

*The Rabbanim of the Old Yishuv wrote to Rav Samson Raphael Hirsch and Rav Ezriel (Ariel) Hildesheimer in Germany, asking them to send medical help. They turned to Moshe (Morris) Wallach, an observant German Jewish doctor, and asked him to travel to Eretz Yisrael. Dr. Wallach was engaged to a girl from a very wealthy family with an illustrious lineage. When he asked her to accompany him, she refused outright. So he broke off his engagement to her, and she subsequently became engaged to his brother.*

*Dr. Moshe Wallach left Germany for Jerusalem in 1892 at the age of twenty six. He never married, and the residents of the city joked fondly about him, "Three never marry: der galach (a priest), der malach (an angel), un der Doctor Wallach."*

*By day Dr. Wallach ministered to the citizens of Yerushalayim, and by night he went from house to house on a donkey, distributing money and food. He was a "Jack-of-all-trades" doctor; **he took expert care of every part of the body and soul.***

AS HEARD FROM REBBETZIN CHANA MINTSER BY VARDAAH LITTMANN

Glendower : "I can call spirits from the vasty deep."

Hotspur : "Why, so can I, and so can any man. But will they come when you do call for them?"<sup>1</sup>

Shakespeare's "Henry IV"

### **Shakespeare as Shaman**

"Almost all primitive groups are desperately in need of help from 'the other side' all the time." Within more involved historical cultures, that happens only at certain moments of breakdown or crisis.

"The Reformation was such a moment and Shakespeare—no one would doubt it—was open to all the winds that were blowing about him. It may still surprise some readers that he "picked the source-myth of Catholicism for his first long poem," then "picked the source-myth of Puritanism for his second."

"The identification is surely more apt to assist the development of Hughes's exposition than to cast light on the religious troubles of the times or their effect on the poet. Hughes claims that Eliot and Yeats were shamans like Shakespeare, if of a lesser kind, and maybe he has it in mind to reserve a place for himself in this ancient profession.

C H Sisson <sup>2</sup>

<sup>1</sup> Hear also Finnish composer Einojuhani Rautavaara "Incantations," a 2009 concerto for solo percussion and orchestra

<sup>2</sup> Review of Ted Hughes: Shakespeare and the Goddess of Complete Being. Farrar, Straus & Giroux,



Henry Fuseli's painting of Hotspur, Glendower, Mortimer and Worcester

In Shakespeare's *Henry IV, Part I*, there is a scene in which two ill-assorted men, the vainglorious Glendower and Henry Percy, aka Hotspur, meet in Bangor. They are there to form a military alliance - and it will prove an ill-fated one. The scene is haunting (Hotspur has not long to live), yet it is wonderfully funny. During the course of it, Glendower, who has a reputation as a wizard, boasts of his magical powers to a sceptical Hotspur. "I can call spirits from the vasty deep," Glendower declares. "Why, so can I, or so can any man," Hotspur dryly replies, "But will they come when you do call for them?" This question haunts each physician as he faces the inner workings and pathology of his patients. The diagnostic dilemmas have been made so much easier with the use of modern innovation but in many cases the cure remains as illusive as calling the "spirits from the deep".

All is not right. Despite modernity, and all its bells, whistles and computerized medicine, robotics and now functional MRI, the patient is not happy. Even using technological wizardry patients feel disconnected from the "healing physician" model and see the clinicians as technicians who report back on the status of the patient's indices such as blood work X ray reports and other diagnostic tools. All for the sake of the "diagnosis" that label that holds the promise of cure. But cure remains elusive in many cases. The "spirits from the deep" are no longer even summoned.

Modern medicine with all its marvels and technology has done wonders in the field of acute medicine but remains elusive in one huge area. Patients suffering from chronic illness such as neurological and degenerative disorders must endure the chronicity of symptoms and prolonged disability with out the hope of cure. Medicine has its limits and we sometimes forget this in our white coats and in our professional societies that have come to own the legal license to practice exclusively. The "spirits from the deep" may have been summoned but they will not come when this type of physician calls. How do we strip away the social role of physician with its legal ramifications and "scope of practice" guidelines from the very human interface between doctor and patient?

The old style physician who dealt with patients facing illness with little in his armament to show for, had to dig deep into his personal human skills to make up for the lack of his clinical efficacy. Much like the shaman in ancient civilizations, he had mysterious powers we glibly describe as "bedside manner" to make up for the absence of knowledge. The shaman well knows the power of the "deep" to heal, or forces from the "other side"; those forces that wish to destroy, and knows how difficult the struggle is. Similarly in chronic incurable disease modern physicians must once again learn to tap into the need to face the unknown and the mystery, the need to manage rather cure disease and disability. Most physicians often "know" ahead of time the outcomes and severity of the disease but are all too willing to wait and rely solely upon the diagnostic test results so as to provide incontrovertible evidence for this diagnostic label or that. We have come to hide behind technology for many reasons. (least of all the fear of the modern "deep" - malpractice). This very fact has altered our perception as healers and transformed us into glorified technicians reporting the results of this or that test to our patient with the cookbook recipe for therapy following on its heels thereafter.

For those of us who care for patients with incurable disease, chronic degenerative disease and those with chronic pain, we painfully have come to realize there are no quick fixes and no magical pills towards cure. The diagnostic tests do not lead to reachable end goals but merely confirm and document the decline or worse, point us in the wrong direction therapeutically than our clinical judgement would suggest.

How do we approach our patients differently? What should we in fact be providing? Where did we go wrong? Why do many patients fear the machines and diagnostic work ups that inevitably take their own toll in terms of iatrogenic diseases, unwelcome side effects, as well as poorly defined outcome strategies.

I worry about this question each time a patient walks in the door with an expectant and hopeful gaze, wishing that this physician will be the key to curing his or her illness. I worried so often that I would be unable to fulfill his or her expectations, that somehow they would leave disappointed. Over the years, however, I have come to realize that my task is as much to educate the patient about their illness as to intervene in some therapeutic manner. That this education *was* therapeutic. In incurable diseases small steps become important in the face of untreatable global cures. In re-educating patients we have to first modify expectation of "Dr Kildare type" cures, and then provide empowerment to our patients so that they can make better and more informed decisions regarding their health care. I give my patients the risks and benefits of doing this or that test and the side effects and detrimental possibilities of this or that drug ahead of time so that they are fully apprised and can make informed decisions. Education also means attending to the spirit.

In neurology and in chronic pain management the single biggest challenge is to be honest about what we as physicians can provide in terms of long term care and cure. An empowered patient is educated about his or her illness and struggles alongside me in determining best course of action. I am then doing my best job when I am providing the information in a way that allows my patient to make fuller decisions about themselves without fear. Fully armed with information most patients do make reasonable medical strategic choices.

Attending next to the spirit means a different type of teaching, less didactic and more sharing. In my interaction with my patients my educational role remains to help my patients to **endure**, to teach them how to "suffer well", because suffer they must. Often their complaints center around the issue of functionality, the things they used to be able to do and tasks they used to be able to perform they can no longer do. My role then is to try to situate their pain and illness in the biography of their lives and to assist them into the transition from ability to disability. This means widening the context and vision of their lives. It means contextualisation.

Only last week an 86 year old woman, racked with pain, cried, not because of the physical pain, rather the gardening she could no longer do. She watches the untended beds of roses and cries each morning. I took her fragile tender hands in mine and cried with her, saying, "you realize this is about your suffering" "I am here to teach you and

urge you to suffer well!" "I want you to suffer with grace as you enter these fragile sunset years". "It's a it like dying isn't it!" Then she calmed down and agreed the issue was not the rose garden but her anticipatory grief, of a lived life that was soon to end. I am unsure whether I calmed fears, but I did plant a seed of acceptance in her soul. I wanted her to see *even* this insight somehow as a gift, this fragility and disability as a slow dying that has begun, and the gift of time to ponder and accept the dying process that may take more time with progressive infirmity.

In this teaching I am no longer a physician in a white coat, for that divides us both in our roles of doctor and patient. I am now a fellow journeyer on life's incredible process of growth and decay. This wonderful life slowly winds down in many ways including infirmity and illness and, besides the injections and drugs we give to alleviate pain, the other side of illness, the human dimension of pain and suffering, the anguish of disability must also be addressed. Often it reveals a different source for the trigger.

As a fellow human being I reach across the divide between healthy and infirm to give counsel and hope through the acceptance of life and death as it is lived and experienced, despite the pain and suffering and even because of it. Through my own traumas, physically, emotionally and in life's experience I can relate fully to my patient. Through my own caring of parents and in-laws I too can understand what the elderly are going through in the frustrations and disappointments of daily life and family issues that arise.

My role then is to make room for their suffering in my own. To make a safe space by which they can enumerate and articulate their pain and a space where I can hold their suffering in empathy and care. In this role we both share life and its vicissitudes fully, together and in that space. Here there is no curing rather "healing". Healing is my ability to make sufficient space in their soul to hold their own suffering better. And unfortunately these days I find anxiety and depression as a trigger substrate in greater incidence than ever before in my career. Rarely do I ever have a woman under 30 with children in a traditional nuclear family, married. Most are single and struggling on the poverty line which magnifies their physical pain. Rarely do I encounter chronic pain syndromes without some element of trauma and abuse in the past history. I am not a practicing psychiatrist yet one can no longer ignore these factors when dealing with pain and disability and merely hand out a vicodin.

The issue of shame is another deep and enduring factor that colors my patient's pain perception levels. Deep shame goes back so far into childhood<sup>3</sup> and is another factor in people's inability to hold their suffering and pain well. Shame extends to older folks who do not wish to be a burden on their children and hide their pain to avoid such dependence. I define anguish as emotional pain; extreme pain or misery; mental or physical torture; or extreme distress of body or mind. It is a terribly distressing symptom, especially in a patient who is already in pain or nearing death. In dying patients, and in chronically ill patients, anguish may be physical, emotional, or spiritual. Physical

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<sup>3</sup> see Alice Miller's groundbreaking work on this issue

anguish typically looks like severe pain, dyspnea (shortness of breath), or anxiety. Emotional and spiritual anguish may look very similar with the patient crying, moaning, wailing, or verbalizing fears or regrets. In my daily practice lesser forms of this definition present themselves as another layer to be uncovered beyond the physical symptoms. T] Patients hide symptoms so well. The fear of another attack of M.S. or migraine at times prevents the patient for living a normal life free of anxiety. In these cases the physician must also dis-cover underlying factors that affect the pain level beyond that of the mere physical perception of nociception. It is also important not to write these factors off as "psychological" since that too has its own baggage as a label. Many patients have been so traumatized by other physicians who told them their pain was "in their head" they are just relieved to hear a new label that is not psychological- "so it's not in my head is it doctor? thank you thank you!" is heard often in my practice ad a neurologist by patients who have been labeled this way. I refuse and resist all diagnostic labels and terms that split between the body and psyche, feeling that that does little to enhance the healing process. We have moved on in medicine and realize on the one hand how much the brain is involved in formerly psychological and psychiatric processes, and on the other how much psychological and especially anxiety influences outcomes in physical disease.

I believe that poverty multiplies the human dimension of suffering for the same degree of illness and disability. Poverty squares the experience of pain. Poverty makes the fear of not being able to support dependents ever worse. In poverty the direct inability to afford therapies or even co-pays compounds the illness' effects and delays the healing process.

At the end of the day I am exhausted. Not because of any physical exertion, although the days are long. I am fatigued by the carrying of the weight of patient after patient's suffering. Their worries about their illness, their fears about their decline and degeneration, their horror at facing all this alone. Carrying this day after day wears me down and I must seek a kind of drainage and refreshment to recharge after a while. Inevitably the seeing all this and feeling the pain of my patients changes my view of nature reality and humanity. This one-sided view, a tragic view of humankind and illness, has forced me to reconsider old beliefs and sacred truths about human nature. In a world where we were brought up to seek and rely upon the values of human justice we see the darker side of human beings on both sides of the doctor/patient divide. We learn to accept that, under duress people's unresolved conflicts surface and get projected onto family, friends and healers We see doctors treating people without compassion for fear of "getting too involved" and the frustration experienced as a result. We also see few great people and learn from their trials how to "suffer well".

In approaching the human divine relationship I have learned to unlearn all the sacred truths I inherited. I have learned that I know nothing about divine intent or rational in "choosing" this or that person to suffer. I have long stopped the unacknowledged attempt to "divine" as to why this one or that "deserves" their illness in some weird way. There does not appear to be any sense of fairness from the human perspective so it is better to abandon such attempts. Easy theological responses to human suffering and

the dogma of the goodness of God are left long ago as cute medieval notions of rationality. We see too much of the human and divine non rational in this world to buy into these old sacred truths. In a world of genocide we too are acutely aware of the need for new myths to hold the new reality of a post Holocaust world.

I have continued to be humbled by my patients above all, their resilience and capacity for endless pain and suffering, and have learned to step up to the plate in such humility and try to meet their expectations. I remain humbled by the complexity of the human brain and its subtending both the central nervous system and the mind in one fantastic organ that remains refractory to decoding.

In the human compassion between doctor and patient I participate in this mysterious dance between being a professional and a fellow traveller and continue to learn to live my own life and decline from my ongoing interaction with my patients. In the interaction I draw on my own life experiences and my own illnesses and traumas to enrich the therapeutic field and invite my patients to entertain the possibilities of psychic and spiritual growth through the very suffering they are going through. I invite my patients to do what I tried in my own pain, to see the illness as an opportunity to confront my life and fragile body with reverence, to accept what had been given to me in this and become ever more grateful for just being alive and to make sense of this illness in the biography of my life.

In this I am teaching though a personal invitation to "suffer better" and hold pain better, not by dulling or anesthetizing it away with drugs or interventions, rather hold the outer borders of the illness and frame it with their own biography the way I have tried. I am resisting the simplistic divide between body, mind and spirit by which we were trained in medical school, and suggesting a more integrative model of seeing the "body of pain as teacher".

The body in pain then becomes the spirit guide forcing us against our will to entertain new possibilities for living , in pain, with pain, with disability, with suffering. The body in pain teaches us our mortality ever so slowly, a slow dying process, of increased awareness of our fragile being and immanent and not so immanent ending.

At the deepest level patient and myself are two spiritual beings along the same life journey, facing our own mortalities together and mutually nourishing the bonds of humanity in this therapeutic interaction. It is only by digging deep into my own pain that I am any use at this level to another spiritual being for it is in the mutual surrender and wounded-ness that we communicate here. The shaman is called from the deep and responds to the deep.

Thank you all.