as motor vehicle crashes and injuries, was also seen as a secondary result of the earthquake. Maternal care and neonatal care, especially the latter, represented a substantial portion of the activity in the field hospitals, since so many displaced people were living in tents without adequate heat and water. Psychological trauma from the earthquake was common, often compounding underlying illness and injury. Every single person in Bam suffered devastating loss. Many people lost their entire families, and many children were orphaned.

Disasters follow no rules. The spectrum of threats ranges from natural and man-made disasters (including terrorism) to chemical, biologic, and nuclear weapons of mass destruction. All disasters, regardless of their cause, have similar medical and public health consequences. A consistent medical approach to disasters, based on an understanding of their common features and the response expertise they require, is becoming the accepted practice throughout the world. This strategy, called the mass-casualty-incident response, permits teams from various countries to work together to meet disaster-related needs, despite language and cultural barriers.\(^1\)\(^2\)

The mass-casualty-incident response has four critical medical components: search and rescue, triage and initial stabilization, definitive medical care, and evacuation. Today, the risk of complex disasters, particularly the threat of terrorism and weapons of mass destruction, has increased the need for specialty teams to provide these critical elements of disaster response in austere environments throughout the world. The severity and diversity of injuries, in addition to the number of victims, will be a major factor in determining whether a mass-casualty incident overwhelms the local medical and public health infrastructure.

Medical intelligence is an essential part of an international disaster response. Data on endemic and epidemic illnesses are critical, but an understanding of the cultural and social norms is of equal importance in meeting disaster-related needs. The Bam earthquake was unique in the experience of the U.S. team in that the sex of patients was a consideration in the positioning of the tents. Interpreters are critical assets in all international disasters, and often we did not have enough interpreters to cope with all the patients in the tents. Interpreters were assigned specific areas, such as labor and delivery, so that their skills could be used most effectively.

Trained specialists, however well-intentioned, do not by themselves constitute an effective medical team for a response to international disasters. Critical to a successful medical response to a mass-casualty incident such as the Bam earthquake are important nonmedical elements such as communication, safety, sanitation, and security. Designated members of the International Medical Surgical Response Team are trained to provide these important functions for the team and to serve as liaisons with the appropriate authorities on the scene. This capability greatly facilitated the entire response to the earthquake in Bam, from establishing the field hospital to providing patient care.

As health care professionals, we know that the care of patients is a calling that knows no borders. The Iranians we met displayed great courage and dignity in the face of devastating personal loss. We hope that the support they received from the international community will help to begin the process of rebuilding.

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God at the Bedside

Jerome Groopman, M.D.

Not long ago, in the oncology clinic where I work, my patient Anna Angelo asked me to pray to God. At the time, prayer was far from the forefront of my mind. Anna (her name has been changed to maintain confidentiality) is a 71-year-old woman from Boston’s North End with long-standing cardiac and hepatobiliary disease. Six years ago, breast cancer developed. The tumor was incurable from the time...
of diagnosis, since it had already spread to bone. The cancer cells tested positive for estrogen and progesterone receptors, and Anna was treated with a series of hormonal agents, which, over the ensuing years, largely controlled the disease. A devout Catholic, she regularly attended Mass and counted her priest among her closest friends. “God has been good to me,” Anna said at the end of each visit.

Over the previous two months, Anna had been complaining to her internist about loss of appetite and fatigue. He ordered blood tests and then a CAT scan. The cancer had metastasized to her liver. A biopsy showed that the hepatic metastases no longer expressed hormone receptors. When Anna arrived for her appointment with me, she had already been informed of her biopsy results. The first thing she said was that she wanted to live as long as possible but was concerned about the toll of chemotherapy.

I explained that the choice of a treatment plan would not be simple, given her complicating medical problems. Many of the drugs could have serious side effects on her heart and would be metabolized by her liver. So, before recommending a regimen, I would consult with her internist, cardiologist, and gastroenterologist. Anna took in my words and then said, “Doctor, I’m frightened. I pray every day. I want you to pray for me.”

Anna looked squarely at me. It was clear she wanted a response. For a long while, I did not know what to say. A doctor’s words have great power for a patient; they can help to heal, and they can do great harm. The specialty of oncology routinely involves treating people who are in dire circumstances and find themselves facing their own mortality. Many of my patients seek strength and solace in their faith.

None of the training I received in medical school, residency, fellowship, or practice had taught me how to reply to Anna. And although I am religious, I consider my beliefs and prayers a private matter. Should I sidestep Anna’s request, in effect distancing myself from her at a moment of great need? Or should I cross the boundary from the purely professional to the personal and join her in prayer?

Dilemmas like this one have become points of sharp contention in the medical world. How should doctors examine and engage religion in the lives of their patients and in their own lives as clinicians? Is there any place for God at the bedside during rounds?

The United States is a deeply religious country, and several surveys show both that a large majority of patients want physicians to be engaged in their spiritual lives and that the sick believe in miraculous healing when medicine can offer no proven cure. But religious beliefs are not always positive or beneficial. One of my most instructive experiences of the effects of religious belief occurred some three decades ago, when I was a third-year medical student. An Orthodox Jewish woman in her 20s was admitted to the surgical service with a large breast mass. She seemed intelligent and animated, and it made no sense to me that she would have ignored a growth in her breast that was the size of a walnut. In my naiveté, I thought that our shared heritage positioned me to communicate with her in a particularly effective way, and I encouraged her to confide in me the reason why she had let the mass grow so large before seeking a surgeon. It turned out that she had had an affair with her employer, and she saw her tumor as God’s punishment for her sin. There was no hope for her, no reason to continue living, because her death was God’s will.

I was in over my head. I had brashly treaded into theological territory without a clinical compass. Was her confession meant as a call for absolution or a confirmation of her transgression? It was not my place to afford either, and with a mix of confusion and shame, I retreated from her. Later, she shared her secret with the attending surgeon. I never knew what he had said to her that convinced her to be treated. Nor, during my subsequent medical training, was I ever taught how to speak to patients about matters of faith.

Centuries ago, when healers came primarily from the ranks of monks, rabbis, and imams, and when nurses were nuns or members of religious orders, there was no clear divide between biology and acts of God in the genesis of an illness or between the physical and spiritual components of its treatment. In the modern era, religion and science are understood to be sharply divided, the two occupying very different domains. Religion explores the nature of God and offers rituals for implementing God’s will, whereas science eschews any such metaphysics and through experimentation unveils the workings of the material world.

But in the minds of many of our patients, there is no such schism. Religion, perhaps more than any other single force, can sculpt the experience of illness. In America today, religious influence can go beyond concepts embodied in the three Abrahamic
faiths. Some patients and their doctors have turned to Eastern philosophies, seeking to integrate Buddhist, Taoist, and Ayurvedic ideas and practices into clinical care.

Different faiths dictate different forms of behavior, social interactions, and views about how to live and how to die. For this reason, some medical educators have argued that religion is a clinical variable to be considered in every case and that a “spiritual history” should become a regular part of the patient interview. Indeed, such a history may yield key diagnostic clues or guide recommendations about disease prevention and suggest strategies to ensure compliance with treatment. But if this kind of history taking becomes common practice, when, by whom, and how should it be done? At the first visit, or only after a close bond has been formed between patient and doctor? By the medical student, resident, or attending physician? And how would doctors manage the theological fallout?

Many doctors, understandably, are leery of moving outside the strictly clinical and venturing into the spiritual realm. As was clear in the case of the Orthodox woman I met as a student, theologies can sometimes be toxic. Religion can be a wellspring of great strength and comfort or a pool of guilt and pain. If we begin taking a spiritual history, then we risk becoming clinical judges of what we hear. But although doctors should not presume to take on the mantle of the clergy, I believe that they cannot always avoid evaluating whether the personal religious beliefs of their patients are salubrious. Unfortunately, this type of evaluation requires deeper knowledge of different religions and their clinically beneficial and harmful conceptions than most of us possess. Venturing into the spiritual domain also means confronting a patient’s expectations about the outcome of an illness, particularly what it means not to be cured despite faith and prayer. If a patient prays for a medical miracle and it doesn’t occur, does that mean that God doesn’t love her or that she is unworthy because her will and character were too weak to exert the “power of prayer”? Popular culture makes much of the ability of will and faith to miraculously overcome dreaded diseases for which modern medicine has no proven remedies. Rigorous documentation of such widely touted spontaneous remissions is scant, and even in those rare true cases, cause and effect are obscure.

A doctor’s practice can also be influenced, consciously or subconsciously, by his own religious beliefs. Moreover, his own faith, like that of his patients, may be tested by the trauma and travail that he witnesses. I came from a home where faith was strong but not fundamentalist, where belief coexisted with doubt. After spending six weeks on a pediatric oncology ward at a time when most children with cancer died terrible deaths, I was on the verge of losing my faith. Theodicy, the question of why a benevolent God would permit such suffering in the universe, can be brought into sharp focus in the hospital. The intimacy of the physician–patient dialogue could cause this question to emerge. What if Anna had asked me why God had chosen her to suffer? Should a doctor participate in such a dialogue?

Even as we ponder whether or how we should step inside the religious worlds of our patients, we should also ask whether members of the clergy should enter more deeply into our clinical sphere. There is a great imbalance of power between patient and doctor. Often, I have been insensitive to this imbalance and have taken a patient’s silence to represent tacit assent to my recommendations. A member of the clergy can speak to a doctor at eye level and act as an advocate for a patient who may be intimidated by a physician and reluctant to question or oppose his or her advice. A priest, a rabbi, or an imam can help patients to determine which clinical options are in concert with their religious imperatives and can give the physician the language with which to address the patient’s spiritual needs.

Facing Anna, I searched for a response. I reminded myself that whenever I wear that white coat I am a physician and that whatever I say or do should be for the clinical benefit of my patient. I briefly pondered the question of whether prayer was “good for health.” This issue had captured the public’s imagination, but published research on the subject was often preliminary and inconclusive. It was a legitimate and intriguing subject of scientific inquiry, but somehow, at the moment, it seemed remote from what Anna was asking for — a heartfelt answer.

And so, unsure of where to fix the boundary between the professional and the personal, unsure what words were appropriate, I drew on the Talmudic custom of my ancestors and the pedagogical practice of my mentors and answered her question with a question.

“What is the prayer you want?”

“Pray for God to give my doctors wisdom,” Anna said.

To that, I silently echoed, “Amen.”

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