Zen, Pain, Suffering and Death

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That's a stark chapter title. Pain, suffering and death evoke some of our deepest sorrows, our deepest fears. But let's start this chapter with some other emotions. I'm at my mother's bedside shortly after she had died from the progressing problems caused by chronic obstructive pulmonary disease. It was evening, just one table lamp turned on, and I was the only person with her. The moment came when she took her last breath and then as the minutes passed came the common progression of changes when someone dies: her skin began looking waxy, a bit yellow, and her mouth was wide open, impossible to close, try as I might before my sister arrived.

Maybe an hour passed before she came into the room, but I wasn't feeling time. I had been sitting there beside my mother, empty of thoughts for the most part, just full of the muscle-dragging sadness that comes with loss. My sister and I are close, and she was certainly close to my mother. A hug when she came but no real need for talking as we sat there, not really convinced that all the worries of my mother's care over the past year were over. It had been a slow progression as her lungs slowly failed and as her dementia made it harder and harder to reach her. But one highlight to her week was the visit to the hair parlor in the nursing home where she would have her hair "done." It reflected her lifelong discipline of dressing well and looking her best without making a fuss about it.

My sister and I sat, quietly, slowly staring through the door that death presents us and looking out into a different world, one without our mother in it. And then she breaks the silence. "You know, that is not a good look for her," meaning the wide-open mouth among other things. And I laugh in the way that only someone who has sat beside a deathbed can laugh. How perfect! How true! How easily my mother would have said the same thing if she had been sitting in my sister's chair. How loving…

I tell this story because once we step inside the world of pain, suffering and death, there are no real rules. All feelings, all emotions can be appropriate – not just the

dark ones - and they wash through that world in mysterious ways. And sometimes in wonderfully healing ways.

Another story, this one in a hospital room just after an elderly man died. I had been with this man, serving as the hospital chaplain on duty that night, sitting there with his wife, his sister and one of his granddaughters. This granddaughter was a vibrant young woman, maybe in her early 20s, and she was the person most attentive to her grandfather as he was dying. She spoke to him without obvious sorrow, using a tone of voice perhaps no different from what she would have used telling him of her eager plans after graduation. During this last hour of his life, she talked about her friends; she talked about the way he would hold her hand when walking as a young girl visiting him. She spoke about the things that she saw happening to his body as his heart continued to fail. And then he died.

She kissed him. She hugged her grandmother and her aunt. And then she said, "You know, I need to eat the biggest cheeseburger I can find." Like my own sister, she spoke seemingly without thought, addressing the kind of hunger that can follow the difficult physical work she had been doing with her grandfather. As we all laughed, the faces of the patient's wife and sister shifted, coming out of the initial numbness into the life still present in the room.

As I said, there are no real rules. Though maybe there is one: don't stand outside the experience of pain, suffering and death, your own or others. Go inside. This "going inside" has a particular meaning in Zen training and that is the theme that connects the many parts of this chapter. But let me say up front – "going inside" is not a mental exercise. It is physical work. It is manual labor. It is only through this whole-body perspective that I can effectively talk about pain, suffering and death. And I'll also say up front – this "going inside" doesn't always distinguish between going inside yourself or going inside another. That's one of the dualities that Zen training is meant to resolve. And that resolution is then meant to be put to service.

Despite the broad nature of the word "Zen" in the chapter title, this chapter presents a very narrow Zen perspective on that world of pain, suffering, and death. But

it is a fairly detailed perspective so I want to show the specific ground I stand on. I speak as someone training in the Chozen-ji line of Rinzai Zen for more than thirty-five years. Ordained in 1988 and receiving *inka* from Tenshin Tanouye Roshi in 1996, I currently serve as the founder and head priest at Spring Green Dojo, a Chozen-ji *betsuin*, in rural Wisconsin.

There are a number of other chapter authors in this book who have been colleagues during those decades of training and they have written about the ways in which Chozen-ji training is highly physical – developing breath, posture and samadhi – under the myriad conditions that training in the formal elements of Zen present. As well as in the martial arts and the fine arts. This is the three-part *Zen – Ken – Sho* curriculum (training in Zen, martial arts, and fine arts) established by the late Omori Sogen Roshi of Koho-in in Tokyo and the founder of Chozen-ji. In my case the martial arts are Yoshinkai Aikido, Kendo, and the Hojo sword form that comes out of the school of Kashima Shinden Jikishinkage swordsmanship. The fine arts practiced are non-fiction writing and calligraphy in the Jubokudo School that came through Tesshu Yamaoka and Omori Roshi.

As you will read, this three-part training provides the foundation for the ways in which I approach all pain, suffering and death – that of others as well as my own. But the broadest application of this training has come through work as a hospital chaplain in two community hospitals. The work began in 2008 in the role of a night chaplain, responding to the full spectrum of needs ranging from tragedies in the emergency room to comforting elderly patients unable to sleep. The principles of this chaplain work were easily understood when I began but there were also techniques for which I sought more formal training through Clinical Pastoral Education (CPE), the training system through which a chaplain ultimately becomes board-certified in the United States. My current knowledge of this training system is limited, however, since I was only able to take enough time away from other responsibilities to undergo the first three months of the year-long training that are required before applying for board certification.

During the short time spent in formal training as a chaplain, I worked to articulate a muscular form of chaplaincy, describing the ways in which chaplaincy is manual labor, labor based on the strength that comes through breath and posture and the sensitivity that comes from use of the senses. Following that first unit of training, I became a part-time chaplain in a Catholic hospital as well as an outpatient chaplain in a rural medical clinic that serves people without health insurance. The work became embodying this new form of chaplaincy.

That is the particular flavor of Zen Buddhism that I know, and the particular application through training and serving others in chaplaincy. Out of all these experiences, a number of principles and tools emerge that anchor this particular approach to pain, suffering and death.

Before addressing these, however, I should also mention one other professional experience that has influenced my work as a chaplain, namely the fifteen years spent as a faculty member of the medical school at the University of Hawaii. I was hired as both a medical educator and as a Zen priest in order to find ways to improve teaching about the ways in which the relationship itself between a patient and a physician can be therapeutic.

The work was both satisfying and frustrating. The satisfying aspect was finding an affinity with a number of physicians and medical educators – people like Jodi Halpern (2001), Eric Cassell (1991) Howard Brody (1992) and Howard Stein and Maurice Apprey (1990) – who sought to deeply understand and articulate the nature of relationships in the clinical care of patients. Rachel Naomi Remen has also worked hard to develop a widely-adopted and respected course for medical students – the Healer's Art – that explicitly works to develop the "therapeutic self" of a physician, a phrase that will be discussed later in the chapter in the context of chaplaincy.

But there was frustration to this work as well: the inability of most people to understand what it means to resolve the question of life and death, the traditional phrasing used in Zen to describe the assault on duality that a Zen student must undertake. That is, there is an unshakeable assumption within medicine that the patient

and the physician are two things. In Zen we wouldn't say they are one thing but we would say they are not two.

I'm using this background as a way to describe why in this chapter I don't draw upon the medical literature that describes research on communication between patients and physicians or the much more scant chaplaincy literature on communication and relationship between patients and chaplains. The principles and tools that I describe here don't come out of a dualistic framework; they come out of Zen training. And that is the permission I have given myself in this chapter – to describe the work of a chaplain as best I can in a non-dualistic framework. Instead of having the significant checks and balances that evidence-based medicine provides in clinical settings, all I have is my experience.

Still, in the Zen world there are indeed checks and balances of another sort – namely the ability to detect the difference between two and not-two, an ability that takes years to develop and decades to hone. The closest phrase we might have in English to describe this ability is "the ring of truth," a phrase that includes both the physicality of resonance but also a standard of certainty. How to bring this ability into the world of clinical research is a big question. For the moment at least, perhaps the closest approach might come through the studies of the neuroscientist Richard Davidson though his work is currently limited to the brain rather than a whole-body approach (see Davidson and Begley, 2012, for an overview of his work).

Principle #1: The fundamental human illness is duality – the separation of self and other, mind and body, life and death.

We could also say that duality is the principle cause of human suffering – the canyon that lies between what I have and what I want. One example of this comes from a native Hawaiian woman who met with a class of medical students just beginning their training at the John A. Burns School of Medicine at the University of Hawaii. A physician

colleague and I had arranged for this woman to describe her experience with a number of chronic medical conditions, including painful neuropathy caused by diabetes and shortness of breath because of her congestive heart failure. She spoke at length and answered questions about her many symptoms and her medical care. Clearly there seemed to be a gulf between what she had and what she must want – to be pain free, to be symptom free.

Then a young woman in the class asked her, "Out of all these difficult symptoms you have described, which is the worst one?" Long pause, and then an answer, "None of them." Another long pause. Then, "I fell in love many years ago with a man. We wanted to be together but my father disapproved of him. He forbade me to be with him. But we were young, and knew what we wanted, and so we married. From that day forward, my father has never spoken to me. Twenty years now. These other things we have been talking about, do you think those are painful? Those are nothing. Losing my father – that is the worst pain." That was not the suffering these students thought they were evaluating. The duality was not between chronic pain and no chronic pain. The duality was not wanting to lose what she lost.

Principle #2: For a priest in the Chozen-ji lineage, the traditional instruction is "Given a choice between Heaven and Hell, choose Hell."

Zen training hurts. It can feel like an assault on all that seems necessary for comfort. Physical comfort, emotional comfort, spiritual comfort. The monastic rule of setting the needs of others before your own sounds good, sounds virtuous, but only until you recognize that the unspoken part of the rule is, "all the time." The rule must be relentless because the natural human ability to seek comfort is relentless. The problem with this very human need for comfort comes when those who need comfort seek to ease the suffering of those who are suffering. The point isn't to be uncomfortable. The point is to not be stuck on whether there is comfort or discomfort at any point. We train in order to be free to work from either position without being attached to it.

One night when I was on night chaplain duty I was asked to visit with a man who had been admitted to the hospital following a suicide attempt. I introduced myself and was told, "I don't need a priest. I need to die." I didn't say anything and just stood there. Finally he said, "I'm just playing along here so that I'll be discharged. I know what they want me to say. I had the dose wrong (of the medications he had overdosed with) and I'll get it right." The answer that came without thought was, "So let's go there. Tell me about being dead." And he proceeded to tell me, talking with the certainty of someone whose decision has been clearly made.

The uncanny feeling was that of stepping into the world in which he had indeed already died. I knew this feeling from my Zen training but had never experienced it elsewhere. We sat there for an hour, talking about children, and songs, and the hellhole of depression he lived in. By many standards, including those of my colleagues also training as chaplains when they heard about this encounter, I was too passive. The situation called for doing something, encouraging him, coaching him in some fashion back toward life. But my deepest instinct was to be there dead with him. To not let there be any gap – me on the side of the river called life and him on the side called death. The patient was indeed discharged the next day and I don't know the outcome. I'm guessing, but that is all I can do, that he is still alive. For that brief hour, he had not been alone in Hell.

Principle #3: Compassion is a visceral experience, not a virtue or an act of moral behavior.

Compassion is as natural to a human being as breathing. It is not something that comes from theology or from moral training, or from a professional code of ethics. It is an expression of being alive. Still, it is all too common to be alive and to not experience compassion. When you live with the conviction that duality is the natural state of things rather than an illness, you cannot know compassion. For a Zen priest the instruction is to "to become one with," to continually resolve duality. That is not an ideal or an

abstract virtue or a metaphor. “Becoming one with” is simply the best way to describe a visceral experience.

The more common way to discuss compassion in Buddhism is to describe the Boddhisattva of Compassion, namely Avalokiteshvara in Sanskrit (Kannon in Japanese). In paintings or statues, this figure is most often viewed as a woman, with a gentle posture and a half-smile. To the degree that any of us associate compassion with our own mother – the loving embrace, the forgiving smile – this depiction brings a great deal of comfort to Buddhists and non-Buddhists alike. As you might expect, however, the Zen perspective on compassion is not so easily categorized.

The defining sutra for this bodhisattva is *The Sutra of the Lotus Flower of the Wonderful Law.* Chapter XXV is entitled “The All-Sidedness of the Bodhisattva Regarder of the Cries of the World” and it starts like this:

> At that time the Bodhisattva Infinite Thought rose up from his seat, and baring his right shoulder and folding his hands toward the Buddha, spoke thus: ‘World-honored one! For what reason is the Bodhisattva Avalokiteshvara named Regarder of the Cries of the World?’
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> The Buddha answered the Bodhisattva Infinite Thought: ‘Good son! If there be countless hundred thousand myriad kotis of living beings suffering from pain and distress who hear of this Bodhisattva Regarder of the Cries of the World, and with all their mind call upon his name, the Bodhisattva Regarder of the Cries of the World will instantly regard their cries, and all of them will be delivered. (Kato, 1975)

In a Western context, this description sounds as if there is a deity that can be called upon for delivery from suffering. And that fits with a common view of compassion: it is something that I offer to you the way I might offer a cool drink of water. The bodhisattva and the living beings are separate, you and I are separate.

Compassion is offered from one to the other. But the translation of the name Avalokiteshvara – "Regarder of the Cries of the World" – is a much more useful way to view the nature of compassion. For this kind of listening to become compassion, it is a very active form, a physical form, of listening. Not just sounds heard but sounds entered into – sounds that one has become one with.

In that becoming, duality is eased and because duality is eased, suffering is eased. In other words, compassion is a physical act – the sensory ability and physical strength to hear all the cries of the world – not something one person gives to another. In Zen training, this work of becoming one with comes out of many years of strenuous training in the use of breath and posture. As I wrote at the beginning of this chapter, alleviating suffering is manual labor.

I'm standing now in the intensive care unit with a mother, both of us at the side of her daughter, a young woman who had overdosed on heroin. This woman had been declared brain-dead shortly after arrival to the hospital, but who was being kept on "life" support so that she could be evaluated as a potential organ donor. In what way was there compassion in the room?

The honest answer is that I don't know. But I do know that something happened as we spent hours together, both talking and sitting silently. The physical work that I felt myself doing was two-fold: filling this skinny, brittle mother with my strength and entering with both feet into her sadness. I say "physical" because the work was to keep adjusting my breath and posture so that as much strength as possible was being given and to keep adjusting breath and posture so that I could feel her sadness as much as possible. That is the work of regarding her cries.

All the time that I am deepening breath and posture I am being challenged by the sadnesses she keeps expressing, some from long ago and some freshly-delivered as we sat through the day. There was the sadness that a mother should feel that her daughter's death was inevitable, given her heroin addiction; that a mother should feel that her daughter's early heroin use may have contributed to the suicide of her own father; that a mother should know that her daughter's boyfriend is being charged with

homicide because of his role in her death; that a mother should worry that her one remaining child, a son in high school, may not know how to handle the loss of his father and his sister in the same year.

One after the other, these are hard to take. Hard to take because they trigger my own experiences of sadness and loss. So I feel each of her sadnesses strike my body as I learn them. I feel each of my sadnesses in my body as they are triggered, and all the while I am supposed to be optimizing the use of my breath and posture so as to give her strength, to give her myself. This is what I call "facing suffering" – the physical act of letting someone's suffering flood through you, feeling it fully, but not letting it wash you away. Difficult work, imperfectly done.

Those have been principles that guide my work as a Zen priest and as a hospital chaplain. But it is also helpful to think of the tools that help someone act upon those principles.

Tool #1: Ignorance – the ability to not know something.

Recognition of the therapeutic power of ignorance came early during my fifteen years as a faculty member at the medical school in Hawaii. Soon after arriving I had been asked to help develop a seven-week family medicine seminar series that focused on the therapeutic aspects of the patient – physician relationship. This work was particularly meaningful to me because of the difficulties my wife and I experienced talking with physicians after our youngest son was born with a condition later diagnosed as a form of cerebral palsy. We had every reason to expect a healthy baby but that is not who arrived the day he was born.

In one of these seminars students would pair up and role-play difficult conversations, including one in which the medical student, acting as a physician, was asked to visit the parent (the other medical student) of a child just born, healthy and normal in all ways other than missing his right forearm, an unusual anomaly in the prenatal development.

During one such seminar, we had an odd number of students so I took on the role of the baby's father, sitting in a chair a few hours after delivery of my son, healthy but without a forearm, waiting for the family physician to arrive at the hospital for a visit. My "physician" made the expected knock on the imaginary door but did so with an anguished look on her face. I waited for her to speak. She was struggling until she finally burst out, "Dr. Greene. I don't know what to say."

This was a profound moment for me. Suddenly I'm crying, really crying, and she is crying, role-play forgotten. In her mind, she had failed the exercise, saying to me in my role as professor that she didn't know what to do with this scenario. For me, however, finally here was the voice of a physician I had been longing to hear ever since my son, my real son, was born. What could anyone possibly say when the baby just born looked like a blue hunk of meat? When said sincerely, as this student had just done, "I don't know what to say" can be one of the most healing things for a parent to hear – acknowledging that there really are no adequate words for what just happened.

By most measures of a medical school curriculum, this student had failed the exercise. Communication skills are highly valued and this student had just admitted that she had no idea of what to do. And yet, her admission of ignorance was healing. This was a turning point for me in my role as a medical educator. In a setting where knowledge is valued almost above all else, I cultivated the power of ignorance, of "I don't know' and this continues in my work as a chaplain.

Tool #2: the therapeutic self. Once you know that you are not limited by the boundary of your skin, you are free to create yourself as an instrument of healing, free to use all of your senses including intuition.

A chaplain or a Zen priest doesn't have much of a tool kit available when facing someone who is suffering. We don't have medications to offer or broad knowledge of community resources and the means of accessing them. We just have our self. That sounds limited but in the development of a chaplain or a Zen priest, that can be

profound. In chaplain training, the work is primarily through the emotions. In Zen training, that work is primarily through the senses. This intense work is meant to shatter one's sense of self such that something much greater and larger can emerge. This something can be called no-self but that is not the opposite of one's ordinary sense of self but something in which there is no attachment to self.

Use of my senses became a critical aspect of my work as a chaplain. I didn't really expect this to be possible until I wrote one of my first CPE assignments, an essay meant to articulate our concept of care. I wrote in the voice of a fictional chaplain, experiencing the magical realism of a new kind of hospital.

> There did come a Saturday when I was on 24-hour call at the hospital. It was a day of calm – my patients seemed to be at some level of ease and the two pages of the day had been for patients who needed help but were not in crisis. It was late afternoon when I headed for that staircase, descended, opened the gate I had thought was impassable and went down one more flight of stairs. The stairway door opened into a grove of white oaks. It looked to be a woodland pasture, with wide swaths of grasses between the trees but there were also small cabins scattered about the grove. And nurses, physicians, lab techs, walking about in their familiar garb but far from their familiar habitats.
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> A nurse recognized my gait as that of a chaplain and motioned me into a cabin with her. Here was a patient, her face showing the wrinkled strains of someone ill and freshly arrived in her search for care. She was resting in a chair as the nurse bought out sample after sample of cloth: some of silk, others of linen, some coarser, some woven. And with each one, she would invite the patient to touch it as she closed her eyes, the nurse watching what passed through this patient as she felt the cloth. And then there was a shift in the atmosphere of the room. The nurse told me, "this is how we choose the bed linens for this woman while she is with us on this unit."

I felt free to move on from this cabin, stopping at another one as I overheard a conversation about food. And not just any food. A nurse with a newly arrived patient was asking for childhood memories of favorite meals or foods. Maybe a kind of squash and sage soup that was served when the weather turned cool in the fall. Maybe a certain kind of cookie in the oven near Christmas time. Or a peach, the first mouthful on a hot July day, mid-day when the air has gone still and all there is to existence is the heat and the sweet juice coming down your chin. And this nurse told me, “this is how we know what smells should come in the window throughout the day.”

I moved on, this time to a cabin where the patient was seated in a porch swing and the nurse was slowly testing different frequencies of the swing’s movement. Watching the patient’s face intently, there came a moment when she saw a broad smile and a slight relaxing of her patient’s body. “Now we know how to move this patient’s bed at night, matching the way his mother swung him in her lap that evening in May as they watched the full moon rise, waiting for his father to come up the sidewalk.”

And I could hear music in the distance as I left this cabin, a cello playing the theme from the “Silk Road” suite by Kitaro. Oh, how that drew me to find the source, but I should have known. There was this woman with hair like spun gold, a woman who had appeared at magical moments throughout my life, now playing her old companion, a cello made long ago in a workshop near Cremona. And the sounds, the notes…as she played, it slowly brought into reality a caravan of travelers crossing the Gobi Desert. There were proud horsemen and sultry women and fat traders in the party and ragged monks toward the back who were carrying litters with people lying on them. And I realized that I was one of these monks, and that the load we bore was that of the clinic patients from the

> grove of white oaks. And all of them were being carried with the majestic rhythm of that cello – the sound of each note carrying us forward to the night's oasis, still some distance ahead.
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> For all of us, patients and travelers alike, with each step we became a little more transparent, a little more of the sandstone and the sky showing through us. With each pulse of a step, with each pulse of a note we became more transparent. And our breathing became longer and deeper, and became closer and closer to becoming the wind that had begun to stir as the first hints of dusk came on. You couldn't tell perhaps when it happened, but at a certain moment, if you had looked away and now looked back, all of us, camels, horsemen, monks, dogs, had dissolved into sandstone and sky and air. Yet still you heard the cello, and all had been healed…(Greene, 2011a)

This piece was written quickly and without much thought. What struck me as I read it later was how I had articulated a core conviction, one impossible to discuss in a medical school setting, but deeply felt out of my Zen training. The conviction? All can be healed but only when any sense of a healer has dissolved. Having lived with my Zen teacher for so many years, I could watch him heal duality all day long in all that he encountered. And somehow, with some instinct, I could always tell that he himself was not doing anything. There wasn't a healer and someone being healed. There was just healing.

In this context "dissolved" doesn't mean gone. It means still present but in a different form. Not so different from the way in which the blades of a moving electric fan are both there and not there. This is the working of that no-self.

Tool #3: the verbatim – a particular format for reporting on a patient encounter that can show these principles and tools at work.

The last tool to be described is a verbatim, a technique used frequently within the training of hospital chaplains. This form of reporting on a patient encounter is centered on a capture of dialogue with the patient (hence "verbatim") but the main feature is the degree of analysis across many dimensions that is also reported. To be effective, a chaplain needs a high degree of self-awareness during any given encounter with a patient or family member, an expectation that would also be familiar to anyone training in Zen. The format acknowledges that there cannot be an objective description of a patient without also including descriptions of everyone interacting with this patient.

I'll provide an example of such a verbatim by showing excerpts from one based on a case seen during my chaplaincy training. It is relevant to this chapter because it shows how clearly my Zen training influences my work with patients.

Date/ Time of Visitation: September __, 2011
Visit Number/ Length of Visit: 2nd visit, 60 min
Patient Age: 40 **Sex**: Male
Marital Status/ Number of Children: married for 9 years, some children but all placed for adoption several years ago
Religious Preference: none
Admitting Diagnosis: "abdominal pain"

Additional Factual Information

A chaplain resident on-call first encountered this family on the previous Saturday night when the patient's wife went to the ER to get drugs to control her anxiety. Apparently this was the second night in a row that she went to the ER for this reason. When I first saw the patient the next day during my 24-hour weekend call, the patient was awake and his wife was present. Their story of their life seemed to overwhelm the story of the patient's most immediate illness, as serious as it was. (The ER physician's preliminary diagnosis included acute renal failure, inflammation of the pancreas and

hypertension.) Both the patient and his wife had previously diagnosed psychiatric problems. No money for rent (though he works) and soon to be kicked out of their apartment. No money for heat, no friends, no insurance. The wife saw no hope for their future. The patient disagreed, "It always works out." But this triggered louder lamenting from his wife that he is a dreamer and can't see the truth.

After seeing the patient on this initial visit, I went out to talk with the patient's nurse, asking her what they do when a spouse stays with a patient, not out of concern for the patient, but because they don't have another place to go. I was worried that the wife might be interfering with the patient's care. The nurse seemed eager to vent, saying, "We are seeing more and more of this (homelessness). It wasn't like this before. It is so hard on all of us. She is way more demanding than he is and he is the one who is sick."

PLANS:

Before going in for this second visit, my plan was to give him strength for his return to his difficult life. Checking in with his nurse first, she said that they had been getting ready to discharge him today but that now his physicians were worried about some heart arrhythmia and so were going to run more tests. I asked whether his wife was still so agitated. The nurse said that she was not in the room, but most likely was down in the family lounge for a while. I thought, "Good. Finally I'll get some time just with J_____." I felt that he could not speak easily about his own fears or concerns with his wife present and I wanted to explore these with him.

OBSERVATIONS:

This was not an easy room to step in to, given my earlier encounters with the seeming helplessness of this patient's living condition. His wife was unexpectedly present, sitting on the couch amidst tangled sheets and clothes, wearing a hospital gown. The shades were drawn almost shut. The room smelled of human sweat, smelling

all the stronger as I got closer to the wife. Unlike during my previous visit, the patient himself was not as antic. His smile was less forced – still friendly but less of a mask. Still, the angry wife was the strongest source of gravity in the room.

THE VISIT:

C: Chaplain **P:** Patient **W:** Wife

C1: Hi there. It's been awhile since I stopped by. I heard you might be leaving today so I wanted to come by and see how you are doing. (I'm standing on the hall side of the patient's bed at this point)

P1: Nope. Not yet. More tests today. I passed out in the bathroom.

C2: Is that good news or bad news? (moving to the foot of the bed in order to stand closer to his wife.)

P2: Hey! (talking to his wife) Move that stuff off the chair so the chaplain can sit. (I help her bundle up some clothes, which she then moves beside her on the couch. The chair is right beside his wife, close to the corner of his bed. The movement of the clothes stirs the air and the smell of stale human sweat in the room gets much stronger. I sit down and lean back like I'm there for a relaxed conversation with friends.)

C3: So, what's happening?

W1: I'm going to kill somebody. (Said with her familiar anger. The patient grimaces as she says this.)

C4: That bad, hunh?

W2: Dude! The fucking computer doesn't work. (She must have been down in the family lounge in order to use the Internet…) And I'm still the invisible one. No one wants to see me, hear me. Nobody wants to smell me – they didn't want me to have this gown but I'm sorry, I can't keep stinking up clothes. All I've got is this sweatshirt and if I keep wearing it while I go up and down stairs (here at the hospital – but, why no elevator…?), it will stink. I've got nothing else to wear… (I'm looking at her at first, but then I glance over at J_____ to see how he is taking this all in…He looks powerless.)

C5: Well, I can see you (talking to the patient's wife). I can hear you. I had to stay over in the hospital Sunday night and I didn't take a shower before working yesterday. I didn't like smelling myself either. This place is supposed to be so clean and tidy. No stink allowed…

W3: Yeah, no poor people allowed…but that's *their* problem. We still have no place to go.

C6: I hear you…so, J_____, what happened to you last night? (He looks eager to answer now that the attention has come back to him.)

P3: Whoa! I got so dizzy (said happily, like he's glad to have a real symptom). I got up to take a piss and I was filling the whole bottle. I mean I was filling that whole thing up – it was just pouring out of me. And maybe it was just too much because I suddenly got dizzy. And I'm looking for a place to set it before I go down…

C7: And then you fainted?

P4: Yeah, straight down.

C8: Wow! I'm glad you didn't hit your head.

W4: Dude! That would have been a mess if you had dropped it. God, the smell would have killed me.

C9: And then what?

P5: Well, the doctor heard about it this morning and he's wondering about my heart now so they want to run some tests before I can go.

C10: I wasn't kidding about the good news/ bad news thing…what do you think? You've been on a roller coaster with this discharge/ no discharge thing. Are you OK being here a bit longer?

W5: Why doesn't anybody ask me that question? He's getting all the drugs. He's getting all the tests. I can't get nothing. I'm the bad guy. Always I'm the bitch. People look right through me.

C11: But you (said to the wife) understand that most people here see your husband as their patient, right? I've never seen a double bed here where they can plop you both in the same bed – you guys would need the deluxe version where each half of the bed has its own mechanics – yours can go up, but his can go down. I can't see you guys agreeing on how to arrange the pillows.

P6: (Laughs) You got that right! We can leave her right over there on the couch!

C11: Those drugs might help you, you know… (spoken to the wife, referring to the bi-polar medications she supposedly left in the place where they were staying before coming to the hospital) Can anybody give you a ride to get your meds?

W6: Dude! I already told you about that bus transfer place. You think I want more of that "Hey, Baby…How about it?" crap? And do you think we've got friends? He called his boss last night, asking about the money from that employee support fund. All that guy had to say was "When are you coming back to work?" No "How are you doing?" Nothing!

C12: (Talking to the patient) Maybe you should do some of that pissing in the bottle at work. You know, you might just get dizzy again and who knows if you could keep from dropping it on the floor a second time. Whoops – sorry.

P7: (Laughs) Yeah! That would be just about right for him (the boss).

Several more minutes of talk about their life once they get out of the hospital… Then, in closing:

C13: So, what do you think? (talking to the patient) If you could become anybody, who would you be?

W7: Cassandra! I don't have to become her – I am her. The gods cursed me to always speak the truth but have no one believe me.

P8: Yeah, and I've thought about being Alexander the Great.

C14: Yes indeed, I look at that profile and you look like you belong on a coin. (His wife does a belly laugh.) You know, Halloween is coming up and I think I can see you both

pulling this off – Cassandra and Alexander (more laughter)…I do need to get going to see more patients now, but I'm going to keep thinking of you both. You guys have got guts – don't give up!

W8: No way, Dude!

P9: I haven't seen anybody make her laugh like this. I'm going to keep thinking of you.

ANALYSIS – the Patient

Theological Concerns:

I've been asking myself how I best serve patients in my role as a chaplain. I've come through a phase of recognizing how valuable it can be for patients to feel seen, gotten, heard, accepted. From the perspective of the training of a Zen priest, that is indeed the primary work: "to become one with" is the phrase used. That is not a "become one with" in your imagination but in a deeply visceral sense. The reason we stop there in describing the work – I think – is that once there has been that joining, whatever happens next emerges from a different context than the one in which there is a concrete patient here and a concrete chaplain over there.

But over the course of the last few weeks, I haven't been satisfied that "becoming one with" and then allowing the "more" to just emerge is sufficient. The pump has to be primed in order for the "more" to flow. The challenge I feel is that it is not enough to simply see a patient through their own eyes. Instead, when I can see through those eyes, how can I (meaning we) alter the nature of the reality we are experiencing? In other words, if I perceive that a patient suffers from an inability to experience transcendence in their life, can I (we) work from within to facilitate movement towards that experience? It becomes an unconscious intention in other

words and what I now realize is that such an intention may not work intentionally unless the seed already exists in me as a chaplain.

I also realize that those things we see as diagnostic may also become therapeutic. In other words, diagnosing an inability to experience the transcendent also suggests the work to be done: namely, facilitating a patient's search for the transcendent. I say "suggests" very carefully because the facilitation I am describing can never effectively be done from outside the patient's own experience. I feel that it can only be done from within that sensation of "becoming one with."

Psychological Concerns

The psychological concern that most comes to mind for me is: why this particular dynamic between the patient and his wife? It clearly is a well-honed coping mechanism: she is the angry bitch and he is the happy-go-lucky guy, friend to all of mankind. Given his wife's very harsh and bitter persona, this is not a couple likely to have very much success in navigating life in normal society. And this is a man not likely to be able to focus attention on his own needs. She will never generate in others a desire to help her unless there is someone ready to walk into her particular version of Hell. And he will never be able to seek the kind of medical help he so obviously needs until he takes control of his needs instead of allowing her to dictate them.

Several questions come to mind. How did they hit upon this particular coping mechanism? Did they ever have a chance for another one? How well does this particular one serve them? Are they stuck with this one? At first glance, my label for this couple is "train wreck!" or "dysfunctional family." But "dysfunctional" is a tricky term. My feeling is that until one explores the way in which their roles actually serve a useful purpose, there is no way that any shift could take place.

There is just about everything to "fix" for this patient and his wife but my feeling is that this is one of those existential situations where the best approach is to

recognize that not only is there no way to "fix" things for them, but to recognize first that there is nothing that needs "fixing." That may sound bizarre but I mean that until one first finds and accepts their current, not potential, humanity, nothing more can happen.

Ethical Concerns

I don't see any real ethical concerns for this patient and his wife. I felt comfortable joining into their lives but did not feel a need for any kind of aggressive advocacy role with regards to his care. The care he was given seemed to be no different than the care that is provided to any other patient.

One issue this raises, however, is one of my attending to the patient's wife perhaps more than the patient himself. There were at least three sets of problems in their room: the problems the patient has, the problems his wife has, and the problems that exist in the two of them together. I felt that the bulk of my work focused on the last problem set, but that didn't leave much attention for the patient himself and that doesn't feel right.

ANALYSIS – the Chaplain

This is the hardest section of this verbatim to write because this patient hits close to home for me. Initially, I felt very much engaged with this patient because his life and his dilemma present such a clear cry for help. There are no easy answers to his medical problems; there are even fewer answers to his social, emotional, spiritual problems. This is a true example of a situation where the only possible approach lies in "being" and not "doing," at least from a chaplaincy perspective. And I often feel most engaged in these situations. So that was what brought me back to this patient for a second visit even though he wasn't on any of my assigned units and I had no formal responsibility for providing his spiritual care.

I have come to recognize in the course of developing this verbatim – especially as I was recreating the conversation in the room when we were together –

that I have a lot of self-identification with this patient. Just like good theatre can take human behavior and exaggerate it to a point beyond reality – but do that in a useful way – I find that the extreme coping mechanism this patient and his wife displayed points a finger straight to my own heart.

Someone close to me came through a long stretch of time in which she was often angry, with me, with others, in ways that felt out of proportion to the circumstances. In the face of this, my role was to be the peacemaker, the Zen guy above it all, the guy who could explain why she would erupt so and ask for understanding from those she hurt. This was the coping mechanism we were locked into and it took a long time for me to see how damaging it was – to her, to me, to all around us.

Part of the coping was that I so clearly thought of the anger as her problem; I was just another one of the victims but because of my Zen training, I could rise above it. This was the story. But it was only once I could feel my own anger that things could begin to shift. I had to do two things: abandon that coping mechanism and be willing to risk the chaos that ensued; and I had to recognize how intimately I was tied into her anger and bitterness. I wasn't separate from that. I was very much part of it.

What was true then is not true today. The original coping mechanism is gone. Overall, I feel embarrassed to admit such things but it illustrates one of the early stages of "becoming one with," namely, "I've had a similar experience, making it easier for me to get inside the emotions you are describing."

PASTORAL OPPORTUNITY

The opportunity is to not lie – to not pretend all is well – to say sometimes how painful this is – to not look for a new coping mechanism – to live with the rawness that I feel. I've been acknowledged for my strengths for so many years that I have swept far under the rug the many years of helplessness I experienced during my life. I thought I had earned the right to say that I have succeeded, that I have overcome so many

emotional barriers, that I don't have to look back. But when I do look back, I see myself looking at myself today. There are indeed many strengths in my life now but there are also times of fresh helplessness. I need to know those for the sake of all my patients. (Greene, 2011b)

End of Verbatim

I'll close with one more story and one more principle. The story is about an encounter with an elderly woman one evening when I was again on duty as a chaplain. I stepped into her darkened room without any particular goal other than to make a visit with a patient who had not been seen by a chaplain since her admission. She was lying in bed, wide awake, as I came to the side of her bed. I asked how she was doing. She said, "I have lost so much in my life." There were no pleasantries, no warm-up, just straight to the core of her suffering. This kind of immediate self-revelation from a patient had never happened to me before but in the context of my day, it was not surprising. Suddenly I felt that I understood the core nature of chaplaincy.

Earlier in the day, I had my weekly private meeting with my chaplaincy training supervisor. Coming after of a number of intense patient encounters during the previous few weeks, I could finally feel several losses I had experienced in life. Ever since my youngest son had been born – the one who was so present during the patient-physician role-play described earlier – I had resolved that I would never feel loss again. That resolution wasn't conscious. Although it was present for all the years since his birth, I couldn't feel it in my body. Until that particular day when I could.

Because that physical sensation of loss was so fresh in my body, it was if I walked into that elderly woman's room with a neon sign blinking on my chest, saying, "I have lost so much in my life." So how could she not so easily feel safe saying the same thing? This experience was much different from the far more common version of empathic

communication, dependent on words. This was a human experience of non-duality. This is the compassion described earlier in this chapter as "the expression of being alive."

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