Responding to Patient Beliefs in Miracles

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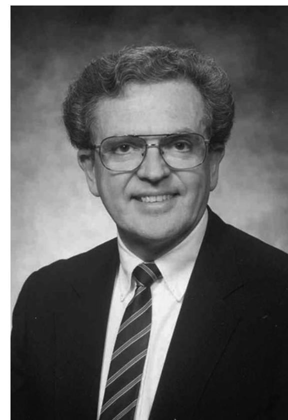
In situations of critical illness, when healthcare professionals have declared that survival or recovery is extremely unlikely, people of faith usually pray. They may pray for continued life, or they may pray for peaceful death. Not surprisingly, even people whose faith has lapsed often return to their old faith, hoping that God has not forgotten them and that their "foxhole prayers" will be heard and answered. In these situations, some even pray for a miracle. How is the healthcare professional to respond to earnest prayers for a miracle? Do doctors even believe in miracles?

The Jewish Theological Seminary did a national survey of 1087 physicians of diverse religious affiliations in 2004 addressing the question, "Do doctors believe in miracles?"[1] Among their findings were that 74% of physicians believe that miracles have occurred in the past, 73% believe they occur today, and 72% believe that religion is a reliable and necessary guide to life. So, if the majority of doctors believe in miracles, how does this affect practice?

Fortunately, other authors in this issue are tackling the more difficult conceptual questions of what constitutes a miracle and even whether they still happen in modern medicine. In all of these discussions, but especially in addressing the more practical question of how to respond to families (occasionally to patients themselves), it is important that we agree on the meaning of the words we use.

It is perhaps a sad commentary on the contemporary perspective of the supernatural that the word "miracle" is used so loosely. "It's a miracle that I passed my driving test!" "It's a miracle that she got out of the burning building!" "It's a miracle he survived the heart attack!" "His life was saved by a miracle drug!" Perhaps I am a skeptic, but I doubt any of these were truly miraculous. The term "miracle" is routinely applied to things that are unexpected, extraordinary, or wonderful. In this regard, the word seems to carry the same implication and significance to me as "Awesome!"

My much narrower definition of a miracle follows the teaching of the Christian scholar and apologist C.S. Lewis: "an interference with Nature by supernatural power."[2] By this definition, the term "miracle drug" is an oxymoron. A drug is a chemical designed and manufactured to achieve a specific goal. That is nature at work. That work may well be guided by a divine hand, and the worker may even give glory to God for the ability to make this drug. But the drug itself virtually defies the concept of the miraculous.



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Some would expand this narrow definition to include "scientific miracles."[3] This would include such medically unexplainable events as spontaneous remissions of incurable malignancy. In our discussion, we will follow Lewis' definition.[4]

Experience With Medical Miracles

I have had little personal experience with miracles in medicine. I guess this should not be too surprising since, in most assessments, miracles are very unusual events. Others have had more intimate and detailed experience with unexplainable medical events attributed to divine intervention.[5] Some, of course, see daily miracles. I would classify most of these events as "awesome."

Case 1

Mr. Robinson was a patient of mine in rural family practice many years ago. He was an otherwise healthy accountant who developed significant coronary artery disease in his late 60s. After extensive workup, he had 3-vessel coronary artery by-pass grafting, but five days postop, he developed a mediastinal infection. This led to multiorgan system failure (heart, lungs, kidneys, liver). I visited the obtunded patient in the intensive care unit (ICU) at the medical center, and I grieved with his wife as we contemplated his "less than 1% chance" of survival. They were people of faith, and I prayed along with her that he would survive. Slowly, unexpectedly, his condition improved. Three months later, he was transferred from the hospital to a rehabilitation facility. Eventually he was able to return home, though he never re-

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turned to work. Wonderful! Was this a miracle? I didn't see any evidence of supernatural intervention that was outside the realm of natural possibility. I suspect divine involvement with the natural processes here, but I am not willing to attribute to God an interference with nature in this case.

Case 2

I was asked to do an ethics consultation several years ago on Beatrice, a 10-month-old child in foster care who was born with complex cyanotic congenital heart disease and congenital absence of the spleen. Following temporizing surgery in the neonatal period, she experienced recurring stenosis of the pulmonary vein requiring repeated surgery and dilations. Chemotherapy to minimize re-stenosis had been considered but was not used because her congenital asplenia would place her at increased risk of life-threatening sepsis. When at 10 months of age she again showed signs of re-stenosis, her developmentally delayed biologic mother requested withholding further interventions since she felt Bea had suffered enough. However, Bea's foster mother and Child Protective Services personnel wanted to authorize further procedures, even considering heart-lung transplantation. We felt it was ethically permissible to deny the request of the biologic mother and to pursue potentially life-saving interventions, which everyone except her natural mother agreed would be in her best interests. However, Bea's foster mother prayed specifically for a reversal of the re-stenosis—what she classified as a miracle. Within a few weeks, her symptoms improved, and no stenosis was found on investigation. Her cardiologist could not explain how this had happened, and he agreed that it could have been a supernatural intervention. Seven years later, there has been no recurrence of the stenosis. Was this a miracle? I'm not sure, but it seems to me like there may been a supernatural interference with nature.

All physicians encounter outcomes they can't explain using natural criteria and terms. Perhaps some of those events are miraculous. It is easier to claim this if there has been a request for divine intervention. But does God require a human request to intervene in a way that defies nature? Perhaps even more to the point, does God require continued natural intervention to supply supernatural intervention?

Should We Continue to Treat, Waiting for a Miracle?

Almost all physicians are supportive when a patient's family prays for healing. Most are willing for the family, the chaplain, or the patient's own clergy to offer intercessory prayer to this end. Such prayers for healing may not be requesting miraculous interventions. There is almost always a small degree of uncertainty in medical prognosis, so invoking divine assistance in the natural process is often eagerly welcomed. Even clinicians who do not consider themselves to be closely connected to the divine usually support such efforts. Those who are clearly nonbelievers more often look the other way, with neither supportive comment nor criticism.

But what about situations where the clinical uncertainty is minimal? When the physicians are convinced that the outcome desired by the prayers is completely out of the question from a physiologic standpoint, how do they—how should they—respond? Even if the word "miracle" is not used, most would consider such prayers as requests for miraculous supernatural intervention.

Case 3

Melissa, age 19, was found to have an incurable posterior fossa medulloblastoma 7 months before I was asked to do an ethics consultation. She had had noncurative surgery to remove the bulk of the tumor, surgical placement of a shunt to reduce intracranial pressure, insertion of a permanent feeding tube, radiotherapy, and chemotherapy. Although she had several medical complications, she was able to go home and enjoy several months with her parents. She was admitted again 2 weeks before the consult request because of weakness, weight loss, and somnolence. She had further chemotherapy and aggressive therapy of her medical problems. However, she developed status epilepticus and a respiratory arrest 5 days before the consultation request. The seizures were controlled with some difficulty, but she had no spontaneous efforts at breathing so remained on the ventilator. Repeat MRI showed diffuse cerebral involvement with tumor and herniation of the brainstem. She remained comatose, but she did not meet the criteria for declaration of brain death. Her parents were informed that Melissa was imminently dying. They reluctantly agreed to a do not resuscitate order but were unwilling to authorize withdrawal of the ventilator because of their faith. They asserted that God is able to perform a miracle that would allow their daughter to live, even though the doctors were convinced she was dying.

Whether to continue therapy deemed inappropriate by the physician depends on at least two significant factors: whether use of that therapy will add to the patient's burden, and whether nonuse of that therapy will add to the surrogate's burden. Since the patient's best interests

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are pre-eminent, if there was consensus on the care team that continued ventilation and support were causing Melissa further pain and suffering, it might be justified to make a unilateral clinical decision to withdraw therapy if relief of her suffering could not be assured. Since it seemed unlikely that she was sensate, this was not felt to be justified in this case.

If the patient's best interests are not being violated by continued treatment, the burden to the family brought on by withdrawal of therapy must be considered. If they believe that it would be immoral to stop, the therapy should be continued until they come to understand the inevitability and imminence of death. If they are hoping for a miracle, they should be gently confronted with the reality that we must use reasonable medical judgment in making clinical decisions. Furthermore, although God is able to intervene supernaturally when He chooses, He does not require our cooperation to produce miracles; He can perform them even after biologic death. This discussion may be between the care team and the family, or it may be beneficial to include a hospital chaplain, or even better, the patient's own clergy. Though this mention of the care team's understanding of miracles is permissible, it is almost always inappropriate to challenge the family's belief if it differs significantly.

It is a valid question how long to continue inappropriate treatment when the family insists that a miracle is imminent. Clinicians are apt to call such treatment "futile," and in one sense it is because, within human reason, such treatment will not restore the patient to health. It is still argued by many that such treatment is not physiologically futile because it is, in fact, forestalling death. When death is imminent in spite of continued treatment, and the family is insistent on continued treatment while waiting for a miracle, I believe it is justified for the benefit of the family to continue the treatment for a few days. Long-term continuation of life-sustaining treatment that will not allow restoration of awareness raises legitimate questions about resource allocation, a policy level discussion that is difficult to solve, and rarely appropriate, at the bedside of an individual patient.

Case 3 Follow-up

Three days later, the patient made some respiratory effort. She was gradually weaned from the ventilator over the next 48 hours. However, she slipped quickly back into respiratory failure and was re-intubated in less than 24 hours. One week later, her blood pressure dropped and did not respond to standard treatment. The following day, her heart stopped.

It is not inappropriate for a physician or other healthcare professional to support a family's belief in God's ability to miraculously intervene in seemingly hopeless human situations. This should not, however, translate directly into an expectation of a miracle in a given situation. Miracles are rare, by definition. A conversation about this is infinitely more difficult if the believer, in contrast to the assertion above, believes that God's performance of the miracle is contingent on their faith and actions, as will be seen in the next case.

Case 4

Joshua was a 4-month-old boy who was admitted to the Neonatal ICU soon after birth with diagnoses of Down syndrome and congenital heart disease. At 6 weeks of age, because of congestive heart failure and failure to thrive, surgery was done to repair a persistent atrioventricular canal and to ligate a patent ductus arteriosis. He had two subsequent surgeries for septic breakdown of his initial repair. In addition, he had repeated bouts of sepsis with antibiotic-resistant organisms and progressive multiple organ system failure. He had been on a ventilator for several weeks and was also on peritoneal dialysis, pressors, total parenteral nutrition, and antibiotics. His nurse reported that he responded to and withdrew from painful procedures. He received frequent sedation because he desaturated when he was agitated. Joshua's family was devoted and consistently requested that "everything" be done. His mother reported that Joshua was named for the Hebrew patriarch, and she was of the belief that many scripture references to Joshua now applied to her son. She said that God had told her that he would get better, and she believed that he had survived this long because of her unwavering faith. She did not expect indefinite life support for him, but she was at that time unwilling to put a time limit on continued efforts to prolong his life. She said that she would be told by God if and when it was time to limit therapy. In spite of the dire prognosis, she believed she could not consent to any limitation of treatment because "God will not save Joshua's life if I do not have sufficient faith to continue full treatment." I was unable to reach her pastor to learn whether his teaching included an understanding that God's performance of a miracle was dependent on her belief and that continued intensive care was required.

Limitation of treatment decisions for children should generally be shared decisions made jointly by the professional team and a caring family. The family's preferences should generally be followed. Rarely, it may be permissible to over-ride a request for continued therapy

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if the team believes that they are clearly acting against the patient's best interests, eg, insistence on treatment which causes unrelievable pain and cannot benefit the patient. In the face of unprecedented survival, there is no consensus on the question of how long to continue life support awaiting supernatural intervention.[6]

Case 4 Follow-up

Full therapy for Joshua's multi-organ system failure was continued for the next four days, along with increased analgesia and sedation. He then suddenly deteriorated even further and had a cardiac arrest, which did not respond to intensive efforts at resuscitation. I felt particularly pained for Joshua's mother. She felt a huge burden. She clearly loved Joshua and did not want to cause him unnecessary suffering, but she felt morally constrained to continue treatment that his professional caregivers felt was inappropriate. I was unable to speak with her after his death to learn whether the sequence of events would have a detrimental effect on her faith.

Discussion

Treatment decisions in critical illness are in most instances both personal and familial. But we must not overlook the fact that they are also communal.[1] Our society has become so focused on personal autonomy that the values of the community are frequently ignored in discussions about what should be done.

In talking with family members who are assisting healthcare professionals to make treatment decisions, we usually focus on "substituted judgment," ie, what would the patient want in this situation, and how can we best know that. This is very important. When the patient's wishes are unknowable, we drop to the lower "best interests" standard for guidance in decision-making. However, in seeking either substituted judgment or best interests, we should not ignore the contribution that a person's religious community may make to the discussion. In fact, representatives from that community may be able to more faithfully translate religious beliefs than can family members who are so emotionally involved and personally torn. Inviting clergy to participate in these discussions is eminently appropriate.

The approach of pastoral involvement may be particularly beneficial in situations where the family member is focusing on one facet of belief while ignoring others that may counterbalance it. The patient's (or family's) spiritual advisor may be able to see not only such matters as the sanctity of human life, the rescue-God of the Hebrew tradition, and the miraculous-healer image of Jesus Christ. He or she may also be able to balance these profound beliefs with the reality of the finitude of human life, human responsibility for stewardship of both life and resources, and the promise of resurrection life for the believer.

In the Christian tradition, the family member may say, "My God can do miracles. He raised Lazarus from the dead. Why can't He raise my son?"* The pastor or priest might respond, "Yes, God can do miracles. But perhaps He had a specific reason to raise Lazarus. Of the billions of people who have died since then, in very few instances do we see God's miraculous intervention in this way. It is fine to pray for a miracle, but that prayer should end with 'Thy will be done' as exemplified by Jesus when he asked to be relieved of the burdensome death of crucifixion." The discussion might move on to discontinuation of mechanical life-support. The pastor or priest might point out that God is not dependent on human interventions if He is going to perform a miracle that is unexplainable by natural mechanics. (As a colleague of mine points out, "God is not ventilator-dependent.")

Pastoral involvement may be either helpful or not helpful if the family member is clinging to an idiosyncratic belief that is not supported by his or her own faith tradition. The belief of Joshua's mother in Case 4 may be an example. A few individuals in some denominations do believe that God will not do a miracle unless the individual has the faith to continue pursuit of the desired outcome. Many would characterize this as "hyperfaith," or faith in faith itself, rather than faith in a supernatural God.[7] The person who is expecting a miracle, based on their own faith, may benefit from having their pastor discuss this concept with them; this may give them a more complete view of the possibilities. On the other hand, that individual with hyperfaith may disbelieve the pastor and feel that his or her own interpretation is correct. In those rare instances where the pastor himself or herself holds this belief, I see no easy resolution.

Many authors have addressed the importance of addressing the religious and spiritual beliefs of patient and family. Some have suggested conversations that may be beneficial.[8]

Rushton has suggested strategies for clinicians when confronted with families who are hoping for miraculous healing of their child.[9] I believe her suggestions are equally valid for adults:

- Search for common ground—Acknowledge a shared commitment to the well-being of the patient.
- Assess understanding—Ensure there is adequate understanding of the clinical situation.
- Understand the meaning of miracles—Conversations about the meaning of the word "miracle" may reveal differences.
- Honor one's faith—The faith traditions of both family

*Similarly, a rabbi may be asked about miraculous healings recorded in the Hebrew scripture, such as that of Elisha raising the Shunammite's son from death.

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and professionals must be understood and should be honored.
- Allow hope for a miracle—This is a way to acknowledge and respect another's beliefs, values, and faith.

In thinking of this hope, I would encourage clinicians to adopt Vaclav Havel's definition of hope: "Hope is not the conviction that something will turn out well, but the certainty that something will make sense, regardless of how it turns out."[10] In this light, hope is about meaning, ie, hope is a spiritual value.

Conclusion

Miraculous interventions in medicine are antithetical to the scientific tradition. Regardless, a majority of physicians believe in miracles, though most agree that these are rare events. Physicians should try to elicit, understand, and generally support the patient's and family's religious tradition. When that tradition, or even idiosyncratic belief, lead the family to request continuation of medically inappropriate treatment because they are expecting a miracle, including clergy in the discussion may help resolve the tension. At other times, it may not. There is no standard way to address or resolve this tension.

Some physicians are comfortable praying with patients or families when they share a faith tradition. Others are more comfortable asking chaplains or personal clergy to fill this role. In either case, I would suggest that such prayers focus on seeking comfort for the patient, wisdom for the physicians involved, and a "peace that passes all understanding" for the family—concluding, as mentioned above, with "Thy will be done."

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> *Miracles are not contrary to nature, but only contrary to what we know about nature.*
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> —Saint Augustine