

The Physician and Community of Faithful in the Integrated Care of the Mentally Ill: An Orthodox Christian Discussion of the Physician's Moral and Professional Obligations

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This article presents the case of a Romanian Orthodox Christian patient in the United States suffering from bipolar disorder. The patient had no family in the United States, and a community of parishioners from the Romanian Orthodox Church, including one of the authors, Mariana Cuceu (MC), cared for him after he was discharged from a psychiatric ward. The case serves as a starting point for exploring the duty of physicians not only to avoid harm but to do good, the importance of coordinating care for such patients and attending to their religious and spiritual needs, as well as the role of the community of Orthodox Christian faithful in responding to the command that we love one another.

Keywords: *community-centered care, mental health, Orthodox Christian, physician duty*

“Those who suffer need [us] to be something more than a doctor; they need [us] to be a healer. And, to become a healer, [we] must do something even more difficult than putting [our] white coat on. [We] must take [our] white coat off. [We] must recover, embrace, and treasure the memory of [our] shared, frail humanity--of the dignity in each and every soul....”. (Berwick, 2010)

I. INTRODUCTION

Individuals with bipolar disorder (and some other psychiatric conditions) have a range of social, medical, and mental health care needs that may not be adequately met when services are not well-coordinated and patients do not have assistance in coordinating services required to meet their needs (Sachs, 2003; Kupfer, 2005; Horvitz-Lennon, Kilbourne, and Pincus, 2006; Kennedy, 2007). This article begins with the description of a case involving a Romanian immigrant patient in the United States suffering from bipolar disorder. The patient had no family in the United States, and a community of parishioners [including one of the authors (MC)] cared for him after he was discharged from a psychiatric ward. The case serves as a starting point for exploring two themes. First, in examining this case, we explore the question of what the medical team could have done differently not only to avoid harm but to have done good for this patient. Invoking a Christian understanding of the duty of physicians to do good, we offer suggestions for how Christian physicians and health care systems can better approach the care of patients. This includes a better appreciation of coordinating care for patients with mental health conditions and incorporating religious and spiritual considerations in their care. The case offers an example of why it is important to coordinate care for psychiatric patients and why the health care community should recognize the importance of religious communities in the care of patients in general. Second, the Orthodox Christian congregation was inspired both by the Good Samaritan (Luke 10: 30–37) and by the New Commandment (John 13:34–35), to “love one another; as I have loved you.” Thus, the case offers an example of how Christians may live out the commandment to love one another. The commandment is not one that merely calls on us to be kind or tolerant or even charitable, but to truly love one another. The call to love is a call specific to particular contexts. Parents are called to love their children unconditionally, spouses are called to love and care for each other through burdens and joys, fellow parishioners are called to love one another, and so on. In the context of fellow parishioners, as we see in this case, love may include helping a person to receive medical treatment and praying for the sick. The commandment to love applies to all Christians, and understanding what that commandment requires in different contexts is vital to the Christian life.

II. CASE PRESENTATION

In order to protect patient confidentiality, no specific personal data are included. The authors and parishioners who participated in caring for the patient did not have access to medical records or health care providers directly involved in the patient's care; thus, no information from such records is provided. In brief, the patient is a divorced gentleman, in his mid-thirties, a US immigrant from Romania, who established his permanent residence in Chicago, Illinois. He had been recently discharged from a psychiatric

inpatient ward after a 10-day stay. According to his friends, he was admitted initially under an emergency hold, which was prompted by an altercation with police. His discharge was allegedly due to his refusal to adhere to treatment and his refusal to cooperate with the medical staff in the hospital. No further details regarding the specific hospital's protocol were available.

The events preceding the patient's admission are unclear, and the patient could not fully describe those events because he was confused. It appears that, while driving his car, he lost his way home and arrived in Indiana instead of his Chicago residence. Convinced by a delusion that he had arrived at his own home, a physical altercation ensued with the owner of the Indiana home. Subsequently, police took the patient to the hospital where he was admitted. The authors suspect that the lack of medical insurance, along with his inability and/or unwillingness to adhere to the proposed psychiatric treatment in the psychiatric ward, contributed to a premature release from the psychiatric facility. The authors believe that the inpatient team could have legally pursued the involuntary commitment process where a court of law would mandate that the patient receive the psychiatric care he needed for stabilization. According to Illinois Law, involuntary hospitalization is warranted when a person with mental illness refuses or does not adhere adequately to prescribed treatment and as a result poses an imminent risk to self or others that may be due to an inability to care for self. ([Petition for Involuntary/Judicial Admission. State of Illinois. IL462-2005, R-4-14](#); [Inpatient Certificate. State of Illinois, IL 462-2006, R-8-13](#)).

Patient History

The patient and his friends shared additional information about his history, and this is offered here to help the reader better understand the situation. He was diagnosed with bipolar disorder in the United States and had been treated pharmacologically in an ambulatory setting with quetiapine (Seroquel) and haloperidol (Haldol). He was not engaged in any psychotherapy services. He may have been diagnosed in the past in Romania with schizophrenia. Significant behavioral dyscontrol ensued prior to his inpatient hospitalization, when the patient was non-adherent with his medication regimen. Prior to medication self-discontinuation, he began to consume alcohol. His mental status deteriorated in the last few months after a medication change from quetiapine to haloperidol, which apparently was more affordable. His friends shared that since he began taking haloperidol, he was not feeling well. Understandably, he stopped taking his medication completely. This left him unable to attend to self-care activities, such as hygiene. He began wandering the streets, essentially becoming homeless, due to an inability to work and support himself.

Faithful Community Involvement

Given the patient's desperate situation, a parishioner from the Romanian Orthodox Church provided lodging to the patient in his apartment. He took

the patient to church more frequently, so as to socialize and engage with people, as church was a familiar and non-threatening setting. The patient was offered employment; however, he was unable to work and continued to refuse restarting his medication or to see a doctor. Unfortunately, the patient began exhibiting aggression towards his roommates. The parishioner was forced to relocate the patient from his apartment to a basement setting. The patient's medical condition further deteriorated, to the point of the police altercation mentioned above. This prompted a parishioner to contact one of the authors (MC), who ended up serving as a community liaison. MC was asked to visit the patient at the psychiatric facility in hopes that she could offer comfort and encourage him to adhere to the treatment plan proposed in the psychiatric ward.

Community Liaison Involvement

During the first visit to the inpatient unit, the patient was found disheveled and in an agitated state, with slurred speech, a rapid flow of incoherent thoughts, cognitive distortions, delusions, and severe paranoia. He recognized the community liaison (MC) from the congregation and recalled she was a physician. Nevertheless, he was resistant to disclose further information regarding his mental condition and did not give her permission to talk to his treating doctors. The patient was telling other visiting parishioners that he feared people from the hospital were plotting to poison him and that he did not feel well there, because he perceived he was being treated in an inhumane fashion. As the visit concluded, he confided that he is a "sinner" and requested to speak with the Archbishop of the Romanian Orthodox Church in the United States and Canada. In fact, this Archbishop was the patient's spiritual father and confessor, whom the patient saw regularly. As the patient was an active member of the congregation, his declaration of being a "sinner" is not an example of religious psychosis or hyper-religiosity, but, indeed, consistent with the patient's cultural upbringing and way of life. Prior to this request, a parish priest attempted to visit the patient, but he refused. At this point, it became apparent that the patient was suffering from intense paranoia consistent with psychosis, which is a break from reality. It became clear that, in order to ally with the patient, it was paramount to bring him into contact with the only person he was able to trust, the Archbishop—someone whom he had known from the parish itself. The liaison reassured the patient that his request would be presented to the Archbishop.

Liaison Contacts Archdiocese

While presenting the case to the Archbishop, the liaison emphasized the importance of establishing a bridge of communication with the patient, a critical component at this point in regaining the patient's trust and perhaps his adherence with medical care. It was also conveyed to His Eminence that,

without the patient's trust, all the parishioners's efforts to assist him would likely be unsuccessful. His Eminence understood the gravity of the circumstances and offered to help to the best of his abilities. He scheduled a visit with the patient in the hospital three days later. His Eminence did not have an opportunity to visit with the patient, because the hospital discharged him in the interim without a disposition plan.

Community Search

Many parishioners visited the patient throughout his hospital stay, and as soon as they learned that he had been discharged a community search for him started because he was essentially homeless. On the day of his discharge, he was found in the neighborhood of the house where he had stayed previously with a fellow parishioner.

Community efforts by the parishioners followed to help the patient apply for a disability pension or some other type of social support. All these attempts were futile, as he would not cooperate, due to a persistent mistrust. Later, the patient revealed that he trusted no one because of what he described as an extremely disturbing experience of a "multitude of thoughts" (in the context of his psychosis) that were confusing and derailing him.

As these events were unfolding just before Pascha (the Orthodox feast of Christ's Resurrection), the hierarch and several parishioners suggested to the patient that perhaps he would appreciate the opportunity to travel to Romania to be with his family for the holiday. They offered to cover his airfare. The patient expressed interest and agreed to this plan while speaking with the Archbishop. However, later he was ambivalent when talking with fellow parishioners, including the liaison.

Liaison Reaches Out and Consults with Psychiatry Colleagues

In the midst of these challenges, the community liaison sought advice and peer supervision regarding strategic planning in the care and safety of the patient. Multiple phone conversations were carried out with three practicing psychiatrists, two in the United States and one in Romania. All strongly recommended attempting to re-hospitalize the patient, as he met inpatient level-of-care criteria (due to an inability to care for himself), requiring safety, containment, stabilization, diagnostic clarification, and intensive pharmacologic and therapeutic interventions. The psychiatrists further advised that without medication, he might have difficulty traveling to Romania and that hospitalization should be pursued against his will, if necessary, by contacting the police. The liaison reported these developments to the hierarch, who fervently disagreed to hospitalization against the patient's will. The Archbishop proposed instead that the liaison attempt to persuade the patient to return to the hospital.

The liaison attempted to persuade the patient voluntarily to re-enter the hospital, but he refused any linkage to mental health care providers, whether

outpatient or inpatient. The liaison experienced severe distress over the patient's refusal to pursue treatment. This was due to the tension between the input from colleagues who favored involuntary (forced) hospitalization (for the patient's well-being) and the hierarch who objected to forced hospitalization for fear of further erosion of the patient's trust. In addition, potentially devastating consequences could ensue due to medication non-adherence, particularly given that the patient did not appear to have global decision-making capacity.

During the next three weeks, there were several visits by parishioners to the location where the patient now resided—the basement of the home of one of the parishioners where he also lived prior to his inpatient admission—to bring him food and clothing and to ensure his safety prior to his trip to Romania. All necessary arrangements for his travel were managed by the Archdiocese. The evening prior to his departure, he was brought to dine with the hierarch and the community of faithful who took care of him during the preceding months. He was given the airplane ticket, and the patient appeared to be very pleased. One of the clergy members accompanied him to the airport, explaining to the airline staff during the boarding process that the patient suffers from a mental illness and would need special attention during the flight. The flight attendant supervisor reassured him that the patient would be well cared for.

Consulate Bridges with Community in Caring for Patient

What followed was unforeseen, although one of the liaison's psychiatric colleagues cautioned that the patient might not be able to navigate the trip unescorted. Indeed, the patient did not arrive at his final destination in Romania at the expected time. The Archdiocese office inquired with the airline, but it refused to provide any information regarding the passenger due to security reasons. The only information given was that he did not board the second plane from Rome to Romania. The liaison contacted the Romanian Consulate in Chicago, which communicated with diplomats in Rome and the United States to request an official inquiry about the patient's status both from the airline and airport officials in Rome. The Archbishop contacted Romanian clergy in Rome for assistance. After 72 hours of profound uncertainty, worry, multiple e-mail exchanges, several phone conversations, and prayers among all of the abovementioned parties, it was learned that the patient, our fellow parishioner, was hospitalized in a psychiatric facility in Rome. He did not board the flight to Romania because he was feeling very ill before landing in Rome. An Orthodox clergy member stationed in Rome regularly visited the patient in the hospital and accompanied him during the second attempt to fly from Rome, Italy, to his home in Romania.

At the time of the submission of this article, the patient was in Romania, surrounded by his immediate family. He was reportedly linked to and adherent

with outpatient mental health care services. The liaison followed up with his family in addition to carrying out phone conversations with the patient. It was reassuring to learn the patient's condition was stabilized; he was able to find gainful employment and regain his capacity to function overall, with improved quality of life. It is not fully known what combination of factors contributed to his stabilization.

This case raises many important issues regarding the care of patients with psychiatric illness. Although the patient appears to be safe and receiving treatment now, there were several times during the weeks and months he was cared for by the community of faithful when things could have become much more serious, resulting in injury or death.

In the remainder of this article, we focus on two themes. One is the obligation of physicians not only to avoid harm but to do good and to attend to the important role of religion and spirituality in health care, as well as the importance of being open to collaborating with religious communities in coordinating care to do good. Second, the community of faithful was instrumental in caring for the patient. The fellow parishioners were moved by the obligation to put into active practice Christ's commandment that we love one another. This case offers an example of what it means to love in the context of a parish community (Reardon, 2012, 94–111) and in view of many problems that modern psychiatry faces, the difficulties in addressing proper treatment of mental illnesses, and the manner in which society responds to those afflicted.

III. PHYSICIAN OBLIGATIONS: DOING GOOD AND AVOIDING HARM

The primary obligation of physicians to do no harm (*primum non nocere*) and to do good is affirmed in the Epidemics (Hippocrates, 1923, Book I, Section II). In the case presented above, we believe there were missed opportunities for the involved physicians to fulfill this obligation. These warrant a closer examination of how we can help develop a broader understanding of physicians's obligations, as well as a more careful analysis of the complex problems and barriers that may interfere with a physician's willingness and capacity to do good. The case also highlights the importance of coordinating care for patients with mental health conditions and the need to attend to religious and spiritual considerations in health care delivery.

Could the Medical Staff Have Persuaded the Patient to Accept Treatment?

The patient was discharged from an acute care hospital without a secure disposition plan regarding placement or lodging or mental health care follow-up of any kind to facilitate continuity of care towards recovery and community reintegration. While he was in the hospital, he refused to give permission for release of information to the treatment team. Although honoring the patient's

refusal to engage with others might be interpreted as keeping with a physician's obligation to respect patient autonomy, should this patient's physicians have done more in an effort to do good in support of beneficence? Should they have tried to persuade him? (We do not know what they actually tried to do. It is possible that they tried and failed. However, for the purposes of this discussion, we assume maximum effort was not spent on persuasion.)

Although much has been written about the duty of physicians to respect patient autonomy, physicians have an obligation also to promote beneficence, for the ultimate well-being of the patient (see, e.g., Engelhardt, 1996; Beauchamp and Childress, 2012; Shaw and Elger, 2013). Sometimes this may involve attempts to persuade without coercing, what Engelhardt (1996, 308) calls "peaceable manipulation" and what Swindell, McGuire, and Halpern call "beneficent persuasion" (2010).

When we appreciate the obligation of physicians to do good, it is important to recognize that we live in a world in which there is not a single, universal understanding of the good (Engelhardt, 1996; Engelhardt, 2000). One very clear example of competing conceptions of the good is the difference between persons who maintain that physician-assisted suicide for the terminally ill and suffering is good and those who recognize it as evil. Saint Gregory of Nyssa teaches that only those actions in accord with the actions of God may be understood as good actions: "actions that are free from all evil, purifying themselves as far as possible in deed and word and thought from all vileness" (Saint Gregory of Nyssa, 1967, 87). It then follows that as Christians we are called to be aware and to imitate in our deeds (the Divine Plan) connected to and driven by God (Saint Gregory of Nyssa, 1967, 87).

In the face of competing conceptions of the good and, particularly, while caring for a Christian patient, these profound writings can certainly enhance the act of care.

Could the Medical Staff Have Persuaded the Patient to Permit the Treatment Team to Reach out to the Patient's Orthodox Christian Community, which Functioned in This Case as an Extended Family for This Patient?

The patient had no immediate family in the area. Thus, it is possible that the physicians might have assumed that he was on his own and there was no one else to whom they could appeal. Did they know or ask about his faith community? It seems that they must have known something or at least should have been able to surmise this, since parishioners visited him and each visitor must be granted a pass after being screened by staff in order to enter a locked psychiatric unit. Did they ask about involving his parish family? Should they have been more diligent in their efforts to involve them? Did they offer him any spiritual care from an Orthodox chaplain? It is not sufficient to offer an Orthodox Christian access to a generic chaplain

(Hughes, 1998; Joseph, 1998). A generic chaplain is one who provides “religion-non-specific, denominationally neutral hospital chaplaincy” (Engelhardt, 1998, 231).¹

For this patient, his individual relationship with God was important. The treatment team should have appreciated and attempted to understand this patient’s worldview in order to develop a goal-oriented treatment plan. This patient clearly had his own set of spiritual beliefs and practices that were shared by a community of faithful. Tapping into his community might have been of enormous help in acquiring resources and advocates for the patient (Sulmasy, 2009). Not only did our current medical professional establishment not earn this patient’s trust, it instead served to deepen wounds that he may have suffered in the past. Had the physicians encouraged the patient to engage with his parish family and facilitated this engagement, they might have fostered some level of trust.

It is evident that the congregation played a critical role in consistently and successfully managing this patient. The parishioners followed the patient’s lead in terms of his wish to be brought back to the church community, actually to his confessor—the Archbishop. Dr. Sulmasy in his article on “Spirituality, Religion and Clinical Care” states that, above all, this is the safest rule in caring for the patients (Sulmasy, 2009). In this case, this faith community not only hosted the patient with much care, but also functioned as his extended family. Had the physicians engaged the community earlier, the patient’s initial discharge from the hospital might have been managed better.

Studies demonstrate that patients who attend religious services, independent of denomination, have better long-term health-care outcomes. Numerous studies have explored the benefits of faith for various conditions (Koenig, McCullough, and Larson, 2001) and have found that spirituality is not only an important component of quality of life but also a critical resource for patients coping with illnesses (Brady et al., 1999; Monod et al., 2010). Therefore, clinicians have an ethical obligation to attend to their patients’s spiritual needs, as Sulmasy highlights (Sulmasy, 2009), regardless of their (physicians’s) own personal preferences or spiritual beliefs. The patient-physician encounter carries tremendous significance and, in many religious traditions, is perceived to represent an encounter with the sacred. If a patient is experiencing a spiritual crisis, the clinician may be able to develop awareness towards recognizing that need so as to be able to make appropriate referrals to help patients cope with the spiritual dimension of their illness (Sulmasy, 2009).

The need for collaborative efforts between the field of psychiatry and clergy members is highlighted in previous studies. In a study published in *Psychiatric Services* (Farrell and Goebert, 2008), the authors present an analysis of the interactions between clergy and patients with mental illness who had a faith orientation. The study underscores the importance of collaboration between psychiatrists and clergy in patient treatment planning and crisis

intervention during acute hospitalizations, as well as the need for adequate clergy training to recognize markers of mental illness that could lead to timely treatment referral.

What are the Barriers to Appreciating the Importance of a Patient's Religious Beliefs and Community and thus to Providing Good Care?

Although it is likely that several factors compromised the patient's care in this case and in others like it, two stand out as particularly important. The first is the fragmentation of the health care system, particularly of the mental health care system (Stange, 2009; Elhauge, 2010). Individuals with mental health conditions face numerous barriers to accessing effective treatment, including stigma, cost, and insurance coverage issues. When care is not integrated across practitioners, patients can be harmed. The second is the under-appreciation of faith communities's participation in patient care. In this case, the patient's Orthodox Christian community could have served as a meaningful resource in providing integrated care. Had physicians deemed this important, they could have encouraged and persuaded the patient to include someone from the community in his treatment and discharge planning. The physicians's failure to appreciate the importance of religion and spirituality hurt the patient. The medical profession must be mindful of patients's spiritual needs and further recognize the role of pastoral love in caring for those who are suffering, particularly those who belong to robust Christian communities.

This case management also serves as an example of a community-based model of care that taps into important resources, which may be available as tools to healthcare professionals for providing patient care in today's communities. Thus, a fundamental recognition is mandated for a deeper understanding of one's culture, traditions, and faith. This can enrich a doctor's understanding of care for the patient (Curlin and Moschovis, 2004), which is vitally important to mental health care treatment success.

Given multiple barriers to integrated care that include rising pressure on physicians and hospital systems to increase fiscal productivity by shortening outpatient clinical encounters and in-patient lengths of stay, fostering dialogue between clinical medicine and religious communities can contribute to creative alternatives and improving patient care outcomes. To secure these benefits, physicians must be willing to engage clergy and religious communities.

IV. CHRISTIAN COMMUNITY AND THE OBLIGATION TO LOVE

The parish involved in caring for this patient over many months was inspired by the new commandment Jesus Christ gave: "A new commandment I give to you, that you love one another; as I have loved you, that you also love one another. By this all will know that you are My disciples, if you have love for

one another” (John 13:34–35). We are reminded in the Liturgy of Saint John Chrysostom that we must love one another:

Priest: Let us love one another that with one mind we may confess:

(The Priest kisses the holy Gifts saying:) I love You, Lord, my strength. The Lord is my rock, and my fortress, and my deliverer.

....

People: Father, Son, and Holy Spirit, Trinity one in essence and inseparable

(The Divine Liturgy of our Father among the Saints John Chrysostom)

So important is the commandment that failure to love one another makes it impossible for us to worship and confess our faith together. The Orthodox Christian community’s response to the patient in this case is an example of what it means to see one’s fellow parishioners as members of the Body of Christ and to love them as Jesus commanded.

The parish was also inspired by the parable of the Good Samaritan (Luke 10: 30–37), in which Jesus tells of a man who was robbed and left for dead traveling from Jerusalem to Jericho. A priest and a Levite who saw him overlooked him, but a Samaritan “went to him and bandaged his wounds, pouring on oil and wine; and he set him on his own animal, brought him to an inn, and took care of him.” The parable is not a perfect analogy here because the man on the road was a stranger to the Samaritan who cared for him. In contrast, the parishioner was not a stranger but a member of the Orthodox Christian parish. Nevertheless, the parable teaches an important lesson regarding how one can show love. In the Patristic view, the “inn” symbolizes the Church; in the same view, Christ is presented as a Physician, who heals human illness; and the Church is seen as the Hospital. In analyzing this parable, Saint John Chrysostom highlights several truths that are presented to us. The Samaritan man who showed mercy to the victim of the thieves is Christ Himself, who came from heaven to heal the wounded man using wine and oil for his wounds—“by mixing the Holy Spirit with his blood, He brought life to man” (Hierotheos, 2006, 27). According to Saint John Chrysostom, the innkeeper is the Apostle Paul, “the one who upholds the churches of God” (Hierotheos, 2006, 28). It is in the Universal Church that the healing takes place—of all men who are sick with sin and earthly passions—and, in so doing, any active participant in the Church may attain communion and union with God “while the bishops and the priests, like the Apostle Paul, are the healers of the people of God” (Hierotheos, 2006, 28).

The motivation behind the community’s team effort was rooted in love, both for God and our neighbor, which is fundamental to the Christian faith. It is only through right worship of God that we are able to know what it means to offer love to others. Love, simply defined as “a way out of the self”

through the living power of the Holy Spirit and not externally motivated by the perceived worth and value of the objects of our love, remains the measure of the genuine Christian life (Harakas, 1992, 163–8). Love is considered to be the light of the soul: “And now these three remain: faith, hope and love. But the greatest of these is love” (1 Corinthians 13:13).

V. CONCLUSION

This article examines an instance where a community of faithful was able to manage the care (physical, social, and spiritual) of a patient and fellow parishioner whose needs were not adequately met during inpatient psychiatric hospitalization. Inadequate medical treatment compromised his health and safety. This case also provides a successful example of how the community of faithful was able to positively alter the trajectory of a patient’s recovery. The love and care provided by the parishioners were inspired by the new commandment of Christ and the parable of the Good Samaritan. This article is also a reminder of the fact that the pathway to Christian healing has been fully charted by Orthodox Christianity since early Patristic times (Larchet, 2002, 2011). The creation of hospitals and hospices is intertwined with the ministry of those we venerate as “holy unmercenary saints” (e.g., Saints Cosmas and Damian, Saint Panteleimon).

The duty of the physician to do good in the care of every patient requires attention to the patient’s spiritual needs and a willingness to engage faith communities as part of providing integrated patient care. It is our hope that this article will inspire other Christian communities to show love through the care of parishioners in need, including those with mental health conditions. Individuals suffering from mental health problems may be stigmatized and marginalized, yet Orthodox Christians must obey the commandment to love them as they love themselves. We also hope to encourage physicians to generate multidisciplinary dialogue that informs the development of integrated treatment plans to incorporate the resources of religious communities in caring for patients.

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NOTES

1. For a substantive criticism of generic chaplaincy, see Delkeskamp-Hayes (1998) and Tollefsen (1998).

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