Is There a Shaman in the House?

Peter de Schweinitz, MD, MSPH

This nonfictional narrative recounts a story of shared decision making between a veteran neurosurgeon and the family of a comatose patient who had suffered a hemorrhagic stroke. After reviewing the option of surgery within the context of informed consent, the family remains frozen in indecision. Leaving behind him the world of the rational, the neurosurgeon makes a statement that reconnects the family to their deepest values. The neurosurgeon is portrayed as a modern equivalent of a shaman. A call is made for consideration of the complex topic of spiritual engagement during patient care. (J Am Board Fam Med 2010;23:794–796.)

Keywords: **Communication, Decision Making, End-of-Life Care, Doctor-Patient Relations, Spirituality**

Every 6 weeks my 80-year-old colleague sits down with third-year medical students for approximately an hour and a half and shares some wisdom from his nearly 6 decades as an endocrinologist, medical school dean, and general practitioner. My colleague has a deep respect for scientific medicine. Nonetheless, he likes to tie students into a tradition that began long before the invention of the scientific method. "Before there was science," he says, "there was the shaman." Perhaps demonstrating one method of healing to the students, he places a warm, wrinkled hand on my shoulder. "The shaman had none of the pharmaceuticals or procedural skills that we associate with modern medicine, but he had something." After speaking of the importance of compassion for human suffering, my colleague ends his story by suggesting that human beings have evolved with shamanism and therefore have come to depend on its healing comforts. "What right do we have—just because we have science—to deny patients what they have enjoyed for millennia?"

This article was externally peer reviewed.
Submitted 16 March 2010; revised 10 June 2010; accepted 21 June 2010.
From the Department of Family and Preventive Medicine, University of Utah, Salt Lake City.
Funding: none.
Conflict of interest: none declared.
Corresponding author: Peter de Schweinitz, MD, MSPH, Department of Family and Preventive Medicine, University of Utah, 375 Chipeta Way, Suite A, Salt Lake City, UT 84108 (E-mail: peter.deschweinitz@utah.edu).

Driving home, I remembered an unusual healer I'd met 10 years earlier when I was a second-year resident in a suburban emergency department. The night had been mundane—an earache or two, a laceration, an admission for pneumonia—when a nurse approached. "Wanna see someone?" I noted the chief complaint and stepped into the room to find an elderly couple. Mrs. Dorsett had permed brown hair and a face taut with unexpressed fear. Mr. Dorsett lay absolutely still, his robust feet protruding beyond the limits of the sheet. Not even a sternal rub would arouse him. The radiologist's reading of the computerized axial tomography scan was superfluous. Even for a novice like me, the pathology was obvious.

By the time the on-call neurosurgeon arrived, a crowd of nervous sons, daughters, and spouses had assembled. With his sharp white coat and tie, Dr. Walker was the image of a medical professional. After a brief introduction, he turned to the white-lit radiograph box on the wall, dispassionately reviewed the images, and turned to address the family. "Mr. Dorsett has had a stroke," he announced. "It's a large one, a large bleed into what we call the cerebellum." Although I'd already made a similar announcement, from Walker the words had more gravity.

"What do we do?" a son asked. No advance directive was available.

Walker explained the possibility of a procedure and its risks in clear, lay language: the process of anesthesia, the opening up of a "window," the dissection of the blood clot. The couples asked ques-

tions about the neurosurgeon's experience, recovery times, and postoperative rehabilitation. "We can try to remove the blood clot," he said. "But, we have to accept the very real possibility that he might not survive surgery."

For a moment the family was quiet.

One son wanted exact statistics. "What are the chances of him dying during the operation?"

Walker rubbed his chin. "To be completely honest, that is a very difficult question to answer. If I had to make my best guess, I'd say there is at least a 50–50 chance that he would not make it through."

A daughter wanted more precise odds regarding postoperative function. Although not without hope, Walker was gravely realistic. "Even if he survives, there is a good chance that he will suffer from significant problems with basic daily functions like eating, walking, and bathing." For the next several minutes Walker answered questions as the family processed the information in a rational and objective manner, chewing on the risks and benefits of proceeding to the operating room.

Despite their health literacy and capacity to reason, however, the path forward remained unclear. Intensive discussion trailed off into a silence penetrated only by the type of in-breath one makes just before speaking. On the edge of anxiety, each family member looked to each other, as if that other might possess the missing fact or insight, or at least the resolve to make a decision—surgery or no. Even Walker's question, "What would your father want for himself?" was met with uncertainty.

As physicians, we render a clear synopsis of the medical facts. We seek to understand the values and preferences of the patient. We express respectful support for the autonomy of the family. But what happens when, despite our best efforts at education and explanation, the family cannot make a decision? Many families do not want us to stay neutral. They find ways to work around our neutrality. They say, "What would you do if this were your wife/husband/father?" Perhaps we're quite aware that our words may deeply influence the trajectory of many lives. Some of us may feel comfortable accepting this responsibility. Others may not.

The family didn't ask this question. Even if they had, I doubt Walker would have answered squarely. Walker had mastered the modern art of informed consent, leaving personal preferences, even values, at the door. Even with my insider's knowledge of physician culture, I could not tell whether he wanted to cut.

As a last ditch effort, an older daughter directly addressed Mrs. Dorsett, who had not yet spoken. "What do you think we should do, Mom?"

Mrs. Dorsett looked down at her husband. He lay still as ever. She looked up at Walker, who returned her gaze with solemn dignity, but no direction.

"I don't know."

Whereas the typical physician seeks answers in the empirical domain, the shaman travels to an invisible realm. Walker had reviewed a computed axial tomography scan, checked pupils with a penlight, and tapped on a few tendons. He'd calculated statistical probabilities and rationally considered the options. Now he turned his eyes to the floor.

For a couple of seconds he seemed lost in the white linoleum, immersed in a separate dimension. I don't know if this dimension is best described in spiritual or poetic terms, as a "higher sphere"; in psychological terms, as a "mental mode"; or in neuroanatomical terms, as a "parallel neuronal circuit." Regardless, when he looked up, he seemed to be wearing a different mantle. Directing his words to no one in particular, his voice flowed with subtle melody.

"No one knows when his Savior will come to bring him home," he said.

All of a sudden faces relaxed into tears. I felt opened from the inside.

A few seconds passed and the older daughter broke the silence: "Dad has lived a good life." When Dr. Walker and I left the room a few minutes later, the family was unanimously resolved to and at peace with the impending death of their beloved.

There are many physicians and patients who aspire to the emotional and spiritual engagement exemplified by Walker's interaction with the Dorsett family. Yet there are many who might also recoil at his use of religious terminology, especially before explicit inquiry into the belief system of the patient and family. And with good reason. In a diverse world, both physicians and patients are and should be wary of easy assumptions and uses of religion in public or even private spheres. Should medical educators introduce and explore more than medical technology, more than rational ethical concepts? Certainly we don't need

more charlatans, be they overexuberant oncologists or mystical herbalists. Should we physicians, as my octogenarian colleague suggests, carry on the tradition of shamanism despite our science? What can we learn by looking past stereotyped images of the shaman: the rattles and drums, the mashed up organic materials and mystical visions?

The shaman serves as a bridge between ordinary and extraordinary human consciousness. He or she steps out of ordinary thought into the world behind the visible, what depth psychologists may understand as the subconscious or mythological realm. In service to humanity, the shaman evokes a ritual space of healing and transformation that circumvents the usual rational mental structures that have blocked healing or growth. But although the shaman can be found in most, and perhaps all, societies throughout the world (universal), his or her methods, cosmologies, and treatments are highly contextual (unique); as an integral yet set-apart member of the community, the shaman works necessarily within a very specific metaphorical space. The buffalo may speak to the Sioux and the rose to the mystical Muslim; other symbols may speak to the white Protestant from Idaho. Walker enjoyed an increasingly rare circumstance; he knew his patients not only from living among them but because, it seemed, he was one of them. Walker embodied a specific community in his healing practice.

Most of us practice among patients of diverse religious, ethnic, and cultural beliefs and values. We rarely encounter patients who match up to us. In contemporary society we can hardly predict the continuation of a faith tradition from father to son. What if Walker had been wrong in his estimation of the patient's and family's belief system? What if there was apathy or even antipathy toward the Christian cosmology by a few or even one member of the family? To add to these dangers, we must recognize the danger of mixing religion and medicine: a patient's trust in the physician's curative powers may shift seamlessly and inappropriately into trust of the physician's ethical or religious authority, even when the physician intends only to engage and not impose. But in this specific context, Walker's use of religion did not seem to limit or oppress. Rather, his transcendent words cut through the veneer of ordinary cognition into deeper sensibilities, opening the family into a visceral and authentic relationship with their father. Although we rightly focus on the dangers of imposing our values on vulnerable patients, it would be intellectually irresponsible to dismiss the power of Walker's intervention simply because he invoked religion.

How do we proceed, then, not only in cases of dying, but at the varied intersections of meaning and health? Must we rely solely on the rational concepts of modern bioethics or is there a primordial language of the soul—a shamanistic inheritance common to human beings—that has survived the diverse evolutions of culture and religion? If not, is it deceptive and unethical to adopt the patient's metaphorical world when it runs counter to the beliefs and values of our own? Or can the physician, chameleon-like, safely use a patient's foreign terminology as a form of trained cultural and narrative competence? What does it mean to personalize care in an age of evidence-based medicine?

Despite the problematic, potentially explosive nature of religious and even spiritual engagement, we cannot afford to discard the shaman. Within the patient's room, Walker took time to reflect. Indeed, the family privileged his silence with their own. Whether by his powers of intuition or reason, but most likely both, he entered the Dorsetts' skulls. He then invoked a familiar but transformative ritual space. I surmise that Walker, in this move, saved our health care system tens of thousands of dollars in operative, anesthetic, rehabilitative, and psychiatric costs. (Completely rational care may be highly irrational.) Moreover, his solution was deeply healing for the family. I do not know what Walker meant by the word "Savior." It is possible that his and the family's definitions and beliefs differed substantially. Did Walker intend to invoke a heavenly host (incantation) or was he reminding the family of the limits of science and technology (revelation)? Whatever his intentions, his singular intervention manifest his profound agility within a shared metaphorical world. His words also marked the moment when, for me, modern physician and ancient shaman became, for the good of our patients, one.

The author wishes to thank Chase Peterson, Rebecca de Schweinitz, Michael Magill, Alistair Bahar, and Susan Cochella for important feedback on this essay.