal apprehension that ethics and spirituality experience when either confronts certain teachings and practices of contemporary medicine, but an investigation from that angle will have to be another talk for another day. Given what I take to be our mutual interest in clinical practice and education—here in this School of Nursing within this medical center—we have to acknowledge that for us and our concerns, medicine is the gatekeeper, deciding whether to take either of these interlopers seriously. It is mostly medicine's discomfort that complicates the path to a truly integrated relationship.

So, let's start with medicine's uneasiness with spirituality, other than the two usually implicit issues I've just discussed. Why else the persistent queasiness and even outright resistance? At perhaps the most basic level, we could speculate that it is because medicine, as a self-consciously scientific endeavor, is concerned that spirituality is not only not scientific but may even be, in some views at least, anti-scientific. Medicine understands itself, correctly or not, to be an objective pursuit; spirituality is incorrigibly subjective. Medicine wants to operate on information and methods that are capable of being proved or disproved. As we hear over and over in this era of evidence-based medicine, "the plural of anecdote is not data"—and it is data that medicine wants and values. In contrast, spirituality is intrinsically anecdotal; it is experiential, nonquantifiable, untestable, capable neither of proof nor of disproof. It is not something we can touch or image or biopsy; it is, to paraphrase Wittgenstein, simply what we do, who we are, how we get on and get by. It will never be data. Spirituality, from the perspective of medicine, is just too uncertain, too ambiguous and vague, too multifarious ever to be assessed or taught in a manner appropriate for good, scientific clinical education and practice.

But then what about ethics? Why discomfort there? After all these years in which bioethics has formed itself into a recognized and generally respected discipline, why still so much disquiet on the part of medicine—whether manifested as simple disinterest or overt disdain and refusal? Again, there are surely any number of reasons; I'll suggest just a couple. One is that for anyone—nurse, doctor, therapist—for that matter, banker, teacher, lawyer—for anyone to acknowledge a need for or the usefulness of a person or group whose special area of expertise is ethics may be tantamount to admitting a

character deficiency, an inadequate moral sense. We generally believe ourselves to be fundamentally moral people—we're not always as sure about each other, but we tend to be satisfied about ourselves, that we do our best to operate at a fairly high level of moral awareness and action. And we who are in the health professions have, after all, chosen to devote our working lives to an intensely moral task, the care of the sick, which surely identifies us as morally sensitive people. What then can it mean that we need an ethicist in the house? Plus, it is hard to set aside the conviction, unfounded though it may be, that only someone at the bedside, only someone clinically educated and experienced can understand a clinical situation adequately for good moral judgment.

Moreover, ethics, like spirituality, is neither provable nor disprovable by the methods of science. There is no certainty in ethics; it is a discipline that makes its living pointing out and enhancing ambiguity. In fact, some say that the job of a good ethicist is to make things less certain, to trouble our most basic assumptions, our discourses of power, our tendency to rely on rules and moral codes that don't really fit the situation before us.

I find the common thread in all this discomfort to be uncertainty. My hypothesis about the manifest uneasiness medicine experiences in regard to spirituality and to ethics is that it has to do chiefly with two enduring characteristics of medicine: One is medicine's chronic uncertainty, its irreducible ambiguity about what is going on in any individual clinical encounter and what should be done about it; the other is medicine's chronic denial of that uncertainty. It has often been said, sometimes seriously, that medical education is training in dealing with uncertainty. We could spend a lot of time discussing all the counter-evidence to that claim, but at the least I expect we can agree

that, like it or not, uncertainty is a persistent hallmark of clinical medicine. No matter how much we learn, how deeply we can track the origins and expressions of generic human biology and its disorders, we are still left at the end of the day with the non-generic patient in front of us, with his or her very own disorder and its more or less individualized, more or less predictable manifestations and responses.

The person of the patient always intrudes into our dream that diseases are what we're dealing with, diseases as independent entities with codifiable symptom lists and etiologies, pathophysiologies and natural histories and standard treatments. The stubborn presence of that person, the patient, brings with it the equally stubborn specter of uncertainty, the very thing about spirituality and about ethics that make them so unappealing to scientific medicine.

Evidence-based medicine can be seen as one attempt to get some control over the difficulty inherent in moving from generic population information to that individual application, as a well-meaning attempt to reduce uncertainty, if not escape it altogether. A more reliable population statistic is surely a good thing to have, an important guide for practice. But it remains the case that knowing for sure the statistical chance of an outcome still tells us nothing for sure about what the outcome is going to be for this particular patient. This is not an indictment of evidence-based medicine, just a reminder that it, too, is trapped within the limits of what can be known. Rachel Remen—from whose work I have learned a great deal—makes the point that science works at the border between the known and the unknown, but that in our clinical encounters we are often at the border between the unknown and the unknowable, that which cannot be known, no

matter the evidence amassed and assimilated. Hence, chronic, inescapable ambiguity, irreducible uncertainty. Not an easy place to live and work.

We try to make our home more comfortable, a bit easier to inhabit. We try to eliminate as much uncertainty as we can, and to rein in what's left. How frustrating, then, in the midst of that effort, to hear the voices of ethics telling us that ambiguity is the human condition and we can only do the best we can, avoiding the obviously wrong and making forced choices among the possibly right, if we're lucky, among the lesser evils if we're not. And how irritating to hear the voices of spirituality, some of which revel in ambiguity, finding in it the richest meaning of existence, deploring science's attempts to banish it; others of which, in contrast, declare an overarching, transcendent certainty, all the while knowing that such a claim can only be grounded in faith, which is itself defined by doubt, unresolvable uncertainty.

One provocative example of the intersection, not to say collision, of interest in things spiritual with medicine's need to manage uncertainty is the growing collection of clinical studies of the relationship of prayer to healing. On the face of it, doing such a study seems an excellent way to reduce the uneasiness and enhance the partnership of spirituality, ethics, and medicine—which all have to work together in some fashion for the study to happen—and with the added benefit of possibly settling some nagging questions. What a good idea. Except that, well meant or not, these studies necessarily fail, not least because they cannot control for the very uncertainty they hope to dispel.

Clinical trials of prayer are bad science, deeply flawed, invalid research. Forgive me for stating the obvious, but it has to be said: There is no way to assure that the persons in these studies who are not being prayed for are, in fact, not being prayed for. And, as

for those who are being prayed for, what possible metric can be applied to the “dose,” the strength of the treatment? This is not just the problem of standardizing how much prayer is to be offered—whether three times a day for one minute; once a day for half an hour; once a week within a worship service. It is also the problem of practitioner skill. What if one patient is being prayed for by the champion prayer warrior of California, and another by someone who has barely learned to say a word of thanks? Which begs the question, as these studies do, of the kind of prayer to be involved, from what tradition? Christian intercessory petitions, Sufi mystical dance, Buddhist meditative chant?

Clinical trials of prayer are also bad ethics. Consider the complexities of informed consent or of truth-telling, given the questions I’ve just raised. Or we could focus simply on the basic moral requirement of respect for persons. To what depth must the investigators analyze the beliefs of the patients being enrolled in the study? Must they control for a level of receptivity to the possibility that prayer could have an effect? Can it be a moral act to ask a patient who already believes in the healing power of prayer to act against her own best interests, as she understands them, by agreeing to risk not being prayed for? Must the study participants refrain from praying for themselves?

Obviously, then, clinical studies of prayer are also bad theology, significantly distorted spirituality. The basic problem is that apples/oranges one: Why would any spiritual or religious tradition think it a good and useful thing to have its beliefs tested by the methods of science? The absurdity may be clearer taken the other way round: Would science submit the germ theory of disease to the methods of spiritual discernment for proof? On top of that, spiritual traditions and people who consider themselves to be spiritual should be troubled by having prayer—which, in all its many forms, is a central

motif of most spiritual paths—reduced to the equivalent of another instrument in the doctor’s black bag, another infusion on the med cart.

There are many more questions to be asked, but a concise summary, not to put too fine a point on it, is that clinical studies of prayer are nonsense. But one of the things one learns at the bedside is that when we hear nonsense, it is time to pay closer attention. Suffering, for example, is fundamentally nonsense: a significant part of its power lies in its ability to disrupt our fixed ideas about the way things are, to change the sense of the world and ourselves in it into no sense at all. In order to attend well to suffering, we pay attention to nonsense when we hear it—when we hear statements like “I have lung cancer because I fell off that ladder last year and bruised my ribs.” Nonsense tends to be a sign that the situation has moved beyond our ability to express it in ordinarily comprehensible ways. The patient with lung cancer may be trying to say something, perhaps about taking responsibility for what has happened, but has only the language of cause and effect to do it with, and the result doesn’t make much sense. Just so, these nonsense studies of prayer may be trying to express something important, but the language is inadequate to what needs saying, so it comes out as something close to gibberish.

Nonsense is a sign to delve more deeply. What is going on in these studies? Why are they being done and apparently even being supported, in some cases, by reputable funding agencies? It would be easy to claim, in some cases at least, that there may be other than scientific motives driving the studies and the funding, that there may be either a debunking mission or an evangelical mission being played out. But, let’s set that oversimplification aside, and instead take the motivations seriously. What is going on here?

I believe that these studies are part of a old and continuing effort—one that long pre-dates this most recent infusion of energy—the effort to find or craft a language for clinical practice, for the work of healing, within which all three voices—of spirituality and of ethics and of medicine—may be heard and mutually comprehended on the spot. In the case of prayer studies the attempt seems directed toward creating an idiom that can handle both science and spirituality, both observable, testable biology and subjective experiences of transcendence. They are but an example of the broader quest for a clinical language that can express, without the need for translation, apparently incommensurable ideas, that can handle talk of pathophysiology, moral obligations, and spiritual beliefs equally well and at the same time—in the same breath.

Unfortunately, the methods often used to solve the translation issue are themselves problematic and likely to fail. The common technique is to impose the language of scientific medicine on the other dimensions, a Procrustean, even imperialistic move and one that effectively garbles or mutes the others. That method seems to be at work in many studies of prayer, but think also, as another example, of the distortion of the voice of ethics caused by using the medical language of consultation to define the role of ethics in a medical center. It is an imposition that effectively sequesters the ethics presence within the domain of physicians—consultation is traditionally an activity of doctors—and that brings with it expectations of decisiveness and expertise that do not map at all well onto the work of ethics.

Another approach to solving the language problem is the attempt to create an esperanto. You may recall the checkered history of that invented language, Esperanto—an artificial construct that used components from a number of European tongues to create

a new, synthetic hybrid. The hope was for a universal language that could become the common speech of international conversation, to be for the world what Latin had been for the medieval West, without granting any already existing language that dominant position. But, as the philosopher Mary Midgeley rightly said, the sad little joke about fabricated universal languages is that no one ever speaks them. They are not live languages.

I am allowed one hour each year to speak about spirituality and medicine with our first-year medical students. For years I lectured to them in a kind of esperanto, grasping for a general, universal vocabulary and grammar that could show them, regardless of their individual spiritual inclinations, the importance of being open to hearing and talking about such matters with their patients. I used the esperantos that are out there in the field—for example, the various mnemonic triggers for taking a “spiritual history.” It was deadly. No one speaks that language. I finally gave up and started instead using most of my allotted time to respond to their questions and concerns about the relationship of spirituality and medicine—and, not incidentally, ethics—and in doing so, I found that I got across all the points I wanted to make, but in a language we could all understand because it arose from our mutual needs and interests.

So, if it is clearly not a good thing to transmute other human languages, other modes of knowing and expressing the truths of our lives, into the syntax of medical science, and if esperantos inevitably fail, where are we to find a language that can express the integrity of clinical practice, a language that can speak of medicine and spirituality and ethics without distorting, or muting, or overriding any one of them. I suggest that what we are looking for, what we need is a creole language.

Creoles, in contrast to esperantos, are living languages that evolve over time, naturally, spontaneously, at the intersection, the point of contact of two or more linguistic communities. They spring from the immediate need for communication, and initially may be a sort of pidgin—pidgin being the really simplified speech used between native speakers of two different languages, historically between colonist and colonized; in a sense, pidgin is what we sometimes use when we try to explain clinical matters in lay terms. Creoles may start out as pidgins, but they grow into true languages of their own; they become the native language of the space where the originating languages first met. English is probably our best model of a mature creole—having developed from the interface of Brittanic tribal tongues with Anglo-Saxon and Scandinavian dialects, and later with Norman French and Latin influences, maturing over centuries into a rich and distinct language with some really complex etymologies.

A creole is what we need, and there is already such a creole within clinical medicine. It has arisen at the place where the distinct languages of medical science and ethics and spirituality meet, at the bedside. The native speakers of this creole are mostly nurses, the consistent figures in the landscape of clinical medicine, the ones most often there at the bedside. Nurses are by necessity the expert linguists of clinical medicine, the ones who in virtually every professional activity translate seamlessly, even unconsciously, among these three dialects—and perhaps more than these—and in doing so, generate this true creole, this language of clinical encounter.

Now, of course, not all nurses do this, or do it well, and not only nurses do it. Doctors who pay attention, who carry on real conversations with their patients also become adept at creole. Although I am today focusing specifically on medical

professionals, it is worth noting that this creole may also be spoken fluently by good chaplains as well as by a few exceptional ethicists. You cannot be fully present with patients and not adopt this blended way of speaking that moves smoothly, intelligibly, simultaneously among EKGs, the significance of a longer life, the meaning of suffering and loss, cholesterol levels, moral obligations to self and family—words of science, of spiritual valuing, of ethical deliberation meeting and converging in the place of the healing encounter.

This creole that already exists at many hospitalized patients' bedsides and in some clinicians' offices should be heard and valued for what it is—neither a pidgin, just simplifying our knowledge for the ignorant patient, nor an esperanto, inventing new words to convey the same old incommensurable ideas—but a pragmatic vernacular of exchange and reciprocity and understanding that has become a robust language in its own right. This is one of many strong arguments for truly attending to the voices of nurses, the ones most likely to be speaking this essential tongue, and it is also an argument for taking this language seriously, because we must determine how best to teach it to our students, how to pass on the creole that all clinicians need to be fluent in for the sake of our patients and the future of our vocations, for the sake of our personal and professional integrity.

Which, as promised, brings us back around to the idea of integrity with which I started, and invites us to think again about medicine's problem with uncertainty, its difficulty talking about the various unscientific concerns that emerge and converge in the clinical encounter, its impulse to control or deny the ambiguity. You recall the analogy between individual integrity as a oneness of body, mind, and spirit and a description of

professional clinical integrity as this partnership of spirituality, ethics, and medicine at the bedside. Well, as we know, most of Western thought, from Plato's cave to Descartes' *cogito* and beyond, can be read as an effort of the mind to escape its queasy partnership with body and spirit—the ancient conviction being that, if the body's demands can be suppressed and the spirit's irrationalities ignored, then the mind and therefore the person can be more nearly pure, more nearly perfect. The Platonic philosopher-king, the Stoic sage, the rational man of the Enlightenment are all ideals based on this conviction. It is a long, rather poignant human dream—feminists would say it's a male dream, but that too is another talk for another day—a dream of utterly self-sufficient rationality, of being able to think, act, live free of physical, emotional, spiritual distractions. Descartes' wistful claim, I think therefore I am, succinctly articulates this dream and its neat evasion of the obvious, that he existed also and necessarily because someone prepared his meals for him and did his laundry, someone listened to his yearnings and read his books.

Medicine's persistent uneasiness with spirituality and with ethics may be, in some ways, analogous to this long intellectual history of the mind's discomfort with the confused, unreasonable demands and distractions of body and spirit. But just as there is no escape for the mind, nowhere but in a body to live, nowhere that spirit does not also inhabit, just so there is no escape for medicine from this partnership, nor should there be. Medicine exists only in the clinical encounter: Medical science may have work to do in the lab but clinical medicine, nursing and doctoring are engaged with persons, with patients, so there is no place for medicine to dwell where ethics and spirituality are not also at play.

This intersection can get quite muddy; it is not always an easy location, not always the nicest place to work. But, the enduring fantasy that perfection can be achieved by separation, by extricating ourselves from the swamp of embodied and embedded human life, by finding some airy pinnacle from which to comprehend and control the activity in the swamp, is a fantasy. There is no place to be, and no place to practice nursing or doctoring, other than on that muddy corner—in the swamp where science and spirit and morality are matted together and cannot be disentangled—and it is there that our various clinical professions must display their integrity.

We need ethics not just to get us out of our moral dilemmas, but to guide and support us within them, within this nexus of human frailty and need and scarce resources, within the ineluctable ambiguity of trying to live out a moral life and practice moral medicine in the midst of this world, not some ideal world, some ideal hospital, some ideal population of healthy and predictable citizens. The same is true of spirituality: It is not just about transcending the morass, dissociating from suffering by losing ourselves in meditation or prayer or certainties about salvation, but it can also be a centering sustenance, a core of value and of hope for life lived among and within the fragmented and unreliable realities of the human condition.

The tension of living and working always in the swamp, in the midst of the inescapable confusions of the known, the unknown and the unknowable—that tension remains the essential source of our compassionate creativity. It is within the tension, within the very uneasiness that will persist in this partnership, that clinicians learn what is most needed if we are to be agents of healing: a finer awareness, a refreshing humility, a compassionate curiosity, an expansive morality, and an articulation of this crucial

partnership in the living language—the creole—by which medicine and ethics and spirituality together can hear and comprehend what is happening in the clinical encounter, and by which they can, in unison, speak words of healing.