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The Park Ridge Center

Bulletin



The New Ritualists: Learning How Ritual Can Transform Your Life
What Researchers Will do to Get Your Consent: Is it Honest?
Losing Sight of the Patient: The Ritualization of Health Care

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A MESSAGE FROM...

Philip J. Boyle
Editor-in-Chief

Ritual Obligation

Rituals can advance or undercut healing.
This issue looks at how...and why.

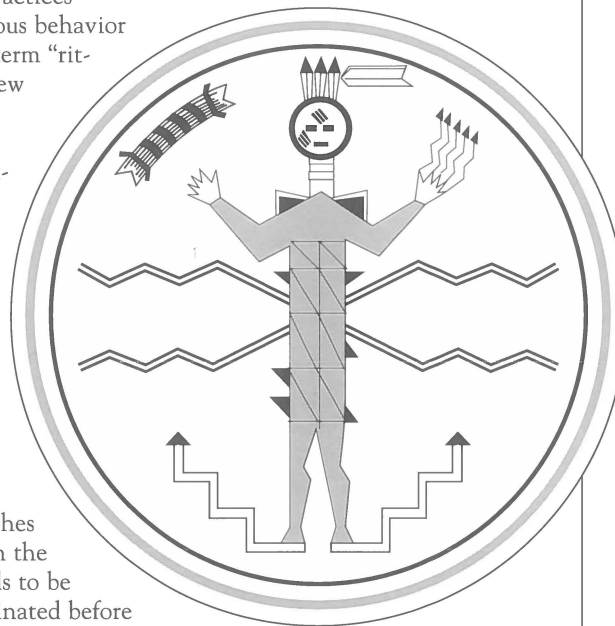
"Freelance ritualists! Sports as ritual! What business do these topics have in your journal?" The answer to this question is as complex as it is simple: It's a moral obligation.

Those who study rituals make the obligation plain: ritual actions in the medical setting can promote or undercut healing and human dignity. In this issue of the *Bulletin*, we highlight routinized healthcare practices — repetitive, unconscious behavior that some theorists term "ritualism." Our interview with Pamela Sankar about her study of informed consent rituals in medical research reveals subtle yet coercive manipulation of desperate patients. Ed DuBose's case study examines hospital infection control policies applied in a nonreflective, ritualistic manner that diminishes healing. Ritualism in the medical setting needs to be recognized and eliminated before it can harm.

As for a positive obligation for ritual actions — those applied in a reflective manner that some theorists call "ritualization" — this issue of the *Bulletin* depicts ritual actions that provide order as patients experience loss of meaning, that build community where patients are isolated in suffering, and that transform patient and family hopelessness into hope. In a risky move, this issue also features some freelance ritualists — as they might be called — to make explicit that novel rituals can build community and meaning at an apprehensive time

such as childbirth and that rituals can comfort even in the face of the inexplicable loss of a young child.

Rituals can be perceived as just an extra, wholly unaffordable within health care. Worse, offbeat rituals can be dismissed with a conclusion that there is no moral obligation to take them seriously or promote them. Yet



Navajo sand painting —
Slayer of Alien Gods (detail)

the *Bulletin*'s stories disclose that some rituals have palpable, although unquantifiable, health benefits. Even if the connection between rituals and health is not always present, the place of rituals and their contribution to a basic need within all of us gives us reason to pause and explore whether and to what extent society and its institutions should promote practices that span human cultures and beliefs.



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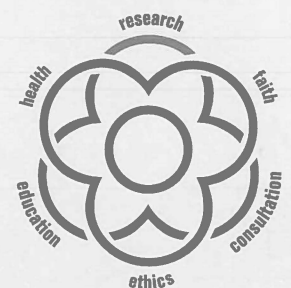
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The Park Ridge Center's six-foil portrays the unending and many faceted interaction which takes place among three major areas of human endeavor: health, faith, and ethics.

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What Healthcare Professionals Need to Know about Ritual: A First Lesson

By Tom F. Driver

A true story

The pain was intense. It began in the right side of his neck and spread into the shoulder muscle. He could feel it coming, just the way it had first come almost two months ago. Almost always, once it started, it grew in fierceness, forcing him out of bed — to walk, to stand, to sit in a chair, to try TV for distraction (a book kept his head too low and too immobile), sometimes to go to another part of the house, shut the door, and cry. Crying helped. A little. He didn't know why. But his training was such that he wouldn't cry unless the pain was agonizing, unless he was desperate. "Oh, God!" he would moan. "Oh, Jesus!"

Then he would close his eyes and sob.

During the two months since the pain began occurring several times a day, he had paid repeated visits, first to one doctor and then a second, not counting the one who saw him at the hospital emergency room where he had gone on a long holiday weekend after losing two nights of sleep in a row, feeling he would crack if this kept on.

As yet there was no real diagnosis. "Pinched nerve" was as close as they came. The X rays, as one of the doctors put it, "didn't look so bad," explaining that there was no sign of injury. Arthritis and spinal degeneration were not terribly far advanced for a person of his age. Then why did the pain feel so bad?

One night he had gone to bed in comfort. There had been no pain to speak of since the previous night and no hint of any when he lay down around 10:00. Maybe the cortisone, begun a few days earlier, was starting to have some effect. At 12:22, the pain woke him up. He first thought that it wasn't going to be very painful, but this wishful thinking was soon routed by a ferocious attack. After pacing about for a time, he climbed upstairs to his study, hoping to distract himself with the

When medical solutions proved futile, one man turned to ritual in the quest for an end to his pain.

computer rather than the inanity of TV channels. No dice. The thing came at him like a wild beast. No physical position into which he could put himself availed him for more than a second. The pain gnawed at him. It pounded. It twisted him. It was the work of a faceless, senseless torturer, sadistic in nature.

Desperation moved him in the direction of ritual. At first, he attempted to use liturgical language, silently mouthing the words of the Lord's Prayer, which in other circumstances were often a comfort to him. Not now. The pain mocked the familiar images and cadences of the prayer, which seemed to come from another world. "Forgive us our trespasses" and "lead us not into temptation" for some reason made the pain worse, and "deliver us from evil" felt like a cruel joke. Later he realized that the prayer bespoke an utter faith and confidence which the pain had removed from him. It was not, under these circumstances, his truth.

So he did, without forethought, one of the things that makers of ritual do when they are not sure what they ought to do. He began to focus, as intently as he knew how, upon the experience he was having. He concentrated upon the pain itself, for the truth was that it had become nearly all-absorbing. Now he put it at the center of his attention, all else fading to the shadowy edge — the Why? the Why Me? the How Long Will It Last? the Who Can Help? the Where Can I Turn? the What's Going to Become of

Me? the Oh, God. Now there was just the pain and the rhythm of its throbbing, not simply there but attended to. It occurred to him that what he should do was just "do" the pain. He had been "having" it. Now he would "do" it. First to give it ever fuller attention. Then to get behind it, inside it, with it. To will it. To perform it.

Thus the words came to him: "I am hurting. I am doing the hurting. I pain myself." It was not just about thinking that. It was joining the words to the rhythm of the pain. "Here I come. I pain myself now. I let go a bit. I do it again. I breathe. Here now once more. I pain myself again. Again. Here. Now. Again." The will of the pain became his own will. The action of it became his action. The rhythm was his. He performed it.

Sometime between 1:00 and 1:30, he realized that the pain had subsided.

Commentary

The problem of healing begins (and ends) with the patient. We might even say that the problem begins with the naming of the patient as patient. For *patient* comes from the same root as *pathos* and *passion*, which means "to suffer" or "to undergo." From the same root also comes *passive*. The problem of healing begins with the regard of the patient as the passive one, the one upon whom the affliction has come. The victim.

This is perhaps a natural way of thinking: The pain has "been sent." It is the work of an evil spirit, a demon. It is a punishment for some offense against divinity. It is an attack, an invasion.

This way of thinking is changed, but also magnified, by medical science: Pain has an origin in some malfunction of the body, called a disease and given a specific name if possible. The aim of medicine is to find the offending

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Losing Sight of the Patient

When routines are ritualized, quality of care may suffer

By Edwin R. DuBose

Severely burned and at risk for HIV, Mary was isolated by the routine intended to protect her.

In the summer of 1998, Mary suffered second- and third-degree burns on her upper chest and arm, the result of an accident while freebasing cocaine (a practice that involves purifying cocaine with ether and inhaling the heated vapors). Following initial stabilizing treatment in the local ER, she was transported to a regional hospital that had a burn center. There the goals of treatment were to prevent infection, avoid further injury to damaged tissues, and close the wound as quickly as possible through primary excision (the surgical removal of necrotic tissue). Since blood loss from the surgical removal of dead skin is common and the cause of Mary's injury suggested a history of drug use, there was concern whether Mary might be HIV infected. At least 38 states require informed consent prior to HIV testing of a patient, even when

a healthcare provider is at risk for HIV infection because of contact with potentially infected bodily fluids. Mary refused consent to HIV testing. At their initial meeting, the burn unit team noted Mary's refusal; they agreed to the presumption of a positive HIV status. Because of her refusal to consent to testing, and since a burn patient has a high risk of infection due to a compromised immune system, everyone was reminded to closely follow the infection control procedures governing most serious risk. These were posted on Mary's door. At a subsequent session, several staff reported that Mary seemed uninterested in her condition and uncommunicative, and she bordered on being noncompliant. A week or so later, at the nurses' station, a hospital volunteer hesitantly mentioned that she had no trouble communicating with Mary and revealed the patient was angry because she felt she was being treated like a leper.

To cross the threshold of Mary's room and provide care required something more than the usual perfunctory knock. There was good reason for cau-

tion: as a result of immune dysfunction, infections of burned skin are common, as are infections involving a burn patient's lungs and bloodstream. Because these last two carry very high mortality rates, patients must be protected from infection. Thus, infectious disease control procedures, posted on the door, dictated the manner in which a visitor should wash, glove, mask, and gown before entering Mary's room and how sanitary gear should be removed when leaving.

In the same way that rituals reify certain actions and set them apart, the infection control policy's flip side was that it served to set Mary apart. It erected physical and psychic barriers between caregivers and patient, barriers symbolized by the sign on the door, the procedure itself, and the thin layer of latex and gauze separating patient and caregiver. In this case, the one who was brought within an institution popularly associated with hygiene — the hospital — was the person ordinarily on the outside of conventional norms of moral behavior:

Researchers Use Ritual to Obtain Consent (But Is It Honest?) Anthropologist Pamela Sankar investigates

*Informed consent is the backbone of ethical research practice. But is ritual being used to delude patients? Pamela Sankar talks with the **Bulletin** about how she discovered the problem.*

Pamela Sankar is studying the ritualization of informed consent to medical research. In particular, she's interested in how researchers ritualize consent sessions in order to gain the participation of potential research subjects in Phase I Protocols, the earliest stage of testing treatments on human subjects. Sankar has observed that researchers may organize sessions to suit the schedules of potential sub-

jects or give them business cards with the researchers' home phone numbers scrawled on the back. These practices invert the normal routine of doctor-patient relationships and create the sense that researcher and subject are equals, partners who are part of the same team. Sankar sat in on consent sessions with a group of terminally ill patients who consented to become part of a drug toxicity study despite the fact that it would have no impact on their disease. Though none were willfully misinformed, when queried most revealed that what they wanted to gain from the study was help or a cure for their illness.

Sankar is an assistant professor at the Center for Bioethics at the

University of Pennsylvania and Senior Fellow of the Leonard Davis Institute of Health Economics.

How would you describe the current practice of informed consent?

One important distinction to make is whether you're talking about informed consent for clinical work or for research. My concern is with research, which is voluntary, but at the end of it, there often dangles the carrot of possible cure. Some research, however, is dangerous to the subjects. And there has been lots of emphasis over the last 30 years on trying to figure out ways to improve the

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the drug user — a drug user who refused to be tested for a disease that places her caregivers at risk. Although its routes of transmission are generally well understood and widely accepted, the risk of HIV transmission via bodily fluids evokes the ancient fear of pollution that usually resulted in the isolation of the “polluted” individual. In such emotionally charged situations, people feel that they are teetering on the edge of danger. What should be on the inside is now on the outside. Because Mary needed to be contained, isolated, or sanitized, there was the potential for her to be stigmatized, even dehumanized.

It is through specific intention that we engender a particular type of ritual activity. While the intent in Mary’s case was primarily to provide her physical care, the carefully followed procedures also served to protect caregivers from infection, easing fears of contagion. If the price paid for this gloving, masking, and gowning was to be interpersonally (and symbolically) distant, they reasoned, so be it. The room was a space to enter, in which to work, and from which to leave as quickly as possible. The goal was to leave intact, untouched by the patient and her disease.

The volunteer’s intention, on the other hand, was to help the person. Like the doctors and nurses, the volunteer solemnly gloved, gowned, and masked, carefully adhering to the policy. But the volunteer broke a barrier, perhaps because she had more time or understanding (since volunteers often are former hospital patients or the family of former patients). Even though literally and symbolically separated from Mary, in a situation delineated by the risks of her condition and the requirements of policy, the volunteer sat and talked with her. For this caregiver, the procedures became a ritual activity that prepared her to enter a dangerous space and touch the person inside.

A key factor in this case: No one had explained to Mary the reasons behind the precautions. While the use of

antibacterial agents reduces its incidence, infection remains one of the most serious complications of burns. In Mary’s case this was further complicated by the possibility of HIV. No one told her the procedures were designed to protect her. Since blood loss is common during burn treatment and Mary’s HIV status was unconfirmed, caregivers were fearful of HIV infection of themselves, of other patients, and staff. No one told Mary the adoption of careful barrier precautions was prudent and necessary for them.

Raised a Southern Baptist in a small west Texas town, Mary had renounced her religious upbringing, a renunciation confirmed for her when some church leaders claimed that AIDS was God’s judgment on homosexuals and drug users. She worried about her mother’s reaction to her drug use. Fearing abandonment, disfigurement, and death, Mary was depressed. She wanted a reconciliation with her family and with the faith that had been an important part of her life, but she felt cut off by the people on whom she depended for help. Not only did the concrete presence of the gloves, masks, and gowns set Mary apart, but the attitudes she sensed on the part of some caregivers reinforced her antipathy.

Unlike the healthcare professionals caring for Mary, the volunteer recognized the way in which the ritual of gowning served to diminish the patient. Because she saw the infectious disease control policy as an opportunity to intentionally break the barrier created by the procedure — to share something, in a sense, of the disordered world of an isolated burn victim, she connected with Mary in a fruitful way. Because of the volunteer’s visits and conversations, Mary called her mother and told her of her condition and of her need for her. The volunteer was present when Mary’s mother, after careful coaching on proper precautions, donned the protective gear and entered the room to hold her daughter’s hand.



The Key Role of Ritual in Modern Medicine

By M. L. Elks

Modern medicine includes many experiences that are similar to primitive healing rituals. Traditional healers often have required the patient to confess misdeeds, wear special garments, and perform certain tasks, while the healer might touch the patient with stylized gestures or interpret various physical signs. In modern medicine, the doctor takes the patient’s history, or “confession.” During an examination, the patient wears a paper drape, and the doctor often touches the patient’s body with a stethoscope and other instruments. Later, the doctor interprets the results of laboratory tests and requires the patient to take certain actions, such as exercising, dieting, or swallowing pills.

Often unconsciously, we doctors use these ritual aspects of medical practice to distance ourselves from the emotions of our patients, to keep ourselves from being overwhelmed by their traumas. We wear “power clothes” while the patient is nearly naked, covered only by the drape. When we keep patients waiting, we send the message that we are more important than they are. We often use technical language that patients cannot understand, in an attempt to deflect their likely emotional reactions to diagnoses of serious illness.

Physicians and other health professionals may not admit that these common practices constitute rituals that relay psychological messages. But many of our patients — especially when they are afraid or in pain — detect ritual messages, as well as logical rationales, in medical procedures such as drawing blood for laboratory tests, in harrowing encounters in the darkness of the radiology department, and in other complex treatments for disease. Instead of allowing the ritual aspects of medicine to intimidate patients, we need to acknowledge the rituals and make deliberate use of them as part of our treatment.

*M.L. Elks is a physician on the faculty of the Morehouse School of Medicine in Atlanta. From **The Chronicle of Higher Education**, November 21, 1997.*

THE NEW RITUALISTS



First the Body, Then the Mind

Effective rituals spring from the depths

By Rebecca D. Armstrong

The function of ritual is to give form to human life, not in the way of mere surface arrangement, but in depth.

— Joseph Campbell,
Myths to Live By

The importance of this quote from the great mythologist lies in the last word — depth. Here Campbell asserts that what is true for myth and dream is also true for ritual, namely that it is not a product merely of the conscious imagination, but it springs from the great wells of the collective unconscious. Myth, says Campbell, is at its deepest level a product of the body first, not of the mind. I make the same claim for ritual.

When people hear the word *ritual*, they generally take it to mean some symbolic action that holds meaning for them and is repeated over time by a particular person or persons. That definition, however, speaks only about ritual after it has been tamed or domesticated. I'm interested instead in the origins of ritual. The birthplace of any single ritual is always in a spontaneous, unpremeditated form, emerging from an individual's struggle to regain emotional balance, a sense of wholeness, or right placement in the face of the immensity of the world. I have coined the counterintuitive phrase "spontaneous ritual" to describe this first emergence of a genuine ritual.

If we think about ritual in the wild, we quickly begin to sense its relationship as a mediator between the body and the emotions. Ritual is embedded in gesture and movement, and when it fits, when it is sufficiently charged with meaning, it does serve as a container and transformer of the

THE NEW RITUALISTS



Perhaps the most vibrant aspect of ritual practice in America is a kind of "ritual revival" taking place today in which practitioners are guided by nothing more (or less) than the spirit and the need to mark a special event with a ceremony of some kind. These rituals aren't formally sanctioned by a religious tradition or the rites of an organization or sect. They are endowed with meaning, not by having been performed over and over again for hundreds or perhaps even thousands of years, but by their connection to everyday events and common human feelings.

emotions. Ritual may be a by-product, as Campbell says myths and dreams are, of the consciousness of the body's organs meeting and competing with each other.

I have been generally disappointed in the recipe rituals found in so many neopagan and New Age books. The mere regurgitation of ancient sacred texts, taken out of their natural and social context, is too often an exercise in cognitive dissonance rather than religious fervor. And the imposition of someone else's contemporary poetry and correlative action rarely engenders ecstasy in others. Genuine ritual is powerful, profound, and deeply religious and requires no contemplation about its efficacy — one knows that one is moved. To be

this genuine, however, ritual must spring from the person or persons who are performing it, evoke their personal symbology, and meet with approval from their own sense organs. This is much harder to achieve.

Creative mythology springs not, like theology, from the dicta of authority, but from the insights, sentiments, thought and vision of an adequate individual, loyal to his or her own experience of value. Thus it corrects the authority holding to the shells of forms produced and left behind by lives once lived.

— Joseph Campbell,
Masks of God: Creative Mythology

What I believe is at the core of good ritual, which is also at the core of a living mythology, is a working metaphor — a symbol system that is still alive with transformative power. This is not merely a head trip or a philosophical mind game, though you might need to employ your verbal skills to articulate the metaphor. Your body will let you know if the metaphor works — you will get a sudden thrill of energy down your spine; the hair will stand up on your arms; your heart will skip a beat; you'll involuntarily inhale — something in you will react to the metaphor. Then you'll know this one has *mana*. In fact, if you learn how to listen to your body, it will tell you exactly what sort of ritual you need to heal, empower, console, activate, or transmute the emotions that are surging through you.

In my long quest to understand spontaneous ritual, I have noticed that the body has an instinctive ability to turn toward the right element

for its own healing. There are many ancient systems that see earth, air, fire, and water as the primordial elements — some add wood, wind, metal, or ether. From what I have observed, your body will tell you through ritual which of these elements is lacking or overpowering and try to bring you, through ritual, into balance, into wholeness. If you ignore the signs from your body, it is likely to impose a mandatory ritual of horizontal balancing, in the form of laying you out with illness.

Coming of Age

*When starting out to build a world,
One starts first with oneself.*
— Langston Hughes

Coming-of-age rituals are being revived as more and more people understand the danger of their absence. In many Unitarian-Universalist churches (the denomination where I received my training and served as a religious education director for a number of years), new curricula for young teens are focusing on initia-

daughter prevailed, and she literally outran her mother, who had to let go of her end of the cord and watch her daughter run free. It was a shocking, yet exhilarating moment on both sides.

Cronings & Crownings

*I am luminous with age
Like corn I cry in the last sunset
I fall and burst beneath the sacred
human tree.
Release my seed and let me fall —
These are the rites of ancient ripening*
— Meridel Le Sueur

In addition to participatory rituals such as dancing, singing, chanting, and praying, there is storytelling. The power of myth is often conveyed in the power of the story as it brings to light secret movements and desires. Jung, late in his career, frequently began his seminars with a story in order to give focus to the material he was dealing with and bring his listeners into the proper place for receiving psychological insights. In the last 50 years, the mold by which women

question) to the present. Sir Gawain, who in the story can be read as the king's feeling aspect, is able to have sufficient empathy with the hag to acknowledge her right to make the decision that will affect her life, thereby granting her the one thing that a woman most desires — sovereignty — the right to rule oneself.

Coming out of patriarchy, this is a very redemptive story, and I use it frequently in croning ceremonies. For a man coming into maturity, the great soul task is to connect with the dark (i.e., alien or unknown) feminine side of himself, which up to now has appeared as a witch or hag. She must be embraced and be given rightful power if the man is to achieve balance, wholeness, and depth as an individual. For the woman, the challenge is to come out from under the enchantment of patriarchal power, where others have made decisions for her and defined her appearance in the world, and accept full responsibility for her own life, both its beauty and its ugliness, light and shadow.

The importance of making these transitions is that only mature individuals who have passed this threshold are truly eligible to rule the kingdom or, in contemporary parlance, to guide and shape society. The kiss of sovereignty is a well-known mythic motif in northern European and Hindu mythology: without the kiss, the king may not rule. The awakened woman holds the keys to sovereignty.

Creating ritual — giving form to life — is one of the most sacred tasks we can undertake. The constant renewal of the outer forms of our inner growth is the only thing that will keep our social fabric from unraveling altogether. Those who are sensitive to the connection between the inner and outer worlds would do well to bring their energies to this most urgent task.



Rebecca Armstrong is a third-generation singer and storyteller in the Celtic tradition. The late Joseph Campbell was a close family friend and ignited her interest in mythology. She has served as International Membership & Outreach Director for the Joseph Campbell Foundation since 1994 and practices her ministry of ritual-making as a freelance minister around the country.

Creating ritual — giving form to life — is one of the most sacred tasks we can undertake. The constant renewal of the outer forms of our inner growth is the only thing that will keep our social fabric from unraveling altogether.

tions, both into the story of their religious tradition and into psychological manhood and womanhood. Frank discussions about sexuality, responsibility, love, ethics, and meaning precede an overnight or weekend away, when the teens will symbolically cross the threshold of childhood and step into adulthood.

As is proper for such rituals, I know only what the women of our congregation did for the girls, not what the men did for the young boys. The girls were brought out into tents to hear sacred stories of first menstruation, childbirth, love, loss, sorrow, and grace. Gifts were exchanged, vows made, and secrets shared. As a tangible sign of moving beyond the parental sphere, one ritual involved mother and daughter each taking hold of a long cord. To the sound of beating drums, each duo began to run, until the youth and strength of the

shaped their lives in society has broken open so dramatically that many older stories have had to be revived in order to provide sufficient breadth for our newfound freedoms.

The archetypal manifestation of the mature, empowered woman that speaks to me and many contemporary women is Dame Lady Ragnel of the Arthurian tale "The Marriage of Sir Gawain." In that story, Dame Ragnel appears first in the guise of the old hag/wise crone who has the answer to the riddle that will save King Arthur's life. The importance of the riddle cannot be overstated and has enormous implications for both the king and the hag — "What is it that a woman most desires?" To keep his life and his crown, the king must know the answer to the question which has baffled adult males from the ninth century (when this story is first told) through Freud (who posed it as the



Ritual for a Dying Child

By Megory Anderson

I always dread calls like this. A little boy was about to be taken off life support, and his family needed help.

David and Susie were a couple in their late 30s. Christopher, their youngest child, was not quite two. He had come down with a bad case of pneumonia several months ago and had quickly gone into a coma. By the third day, the doctors had told David and Susie that their son was brain dead and had put him on life support. For about six weeks now, he had been in the same state. Everyone was convinced there was no hope. It was time to let him die.

I would help the parents create rituals for the moments when the machines were turned off, to help Christopher let go of his life and to help David and Susie let go of their child.

We talked for several hours that afternoon. David and Susie told me about Christopher's life and his love of learning new things. They told me about his older sister, Emma, who was almost five. They talked about their religious beliefs. David was born and raised Lutheran, but his family only went to church now and then. Susie was Chinese-American and grew up with a mixture of Protestantism and Buddhism. Her grandmother, who was still alive, was a Buddhist. Susie wanted her to be with the family for Christopher's last moments.

The next morning I met them at the hospital. Susie's grandmother was there, and in a corner by herself was Emma. She was tiny and beautiful, looking more like her Chinese mother than her German father. I knelt down and introduced myself. She was silent, but her eyes were big.

The room was filled with machines making all sorts of sounds, pumping and beeping and swooshing. In the middle stood a huge crib containing a very small boy with black hair and pale skin who seemed to be swallowed up by all the tubes and monitors.

We gathered around Christopher's

At a time of tragedy, ritual helps family members deal with the painful task of letting go.

crib, and I began by asking God to be present in this room and with all of us. I asked that special help be given us in this difficult thing we needed to do. Susie's grandmother prayed something in Chinese, and Susie smiled, telling us that her grandmother asked especially that the good spirits come down to assist us. Emma looked to the ceiling, hoping — I imagined — to see an angel or two.

David rearranged Christopher's bed sheets. Susie put some new socks on his feet and placed a stuffed rabbit next to him. David placed their son's favorite bowl and spoon beside him and then laid a very worn-out copy of *Goodnight Moon* next to his hand. The grandmother had brought a red jacket she made for him, and she put it on him around all the tubes and monitors. And then David lifted Emma so she could give Christopher his pillow from home.

"Let's take a few minutes to tell Christopher thank you for being here with us for his short life," I said.

David began, taking Christopher's small hand in his. "Son, I remember when you were born. I was so happy. You brought such joy to me. I would look into your eyes and see all the things you were going to do when you grew up.

"Well, I guess you won't get much of a chance now. But we will always remember all the things you did do. You loved to dig. Remember when you dug up all those flower bulbs your mother had just planted?" He looked over at his wife, who was crying now.

"And remember last Christmas when we played all afternoon with your

new train set? I'll keep it for you, Chris. I'll keep it going for you. Thank you, son. Thank you for being our baby."

"I want to go next, Daddy," Emma said, looking back and forth from her father to her mother.

David picked Emma up and swung her over the bars of the bed. She sat cross-legged next to her brother and began, "Christopher, it's me, Emma. Can you hear me?" She waited a moment and began stroking his hair back from his forehead.

"Chrisser, Mommy and Daddy told me that it was time for you to leave. You are going to die. I really don't want you to go, but they say you have to. Will you remember me in heaven? Will you wait for me to get there too so we can play together? I'm not sure when I can come, so watch for me, okay?"

Her parents eyes were wide open.

"I will help you paint when we both are in heaven. Just let me know what you want to play with, and I will help. I like helping you. I'll even bring your jacket if it gets cold there."

"Why don't you tell him thank you for being your brother, Emma?" said David.

"Okay," replied Emma. "I like having a little brother. Thank you for being mine. I remember when you were a baby and cried a lot. I still liked you even then. Remember when you fell out of your crib, and I helped pick you up? Or when I tried teaching you how to brush your hair? Or when I showed you how to flush the toilet?" She giggled. "You did that all day long." Emma looked up at her parents with a grin and then back at her brother. She leaned over and began whispering in his ear, giggling and babbling at the same time. None of us could make out what she was saying, but the look of conspiracy in her eyes was delightful.

"Bye Chrisser," she finally said. "I'll see you when I get to heaven. Wait for

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Jose and Mirza hold their baby for the last time.

When a Life Ends Before It Begins

The parents in these photographs, Jose and Mirza, are saying good-bye to their newborn infant, who was born with incurable birth defects at Lutheran General Hospital in Park Ridge, Illinois. Chaplain Jill James, a former R.N., baptized the infant, Jesus Ricardo, just moments before he died. "In their tradition," says James, "baptism is a marker that their child is claimed as a child of God. It's something that the parents can do for their child at a time when they feel that there is not much else."

Photos by Todd Hochberg



The chaplain baptizes Jesus Ricardo while NICU staff lends support and prayers.



Jose helps to extubate his son, Jesus Ricardo, while Chaplain James prepares for the rite of baptism.

Left: Chaplain and parents bless the baby.

Rituals of Remembering for Parents and Caregivers

How do you create rituals for people who have few memories of the loved one they have lost? "When an older person dies, each religion has its set rituals," says Beverly Kravitt. "In the case of a baby dying at birth, nobody has known that child, so there are no communal memories."

Beverly and Jason Kravitt started the Cameron Kravitt Foundation in 1982 in memory of their son, who was stillborn. The Kravitt Foundation helps support programs like the one at Ravenswood Community Hospital in Chicago.

In trying to help families cope with miscarriage and infant death, Dr. Carroll Cradock, director of the Community Mental Health Center, and Hope Hornstein, the assistant director of Consultation and Education, have instituted a staff-education program that provides both patient and caregiver with tools to address the unique pain and sadness of such a loss. They and other healthcare professionals have found that ritual plays an important role. "We try to educate the medical staff to help families integrate this experience with their own religious rituals," says Cradock.

Remembrance plays a central role in rituals that deal with loss, and objects are vital to it. "One of the worst things for people is that they come to the hospital, lose their child, and then leave empty-handed, with nothing," says Cradock. "We give them memory boxes so that they have something they can take with them." The memory box contains the baby's hospital bracelet, the baby's footprints, a tiny handmade gown, even a photograph.

Lutheran General Hospital of Park Ridge, Illinois; Ravenswood; and other hospitals now offer memorial services several times a year for the families of all children under the age of 18 who died there. At Lutheran General, that includes a candle marked with each child's name. If family is not able to be present, a staff member who cared for the child will be. "The room is filled with parents who've lost a child," says Kathy Kobler, R.N., Lutheran General's bereavement coordinator. "The last time they were here, their child died, and yet they choose to come back. There is such a need for recognition of parents who are grieving."

THE NEW RITUALISTS



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me there." She lifted her arms up to her father, and he gently brought her out of the crib.

Then the grandmother leaned over the bars and began talking, half in English and half in Chinese. She stroked Christopher's arm and his face over and over again. She clearly loved this little boy, this great-grandson of hers.

As she stepped back, we each looked at Susie. This was going to be the hardest. "My baby," she cried. "You're my baby. Thank you for coming to us. I love you so much, and you were such a good baby. You made me so happy. I wish I could make this all better, but I can't. I'm your mother, and I can't make it go away. I'm sorry, sweetheart." She burst into tears and fell into David's arms.

"Darling, tell him thank you for being here with us this long."

"Yes, alright," she said. "Chrisser, thank you for being my little boy. We will always remember you and keep you alive in our hearts. You're my baby, and I love you."

That was as much as she could say.

"Let's give him our gifts now, to help him know how much you love him and to help him feel strong for his journey," I said.

In turn they each put something special into his crib. The grandmother offered a beautiful red chrysanthemum and placed it on his chest. David gave him a little locomotive. Emma reached in and handed him her rag doll. And Susie placed a beautiful quilt around his feet.

"Oh," said Emma. "I forgot. This is for you too." She reached into her pocket and pulled out a little chocolate bar and put it beside her brother's hand.

I looked over and saw the doctor and nurses peering through the window. I invited them to join us. Then I rested my hand on Christopher's chest and began talking to him.

"Christopher, we are going to stop the machines now. That means you can begin to let go. You won't have to work so hard anymore to stay with us. You can move on. It will be alright. Your mommy

and daddy will hold you while the machines are turned off. You will go to a wonderful place, and God will be there waiting for you. It will be just fine. Are you ready, sweetie?"

I motioned Susie to pick him up, and she reached into the crib to bring him into her arms. The nurse beside me helped her, rearranging all the tubes. I pulled over a chair for her to sit in.

"Talk to him. Tell him it's alright. Tell him how much you love him and will miss him. And that it's time to do this."

Susie sat with her child in her arms. David knelt beside her and held him too. The doctors began turning off the machines, one by one.

The grandmother began crying loudly, and Emma turned very pale. I picked up a Bible and began reading, "The Lord is my shepherd. I shall not want. He maketh me to lie down in green pastures."

Both Susie and David continued to talk to Christopher, telling him how much they loved him. I heard Susie say, "It's hard, baby, but you can let go now. It will be alright. We'll hold you until you go."

Suddenly the room was quiet. I had not realized how loud the machines were until they were silent. Then the heart monitor squealed. I looked up and saw a flat line. Susie buried her face in her son's body and wept.

We put a candle beside the bed, and the room took on a hushed feeling. I said a few prayers and excused myself. David walked me to the door.

"I understand now. He made that transition you were talking about, didn't he?"

I nodded.

"I can feel it too. I know he's gone now. We'll have to grieve, but I do know he is where he is supposed to be. I felt it immediately."

Emma came over and reached for me to pick her up. She spoke softly in my ear, "He told me something. He told me he was glad."

We hugged, and I left the family to grieve.



Megory Anderson is a theologian and author living in San Francisco. This article is an excerpt from her book, *Sacred Dying*, to be released next year by Ballantine/Random House.

Celebrating New Life

Modern birthing rituals are part of an ancient tradition

Elizabeth Feldman and Amy Schuman share how they use ritual to help ease the fears that are a normal part of childbirth.

Throughout history, women tended to the important transits in human life: birth, illness, and death. The unseen acts of women wove communities together by providing care and support at the bedside. Women neighbors assisted in childbirth and washed the newborn child, swabbed the body of the feverish elder, and cleansed the newly dead in preparation for burial.

In Chicago, a group of women has found its own way to reconnect with these ancient female rites, in an energetic creative spirit that is thoroughly modern. Elizabeth Feldman is a physician teaching in a family practice residency program at Ravenswood Hospital, Chicago. Amy Schuman is an organizational development consultant with special expertise in issues relating to families. Both are members of a small, alternative Jewish community, founded almost 15 years ago, which meets for prayer services, holidays, study sessions, and explorations of spirituality. "We started doing rituals around pregnancy and birth simply as a response to our own need for them," admits Feldman. The rituals they create recall the traditional role of women in the birthing process and celebrate the ways that women help each other to confront the fear and threat of loss that even today's relatively safe childbirth cannot fully eliminate. Though the women were familiar with Native American "blessingways" or birth rituals, they relied on no formal structure or tradition in creating their rituals, other than what Feldman calls their "shared experiences of singing, chanting, and praying together."

Reflecting on the process of making these rituals, Feldman says, "We feel deep gratitude. We feel filled up just remembering them!"

The group's first ritual experience together was for their friend Sarah, to help her safely sustain her third pregnancy after two miscarriages. "We always try to gear rituals to specific concerns or blocks a person is experiencing," says Feldman. "One of Sarah's issues was how becoming a mother would radically change her life as an artist. Sarah was very into the color red, perhaps related to the blood of her previous pregnancy losses. So everyone brought some red item — a scarf, candle, flower." Fresh flowers, herbs, and greens symbolized the new life that was developing.

With Sarah in the middle, the women sat in a circle and chanted melodies and songs. They washed Sarah's hands and feet with warm water scented with flower petals and lit candles and set them in nutshells floating in a large bowl of water. "At one point we formed a human passageway and massaged Sarah as she crawled through this loving 'birth canal' and reemerged," says Schuman. "Then we gathered around as she lay on a padded table and stroked and massaged her. We tried to send energy to her gently rounded belly, to her chest and neck, to her lungs to open up her breathing, and to her head, firmly holding both temples and gently pressing on her closed eyes."

The ritual was relatively unstructured, with participants acting as the spirit moved them while a tape played meditative music. But like the best rituals, it created a deep connection to the psyche of the woman being honored: Sarah's pregnancy went full term, and she gave birth to her first daughter eleven years ago.

When the group plans rituals, a few women step forward to be responsible, often those with a special connection to the person being honored.

They meet with the honoree to talk about what she wants from the ritual. She shares the issues, challenges, opportunities, associations, fears, and hopes linked to the coming birth. The outline of the ritual begins to take shape as the women identify a color, a feeling, a theme, or an image around which to organize. They try to address all the senses: sight (flowers, scarves, pictures, objects from nature, candlelight, dry ice to create the effect of a mystical fog), smell (flowers, incense), sound (music chosen for the particular feel or theme of the ritual: for a "blue" ritual someone made a tape of water songs and wave sounds), touch (for the blue ritual, blue fabric draped on the floor and chairs), and of course, taste. The rituals almost always end with food, the kind and quantity to be specified by the honoree, e.g., desserts that are gooey, white food, hearty food, or natural, uncooked food. For one woman, who had on occasion pampered herself with Belgian chocolates, the food included chocolate fondue, brownies, chocolate cookies, and Belgian chocolate candies.

The ceremonies almost always include the giving of gifts — not store-bought presents but gifts of the heart, they say — stories, poems, loans of treasured objects for the duration of the ritual, pieces from nature or their own lives. On one occasion, a participant brought a bagamulet necklace containing special objects and a chart for the mother-to-be to perform a "counting ritual" for the ninth month.

Says Feldman, "The entire process is one of pondering the possibilities and letting our spirits find new, fun, meaningful, sensuous ways of expression. Everyone leaves the ritual feeling renewed, not just the person being honored. The energy generated at these ceremonies is inspiring! We feel as though the Divine Presence has dwelt among us."





Rites of Compassion: Three Days with the Dalai Lama

By R.T. Both

The Buddhist holy man visits Madison to pursue not politics, but transcendence, teaching about Buddhist ritual and practice.

Like most religious traditions, Buddhism makes use of ritual to draw practitioners into the circle of the initiated. However, the emphasis is not on saving the soul of the practitioner but on altering her consciousness. The foundation of Buddhism is not belief in God, but the experience of emptiness, the absolute state of mind beyond relativism and duality. As a Buddhist master once put it, "Liking and disliking are the disease of the mind."

For a Buddhist, to receive teachings is to come into direct contact with this realization. This explains both why Buddhists revere their teachers and why there are so few Buddhists.

In mid-May, two friends and I joined 3,000 people in attendance at the Dane County Expo Center on the outskirts of Madison, Wisconsin, where Tenzin Gyatso, the 14th Dalai Lama, held three days of teachings. The Dalai Lama did not give a speech about world peace or why the Chinese should free Tibet. Rather, his visit — to a city where his lineage monks have established a teaching center, the area with the highest concentration of his followers in the United States — served a spiritual purpose.

The world knows the Dalai Lama as both a political leader — albeit one who represents a distinct set of values — and as a media figure whose life has been portrayed in such popular films as *Seven Years in Tibet* and Martin Scorsese's *Kundun*. He is the regular subject of news reports about his exile by the Chinese dictators who now rule Tibet and have outlawed religious practice there, jailing and torturing monks and nuns. Recent reports have highlighted conflicts within the Tibetan exile community and the broader Tibetan Buddhist community.

Our purpose was to experience the Dalai Lama as a teacher and to participate with him in some of the rituals that are common to all lineages of the practice. The gestures themselves are simple, but to perform them in the presence of a great teacher is to be moved to a new level of awareness.

Like a layer of fresh asphalt on the highway of consciousness, the Dalai Lama's teaching in Madison defined the principles basic to the Tibetan tradition and distinguished it from the Zen Buddhist path, which has long been more widely known in the West. Zen emphasizes the cessation of all thought to induce instantaneous awakening. In Tibetan Buddhism, thought is an essential instrument for developing compassion, the mind of awakening, and wisdom. The Dalai Lama defined the Buddhist concept of

consciousness that is not defined by the neurons. "I accept my condition and the fact that it will eventually lead to total disability," he says, almost matter-of-factly. "But I'd like to change that thought."

Perhaps Western medicine will never be able to incorporate Buddhist notions of compassion, and perhaps it shouldn't. In the Buddhist way of looking at the world, suffering is never "cured" and can only be eliminated, in all its many forms, by realization.

Behind the Dalai Lama on the dais hung three tangkhas representing Avalokiteshvara, the Buddha of Compassion. Tangkhas, intricate paintings on canvases of silk, are a Tibetan form of sacred art. But these paintings are not meant to be mere representations of enlightened beings. Tangkhas are intended to alter con-

The practice of ritual does not, in itself, imply good or useful behavior toward oneself or society. Ritual is a pervasive form of human conditioning, whether demonstrated by the deep bonding of military hazing or the primitive assertions of racial identity paraded by Northern Ireland's Orange Men, the Aryan Nation, or the Ku Klux Klan.

"mindfulness" as "maintenance of an ethically disciplined way of life (which) guards one from falling into negative or destructive actions."

Compassion, as both a practice and an emotion, is fundamental to Tibetan Buddhism. The focus is not simply on altering one's internal feeling states but on living the philosophy that regards all people as equals by freeing oneself from both clinging to close ones and rejection of enemies.

The Dalai Lama defined compassion as that which "inspires others to be free of suffering." One of the friends accompanying me to Madison suffers from a deteriorating form of MS. While Western medicine has failed to find a cure, or even a profile for his disease, he doesn't turn to Buddhism for a solution so much as for an experience of wholeness that is not centered in the body and an experience of con-

sciousness. One of the unique features of Tibetan Buddhism is its emphasis on visualization, or guided imagery. The Dalai Lama taught that when we visualize an enlightened being, our mind becomes that being. This is not meant to suggest that we assume another identity, but that Buddhas are representative of states of consciousness that exist within all of us, regardless of our physical or mental health. Visualization requires an act of devotion, an outpouring of energy. Compassion is an emotion, the Dalai Lama taught, that can be activated and practiced. "We are not paying enough attention to the development of the heart, compared to the amount of attention we pay to the development of the brain," he said.

On the third day of the teachings, the formal rituals were performed. The

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In Vitro: A Whites-Only Therapy, But Everyone Pays (through the Nose) for It

By Dorothy Roberts

A noted law professor responds to Christine Gudorf's take on the McCaughey Septuplets ("Gifts of God after All") in the last issue of the *Bulletin*.

Christine Gudorf's thoughtful essay on the McCaughey septuplets (*Bulletin* No. 4, May/June) focuses on ethical questions concerning God's will and individuals' moral responsibility for the reproductive choices they make. This focus reflects a common approach to reproduction. Reproductive rights are often framed as a matter of individual autonomy and freedom from government interference in personal procreative decision making. For most Americans, reproductive freedom means the right to choose. Discussion about the ethics of reproduction tends to center on the morality of the choices people make.

I take a different approach to the controversy surrounding the McCaughey septuplets and to the ethics of reproductive decision making in general. While Gudorf explores the personal desires and emotions entailed in childbearing, I am concerned about the wisdom and fairness of social policies that regulate childbearing. The ethics of reproduction are more a question of social responsibility than individual moral culpability. I do not deny the importance of autonomy over one's own reproductive life or the obligation of each individual to make ethical decisions about his or her body. But people make these decisions in the context of their social circumstances, and reproductive policy affects the status of entire groups within our society. For me, reproductive freedom is a matter of social justice, not just individual choice.

If we focus too intently on whether or not the McCaugheys made the right decision when they chose to have seven more children, we miss far more critical issues raised by reproduction-assisting technologies. We should not be asking whether the McCaugheys

contravened a moral consensus but what a moral social policy regarding fertility enhancement would be. At present, there are disturbing race and class disparities in policies concerning childbearing. The current consensus on the use of reproductive technologies appears to treat white middle-class couples and poor minority families in stark contrast. The fertility business serves primarily white people even though blacks have a higher infertility rate. White women seeking treatment for fertility problems are twice as likely as black women to use high-tech treatments, such as in vitro fertilization (IVF). Many black Americans were troubled by the celebration accompanying the birth of the McCaughey children, who are white, when compared with the media's disregard of a black couple in Washington, D.C., who conceived six babies (without medical intervention) at about the same time.

The cost of high-tech procedures places them out of the reach of most Americans. The median cost of one IVF cycle is approximately \$8,000; because success rates are low, many patients make several tries before having a baby or giving up. Using donor eggs raises the price still higher — \$10,000 to \$20,000 for each attempt. Most medical insurance plans do not cover IVF, nor is it included in Medicaid benefits. Indeed, state lawmakers have begun eliminating any existing state subsidies for fertility treatment for the poor. The current political climate is quite hostile to the notion of helping poor women, especially women of color, have additional children. Treating infertility at public expense conflicts with popular policies designed to reduce the numbers of children born to mothers on welfare. At least 20 states have recently passed child exclusion laws, or "family caps," that deny additional benefits for children born or conceived while the mother is receiving public assistance.

We do not need to question individuals' reasons for using reproduction-

assisting technologies in order to question the societal impact of these disparities. We should think carefully about a system that channels millions of dollars each year into the fertility business instead of spending similar amounts on programs that would provide more extensive benefits to infertile people. Researchers are already concerned about the social costs and benefits of IVF. Covering the cost of expensive high-tech procedures means raising the price of insurance for everyone. The Massachusetts Association of Health Maintenance Organizations, for example, says that its members pay \$40 million more in premiums to cover infertility treatment for 2,000 couples. A study recently reported in *The New England Journal of Medicine* calculated the real cost of IVF at approximately \$67,000 to \$114,000 per successful delivery. For older couples with more complicated conditions, the cost rose to \$800,000. One reason these figures are so astronomical is that IVF entails the high incidence of risky multiple births, like the McCaughey septuplets, that require extremely expensive neonatal care.

Can we justify devoting such exorbitant sums to risky, nontherapeutic procedures when so many Americans' basic health needs go unmet? How will we address the pernicious message sent by a fertility business that caters primarily to affluent white couples while welfare policy discourages childbearing by mothers who are poor and disproportionately black? Research designed to reduce infertility and policies that increase access to general health care would help a far broader range of people. As for God's will, I believe it is for human beings to strive for social justice here on earth.



Dorothy Roberts, who will join the faculty of Northwestern University School of Law this fall, is the author of *Killing the Black Body: Race, Reproduction and the Meaning of Liberty* (Pantheon, 1997).



Ritual Practice and End-of-Life Care

A Park Ridge Center project reveals the need for ritual to aid the dying

By Laurence J. O'Connell

Caring at the end of life has been a central concern at the Park Ridge Center for several years. We have been deeply involved in furthering the cause of dying well with activities that run the gamut from intimate patient care to public policy initiatives. In 1996, we began to investigate ritual as a realm of human experience that responds to the most intensely felt needs of dying persons, their families, and caregivers. A year later, with a grant from the Robert Wood Johnson Foundation, we brought together a diverse group of practitioners and theorists to explore rituals at the end of life. Although our investigation sought to achieve a number of objectives, we concentrated on rituals surrounding the process of dying in institutional settings. Our modest goal was to map the key issues for future exploration rather than beat a fast track to resolving them superficially.

authentic needs and sometimes supported one another, at other times they clashed and undercut all hope of achieving the best outcome, i.e., a better death for the patient.

To learn more about the in-depth character of these ritualization processes and what evoked them in the context of institutionalized dying, we asked a series of leading questions. For example, how can rituals that spring from different yet legitimate needs serve a single interest like dying well? How, for instance, might medical, cultural, and religious rituals explicitly complement one another? Can they be more clearly identified, carefully orchestrated, and strategically deployed to improve the care of the dying? What can assist participants in appreciating the need for and meaning of each other's ritual practices as part of dying? Might new rituals be elaborated

circumstances, a certain dignity should attach to the passing of a human being. Ritualization provides both the framework and the means for adding a note of dignity to the dying process. Ritualization is, according to Bell, "a strategic way of acting in specific social situations." The often emotionally charged and socially complex dying process invites and indeed seems to naturally evoke the human tendency to cope through ritualization.

Currently, major initiatives are under way to improve the care of the dying in America. Human and financial resources are being marshaled at an unprecedented pace to transform the culture of dying. Important institutions (e.g., the Robert Wood Johnson Foundation through its *Last Acts Initiative*) and influential individuals (e.g., Mr. George Soros through his *Project on Death in America*), as well as some insightful policy makers (e.g., Senators Rockefeller and Collins, sponsors of the *Advance Planning and Compassionate Care Act*), have decided we need "strategic ways of acting" and intervening as the process of dying unfolds. Ritual theory and ritual practice bear special relevance to these initiatives. Exploring and exploiting ritualization as an important source for the stratagems we need will enhance our chances of ameliorating the sting of death in America.

The Park Ridge Center is committed to the design and implementation of research projects and educational initiatives that highlight the importance of ritual in the provision of care at the end of life. We are developing practical tools that will illustrate the inherent power of ritual to contribute to a better, more humanly fulfilling death. We are convinced that a deeper appreciation of ritual practice will lead to important changes in end-of-life care. Ritual celebration can and will, if appropriately acknowledged and nurtured, transform the experience of death for patients and those who attend them.



Physicians tended to engage in rituals of medical practice to control the clinical environment, while families drew upon their own religious and/or cultural rituals to find meaning.

Earlier research, as well as the experience of our clinical consulting staff, supported our guiding assumption: Various forms of ritual activity come into play as the dying process unfolds. In our work, we had observed that as someone approaches death in the acute-care setting, a wide range of actors directs and participates in multiple rituals. We had already noted that the beginning and end of these rituals as well as the movement of different actors in and out of them were hard to mark. Further, it had become apparent to us that these actors did not usually have consistent intentions, uniform agendas, or a shared understanding of the rituals as they unfolded. For example, physicians tended to engage in rituals of medical practice to control the clinical environment, while families drew upon their own religious and/or cultural rituals to find meaning and practical guidance in the face of impending death. Although these rituals generally met

to meet the various needs of patient, family, and practitioner in the institutional setting? Disclosing the potential contribution of ritual practice to end-of-life care, we concluded, will depend on answering these and many other questions.

Catherine Bell, a professor at Santa Clara University, served as an important resource in our discussions. In her insightful analysis of ritual activity, *Ritual Theory, Ritual Practice* (Oxford University Press, 1992), she manages to almost effortlessly guide the imagination of anyone interested in the place of ritual in end-of-life care. Her description of ritualization as "a way of acting that is designed and orchestrated to distinguish and privilege what is being done in comparison to other, usually more quotidian activities" is strikingly relevant, although dying, despite being part and parcel of the human condition, is hardly a quotidian pastime. No matter what the

Life in Balance

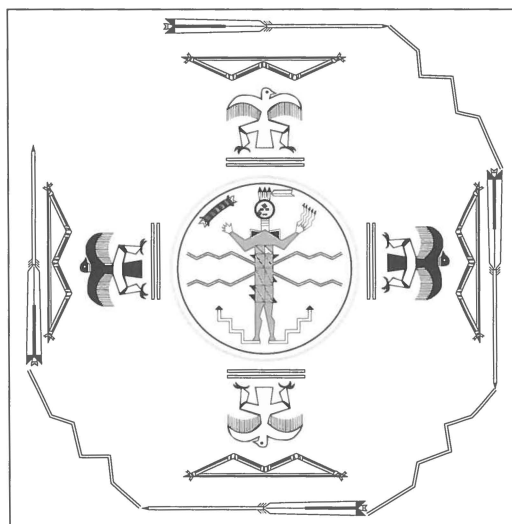
Navajos seek healing in both western medicine and native traditions

By Madelyn Iris

Contemporary Native American nations like the Navajo (*Dine'é*) are often looked upon as models of ritual practice. In a world of rapid shifts in economic, social, and political systems, ritual practices remain one of the most stabilizing forces in contemporary Native American life. The contemporary Navajo example demonstrates how traditional philosophy and ritual can be reinterpreted to accommodate a changing world.

The Navajo Nation is one of the largest Native American nations in the United States, with an estimated population of more than 150,000. The *Dinétah* (Navajo homeland) lies between four sacred mountains in the Four Corners area of the Southwest, occupying an area slightly larger than West Virginia. Today, many Navajos live "off-reservation" in border towns such as Gallup or Farmington, New Mexico, or in Phoenix, Albuquerque, Los Angeles, or any other urban or rural area of the U.S. Navajo people themselves recognize many regional differences in language and culture as they move from one area of the Nation to another.

The many complex Navajo healing ceremonies or "ways" (as in the Nightway or the Enemyway) use songs, chants, sand paintings, sacred objects, and dance to recreate or enact stories and events that link ceremonial participants to their sacred origins. The ceremonies link the patient, the *hataali* (singer), and all the participants to the *diyin Dine'é*, the holy people, and to the sacred past, before man emerged on the earth. The songs and chants retell important events and stories of Navajo creation. Sacred bundles, called *jish*, contain objects that derive their value from their connection to that same sacred past. Sand paintings, perhaps the best known of all the ritual practices, incorporate symbols that also link the creator and the patient to specific people or objects associated



Navajo sand painting — *The Slayer of Alien Gods*

with the mythological origins of the *diyin Dine'é*.

The *hatáál* (also called "sings") are often described as healing ceremonies that blend public and private rituals into a coherent whole. They have long been viewed as representing the intersection of religion and health or traditional medical practices. But the *hatáál* are not primarily a source of healing in the physical sense. The cost and time involved in carrying out a full ceremony or sing can be great and would not be warranted for the common cold. Instead, one might seek a remedy from an herbalist. If the illness were persistent or severe, one would first seek out a traditional diagnostician, such as a star gazer or a hand trembler, for a diagnosis of the cause of the illness and direction on what type of *hatáál* should be performed. Then a *hataali* known to be an expert in that ceremony would be engaged. Since the *hatáál* are seasonally prescribed and require a great deal of preparation, months might elapse before the ceremony could actually be performed.

Many Navajos today continue to

Italicized words are as close to Navajo spelling as possible within our technical limitations.

seek healing through sings. However, it is now most common for a Navajo to pursue numerous options, sometimes simultaneously. One Navajo woman, pseudonymously named "Mrs. Brown" when studied by Vijay Singh, visited a diagnostician, traveled to an Indian Health Service clinic to see the doctor, have lab work done, and receive a prescription. She also sought out a *hataali* to have some chants performed, or, if possible, a full-blown multiday ceremonial. She was visited by a Roadman from the Native American Church. She also visited the Catholic Church to pray for healing and seek counsel from the priest. Today, Navajo ritual practice and ceremonialism is highly syncretic.

There have been many efforts to incorporate Navajo healing ceremonies and rituals into the practice of western medicine. In *The People's Health: Anthropology and Medicine in a Navajo Community*, Adair, Deuschle, and Barnett (1988) describe the Navajo-Cornell Field Health Project, a collaborative effort to create a true cross-cultural health delivery system. During the 1970s, the Navajo Health Authority (the official health department of the Navajo government) created a school for *hataalii*, to train them to work with Western physicians and to enable them to carry their rituals and ceremonies into the Western health setting. While the clinic established by the Navajo-Cornell Field Health Project has closed and the school for medicine men failed to achieve its goals, opportunities for the incorporation of Navajo healing ceremonies into Western medical settings do exist, although on an ad hoc basis. Today it is not unusual for a Navajo healer to perform some piece of a healing ceremony in the clinical setting, and many Navajo people are engaged as

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DALAI LAMA

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members of the audience took bodhisattva vows, dedicating ourselves to continuing to practice the dharma until the enlightenment of all sentient beings. The monks who surrounded the Dalai Lama on the dais brought out the yellow hat that is the sign of their order, the gelugpas. Bells rang. Visualizations were called forth and prayers recited. Mantras were said. We were given white envelopes containing ritual objects — a dried lotus petal, an orange string to be tied around the neck or wrist as a symbol of having received empowerment.

The practice of ritual does not, in itself, imply good or useful behavior toward oneself or society. Ritual is a pervasive form of human conditioning, whether demonstrated by the deep bonding of military hazing or the primitive assertions of racial identity paraded by Northern Ireland's Orange Men, the Aryan Nation, or the Ku Klux Klan. The mere absence of ritual can convey unbearable scorn, like the burning of Pol Pot's body on a pile of garbage.

In Madison, the rituals we participated in with the Dalai Lama reinforced our experience of ourselves as Tibetan Buddhists. The subtle transformations of the gradual path demand patience and a long-term commitment to practice. As we struggle to maintain our commitment, it is helpful to have the example of a dedicated teacher. In Madison, the Dalai Lama demonstrated his wisdom in his joyful embrace of humility. Despite holding the office of supreme living practitioner, manifestation of Buddhahood, he refused to lay claim to the realization of emptiness, the ultimate reality that is at the core of all Buddhist teaching. "I am not even on the path," he said through his translator. "Maybe I'm at a point where I can just about see where the beginning of the path lies."

The Dalai Lama's acceptance of himself and all of us was a demonstration of the dignity that Buddhism confers on all who suffer. It implies freedom from the pride and arrogance that arise out of the need to make distinctions: between well and sick, rich and poor, ugly and beautiful. Within the powerful embrace of Buddhist compassion is the experience of being made whole.



PAMELA SANKAR

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informed consent procedure to make people aware of the risks.

Much of what has gone on in the last three decades has been making policy and then figuring out how to impose that on physician researchers who are extremely autonomous beings. For research subjects, the Federal Office for Protection from Research Risk has attempted to impose a standardization of policies and procedures. The research institute has to absorb the rules. But once physician-researchers get approval from the Institutional Review Board (IRB), no mechanism is in place to check up on them.

How did you become interested in the issue?

By and large, the informed consent process works. But I'm interested in the subtle ways in which it doesn't. There hasn't been a lot of research where people actually watch the consent session. When I sat in on one, I thought, That's really interesting. On a certain level they did it right. But I implicitly felt that the patient didn't understand what they were doing. What physicians will say, though, is, "I did my best, but I can't bridge this communication gap."

How does the concept of "ritualization" apply to informed consent?

Ritualization is a resource that all of us use at various points in our lives. It's a kind of communicative behavior that people learn over time and take on as a resource. In my paper, I use the example of the Thanksgiving dinner and how it's set apart from a normal meal by being served on special plates. This both distinguishes and privileges the event and the values that it implies. Researchers highlight consent sessions to privilege what happens there. But the researchers are really in control of the situation. They have much more equanimity at such times and that allows them to figure out the best strategies. They have a need or a desire, and implicitly or unconsciously they think about the best way to fulfill it. They draw on ritualization as a resource.

Is this the result of intentional obfuscation on the part of researchers?

I don't really think it is. As a group, they're no different from other citizens. I believe they're being earnest. I don't think they think they're tricking people when they say they're giving adequate information. But when you're dealing with terminally ill people, you have a particularly vulnerable group.

How should informed consent be handled?

I think there should be changes, but so far even implementing small reforms has been an enormous struggle. The next step is going to take a long time. It will probably involve strengthening of IRB oversight and monitoring or evaluation of consent procedures. But to get physician-researchers to agree to that is going to be very difficult. The system cultivates a certain kind of person to become a physician-researcher. They have immense autonomy. They want to control their own domain. They tend to agree to regulations because they don't have much choice. Many think it's a good idea that patients should understand, but they don't place a lot of value on outside review.

If there are changes in informed consent, will it put an end to certain kinds of research?

An important counterbalance to what I've said is that there is a subgroup of patients out there who know they are dying and want their deaths to be meaningful, and so they do become research subjects, but this tends to gloss over patients who agree to be subjects when that's not the case. You have to be extremely clear about what options patients have. One of the federal rules of informed consent is that you must outline alternatives to the patient. What researchers usually say is, "You can do my protocol or you can do protocol B." What they don't say is, "You could go home, go to hospice, be with your family." That's the part that never gets added in.



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disease, analyze its cause, eradicate that cause, and thus bring an end to the pain. For weeks, the patient in our story had been virtually obsessed with locating the cause of his suffering. He faulted his doctors because they could neither tell him what it was nor prescribe a remedy.

The search for offending causes is a rational way of thinking and has led, as we know, to an enormous array of cures. But it compounds the problem of suffering. This is where ritual wants — needs — to come in.

Among the many functions of ritual, the one I focus upon here is its turning of the sufferer into the actor — that is, into an active agent. Rituals vary in the degree to which they do this. There are occasions, and also traditions, in which the performers of ritual (priests, liturgical leaders) are few, while the more or less passive attendees, including the ill who seek healing, are many. But this is a late development in ritual, stemming from a certain professionalization that is analogous to, and sometimes actually part of, the professionalization of the medical arts. In principle, it may be argued, there are no spectators at ritual, for ritual is not, in the first instance, something to watch or listen to but something to perform.

The impulse to make ritual is the impulse to become actively involved in a process transcending one's rational comprehension. This is what is meant by calling ritual a kind of "magic." In the beginning, there is nothing irrational or superstitious about such an impulse or such a practice. It is a way of participating actively in something that one is already involved in but cannot well understand. It is a means of linking the known and the unknown in the mystery of the self's own willing participation. It is an embrace between the mystery beyond and the mystery within, brought about not in theory but in practical activity.

This view of ritual is pragmatic and hands-on. It is not antiprofessional but counterprofessional, since it advocates ritual making as a do-it-yourself activity. I have much respect for the medical profession, which has more than once come to my rescue. Moreover, I am myself a professional religious leader, being both a clergyman and a theologian. Nonetheless, I know the truth of

the words George Bernard Shaw put into the mouth of a character in *The Doctor's Dilemma*: "All professions are a conspiracy against the laity." To counter this, we should encourage ritual as a means to empower the sufferer.

In such empowerment, the professional, whether of the medical or the clerical kind, has an important role to play, a role perhaps more like that of a physical therapist than a surgeon or a drug therapy specialist. It is the work of showing the patient, who is really a learner, what she is able to do for herself. The patient needs to learn a practice of heightened attention to, and willing participation in, the mysterious process of pain and restoration, of death

and life, that is going on within her, through her, and by her, in this place at this time in this way.

The first thing to know about ritual is that it is a way of calling ourselves to a radical affirmation of the here and now. Pain and all. The business of ritual is to unify. That is why tears are sometimes effective: They are the first outcry of empathy and as such are a primitive form of ritual.



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NAVAJO

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community health representatives, nurses, and interpreters, among others, in the health delivery system on the Navajo Nation. Although there are few Navajo physicians, the Indian Health Service has developed a sensitivity to Navajo ritual and healing practice.

When I arrived at the Navajo Nation (then called the Navajo Indian Reservation) in the summer of 1972, one of my first experiences was to attend a house blessing ceremony. At the time, I had only an academic knowledge of the Navajo language (that is, I couldn't understand a word of spoken Navajo), and my knowledge of the culture consisted only of what I had read in books, some of which were very old. It was kind of my hosts to invite me to the house blessing, and I went eagerly. Something of a crowd had gathered, but what I best remember is the seeming disorganization, the apparent lack of interest on the part of most of the guests, and the meal that followed (mutton stew, cooked in a brand new 20-gallon garbage can, along with Navajo fry bread). I couldn't figure out what was going on. This ritual occasion was, in many ways, typical of Navajo ceremonials and ritual practices: lots of things happening at once, a sense of timelessness in that only a few people seemed engaged in the proceedings at any one point, a lack of concern for the passing hours, and my own impression that a main objective of attending was to socialize and share a meal.

I later learned that what I had observed was the recitation of House Blessing Songs from the Blessingway ceremony. John Farella describes the Blessingway (*hózhóóji*) as the main "stem" from which all other ceremonies branch out. According to Gary Witherspoon, the prefix *hózhó* denotes the holistic aspect of the environment, the world, or the universe. He writes, "It is beauty, harmony, good, happiness, and everything that is positive." *Hózhó*, like the *hózhóóji* that enacts it, encompasses one of the most important concepts in Navajo life. Navajos employ multiple pathways to *hózhó*, through restoration of harmony, well-being, and thus health, both physical and mental. James McNeley believes that the purpose of ritual may be to create *hózhó* in the individual and in the world.

Today, traditional Navajo ceremonials and rituals occur with less frequency than in the past. The *hataalii* are growing old and fewer and fewer young men (or women) are disposed to engage in the many years of apprenticeship required to become a competent *hataalii*. The future of the *hataál* is of great concern, as is the desire to preserve such sacred knowledge for the *Diné'é*. However, ritual remains a vibrant part of the fabric of Navajo life. As a people, the Navajo are deeply interested and committed to seeing that their unique worldview, beliefs, and practices continue to thrive and become important sources of strength for their children.





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The Park Ridge Center

Bulletin

The Park Ridge Center *Bulletin*
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Ritual in Sports, Sports as Ritual

Ritual is everywhere, even in some of America's favorite pastimes

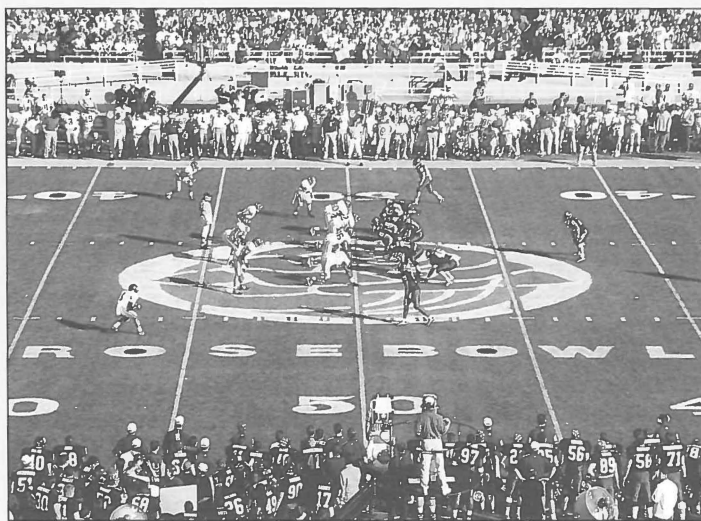
By Martin E. Marty

People who watch an athletic contest, be it Little League or the Super Bowl, may think of themselves as just plain enjoying sports. They can cheer or boo, drink beer or soda, laugh or cry, bet or care little, and let it go at that. Anthropologists, sociologists, liturgiologists, and all the other -ists who study human behavior, however, will not let them go it alone, unobserved. Seldom, say such scholars, do people show themselves more involved with ritual than at sporting events.

The formally religious among the players or crowds may think of themselves as engaging in ritual only at Passover rites, on their *hajj* to Mecca, at Mass, or at their daughter's wedding. But students of the ways of mortals often see more passion, more disclosure of meanings, and more revealing teases about ultimate reality when the same folk participate in or observe sports.

Looking for ritual in sports and for sports as ritual is an attempt to learn much about both ritual and sports. Athletic doings need rules of the game, and so do we. At the moment, the rules require that we define *ritual*. And we find that there are more definitions of

We're not dealing with tics and quirks but with planned and ordered behavior. Boxers are out to "kill" each other with in three-minute rounds but are penalized for any punching before or after the



rounds. They know what they're doing, at least until they're beaten senseless.

"Voluntary"? No problem. One chooses to be on the team and to enter the arena for contact sports, in which one is likely to feel pain and may get maimed. Ritually crashing onto the field in a row of helmeted warriors makes possible a readiness for both sacrifice and an experience of glory beyond the bounds one normally sets or gets.

Athletics point to ways the world is arranged. More and more the erotic element in sports is being reexplored; we use ritual to routinize and celebrate the way sex fits into the framework of the universe.

ritual than there are scholars and rites, since each onlooker may bring several inquiries to mind in various circumstances. But — and I am here listening to Evan M. Zuesse — we can understand "as 'ritual' those conscious and voluntary, repetitious and stylized symbolic bodily actions that are centered on cosmic structures and/or sacred presences."

"Conscious"? That's no problem.

reach for the wrong part of the anatomy, and they will be put on trial. Sports legitimates some stylized gestures only.

"Symbolic"? Yes, in most contests ordinary actions point to extraordinary meanings. A National Hockey League player in Canada was once killed on the ice. The rites and ceremonies of the skating teammate acolytes were as intricate and fraught with meaning as a papal coronation or a monarch's last rites. There could be no closure otherwise.

"Bodily"? Indeed, that is what sports are all, or almost all, about. Ritual provides boundaries for bodily action and legitimates what would normally be out of bounds.

That leaves only the centering on "sacred presences" and/or "cosmic structures." One does not have to be a social scientist to see athletes as superhuman icons, sports heroes as idols, and Hall of Famers in any sport as a kind of posthumously invoked "communion of saints."

"Cosmic structures": Athletics point to ways the world is arranged. More and more the erotic element in sports is being reexplored; we use ritual to routinize and celebrate the way sex fits into the framework of the universe. Sports involve sacrifice, of energy and limb; who sacrifices without ritual? Losers and flubbers experience shame. Ritual helps one cope with disgrace. Violence? Yes, or haven't you noticed how integral it is in its many forms, from cerebral in the warfare called chess to physical in contact, now called collision, sports?

When one consults the 16-volume *Encyclopedia of Religion*, sports and athletics will turn up marginally. It seems a bit cute and precious to say that sports are religion. But bring up ritual, the cosmos, and the sacred — all of them at the edge of religion or standing behind it — and sports will receive privileged attention. Or, at least, they should.



"Repetitious"? Put on ritual-seeking spectacles and you will soon have trouble seeing the nonritual in sports. Children are schooled in repeated activities, whether in the game or cheering and cheerleading. Just listen to their coaches and to them.

"Stylized"? Let men pat each other's rumps in skintight trousers anywhere else as they do after a football play and you will see them stigmatized. Let them

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