

Spiritual Direction and Health Science Students

William K. Dolen

Christian spiritual direction

Christian spiritual direction is a pastoral ministry in which two or more people meet to listen prayerfully for the “movements of the Holy Spirit in all areas of a person’s life.”¹ For the director, this is a formal process of attentive and compassionate listening – listening both to the directee and to the guiding voice of the Holy Spirit. In listening for signs of God’s presence in the directee’s life, the director can help the directee identify ways of prayer (such as verbal prayer, meditation, and contemplative prayer) that might help the directee make and maintain contact with God. Some form of spiritual direction is present in many of the world’s religious practices. In the Judeo-Christian tradition, it seems likely that the rabbis provided some sort of spiritual direction to their *talmidim* and Jesus to His disciples. If so, this practice might have continued in the apostolic era. One can trace Christian spiritual direction to the practices of the desert Fathers and Mothers in third and fourth century Christianity. Many of these early directors lived lives of solitude, while making themselves available to others as spiritual advisors. As monastic communities formed, their leaders brought spiritual direction out of the desert caves and anchorite cells, and into the community. In the early 20th century, spiritual direction was common in religious orders and seminaries,² emerging in other branches of Christianity as a distinct pastoral ministry to clergy and laity in the era of the late 1960’s.³ Ideally, a spiritual director 1) is a man or woman of mature faith, 2) has the requisite *charismata* for this ministry, 3) recognizes that the Holy Spirit is the true director, 4) hears an internal

¹ Tilden Edwards, *Spiritual Director, Spiritual Companion* (New York: Paulist Press, 2001), p. 2.

² William A. Barry and William J. Connolly, *The Practice of Spiritual Direction* (New York: HarperCollins, 1981).

³ Spiritual direction made its way into Anglicanism early on. Kenneth Leech, *Soul Friend* (Harrisburg, PA: Morehouse Publishing, 2001) traces the development of Anglican spiritual direction from the 17th century onwards.

spiritual call to this ministry, 5) others recognize the director's gifts and call, 6) has had supervised training in spiritual direction, 7) has a personal spiritual director experienced in supervision, and 8) accepts the special ethical standards of this ministry.⁴

Spiritual direction differs from pastoral counseling, secular psychological counseling, and psychotherapy. Edwards notes that secular counselors adopt a mind-based rationalist approach based on "physiological, intrapsychic and interhuman forces."⁵ He observes that pastoral and secular counselors focus on "emotional hang-ups" and the goal of counseling is to "gain insight and greater flexibility related to the way we function in daily living."⁶ In contrast, spiritual direction does not necessarily deal with "problems." In this ministry of careful listening and guidance, the directee learns how to recognize the internal and external presence of God in all aspects of daily life. The directee engages, interacts with, and becomes closer to God through various types of prayer and reflection. In describing situational spiritual direction, Max Thurian writes, "Spiritual direction, or the cure of souls, is a seeking after the leading of the Holy Spirit in a given psychological and spiritual situation."⁷ As the director and directee identify and address problems, the ultimate goal is transformation by the power of the Holy Spirit, rather than mere insight or adaptation. In time, the directee learns how to discern between the workings of God and the attempts of other internal and external forces to disrupt one's relationship with God.

⁴ Thomas M. Hedberg and Betsy Caprio, *A Code of Ethics for Spiritual Directors, Revised Edition* (Pecos, New Mexico: Dove Publications, 1992).

⁵ Urban Tigner III Holmes, *Spirituality for Ministry* (Harrisburg, PA: Morehouse Publishing, 1982), p. 23.

⁶ *Ibid.*, p. 24.

⁷ Cited by Leech, p. 30.

In the course of spiritual direction, the director and directee may identify certain issues that might better be addressed in counseling, psychotherapy, or the Rite of Reconciliation of a Penitent (“confession”), since psychopathology and sin interfere with a person’s relationship with God, and that person’s prayer life. In these situations, the director may have the training, certification, experience, and authority to take on these functions, but doing so is not true spiritual direction.⁸ When a directee needs formal counseling, psychotherapy, and other types of pastoral care (including formal confession with absolution of sins), referral to another person is usually appropriate. Margaret Guenther, who is a spiritual director and also an Episcopalian priest, notes that while there is a distinction between spiritual direction and sacramental confession, there are times when a directee confesses sin in the course of direction, and that it is appropriate to provide absolution at the time.⁹ Spiritual directors who use a counseling-based model for direction¹⁰ nonetheless need to maintain focus on the ideas that the Holy Spirit is the director, and that the purpose of direction is to identify God’s actions in the directee’s life.

Spiritual direction and Christian healing

Christian spiritual direction is a healing ministry, with focus on the soul and aspects of the psyche. Christianity, like all religions, also has a physical healing tradition. Just as religion and medicine are linked, so are the ancient roles of priest and physician. The Christian Scriptures leave no doubt that Jesus is a healer, that the apostles healed by his

⁸ Hedberg and Caprio, p. 6.

⁹ Margaret Adah Beltz Guenther, *Holy Listening: The Art of Spiritual Direction* (Lanham, MD: Cowley Publications, 1992), p. 31. In Christian tradition, only a priest or bishop can absolve sins in the name of God. Some branches of Christianity do make provision for absolution by the laity. Leech also discusses the role of director as confessor.

¹⁰ Edwards, p. 99.

direct authority, and that they passed on a tradition of healing in the name of Christ.

Healing is one of the gifts of the Spirit listed in 1 Corinthians 12:4-11.¹¹

The Hebrew Scriptures teach that health is God's blessing, that disease is generally a punishment for sin,¹² and that God is the physician for humanity. The Book of Tobit¹³ describes Raphael (רפאל, "God heals") as a messenger (angel) of God, and the noncanonical Book of Enoch prominently mentions Raphael by name. Medieval mystics compared the attributes of Raphael to those of the Roman Mercury and Greek Hermes. To this day, Raphael has a strong tradition in Judeo-Christian folklore as the archangel associated with medicine and healing. The Roman church considers him to be a saint, associating him with the angel at the Bethzatha healing pool.¹⁴ The Hebrew Scriptures state with clarity that God is the source of healing. In the context of the story of the complaints about the bitter water in the wilderness (Ex 15:23-26), YHVH states, "I YHVH am your healer (*rapha*, רפא)." Moses, if "learned in all the wisdom of the Egyptians" (Acts 7:22), would have known about the Egyptian healing tradition, but it does not appear that he used it. The story of King Asa (2 Chr 16:12-13) states that he died because "in his disease he sought not to YHVH, but to the physicians (*rapha*, רפא)." The Psalms carry on the theme of God as healer, as does Isaiah. Sirach 38:1-2 states, "Honor a physician with the honor due him, according to the need that you have of him, for the Lord created him. For healing comes from the Most High..."

¹¹ Also see 1Cor 12:28-29 and James 5:14. Dearmer (*vide infra*) counts twenty-four healing miracles performed by the Apostles and others, mostly recorded in Acts.

¹² See Deut 28 for a series of examples that are not unique in the Torah. In the Book of Job, however, illness comes from Satan as a test, albeit with God's permission, or a means for spiritual advancement.

¹³ The Book of Tobit appears in the Septuagint (LXX) and the Christian Apocrypha, although it is not part of the official Hebrew canon.

¹⁴ The probably unauthentic verse, John 5:4.

Hospitals as temples of healing

The temples of Imhotep were the first hospitals and medical schools, and the priests of Imhotep wrote the oldest-known medical and surgical texts. In Greece, the temples of Asklepios were also hospitals and institutes of learning.

Modern medical school hospitals are secular centers of healing, learning, and scientific research. They also offer opportunities for the spiritual growth and development of patients and medical staff. Gordon Self writes, “The hospital has become the modern-day monastery, for it is within these walls that we size up the meaning and value of our lives.”¹⁵ On a daily basis, patients and medical staff find themselves facing the boundaries of life and death. While babies are being born on the obstetrics unit, other persons are dying in the emergency department and the intensive care units. Patients and their families face the challenge of disability and impending death.

While most medical facilities are not affiliated with religious organizations, most recognize in some way that illness affects body, mind and spirit. The injured, sick, and dying need spiritual ministry. Some clergy have training and experience in crisis ministry, provided by supervised Clinical Pastoral Education (CPE) while in seminary. Others with more extensive postgraduate CPE training become professional hospital chaplains providing full-time crisis ministry to patients and hospital staff.

Hospitals are places for experiential education. The true art of healing, whether physical, psychological, or spiritual, cannot be taught by having students read books or attend lectures. Yet, physicians and other medical professionals receive little formal training or

¹⁵ Gordon Self, “A Little Soul Work Does a Hospital Well: Spiritual Direction in Health Care,” in *Spiritual Direction in Context*, ed. Nick Wagner (Harrisburg, Penn.: Morehouse Publishing, 2006), p. 86.

experience in pastoral care and spiritual healing. These areas are generally part of the experiential “unwritten curriculum” of medical education. Medical students face unusual spiritual challenges not well known outside of the medical profession.

Health science students

A typical medical student graduates from high school at age 18 years and four years of undergraduate study to enter medical school at age 22.¹⁶ Erikson describes this “traditional” student as being at some stage between adolescence and its struggle for identity, and young adulthood with developing relationships of intimacy.¹⁷ Fowler notes that this is a time of discerning one’s particular gifts and sense of vocation, while shaping one’s future life.¹⁸ These are also years of emerging spiritual yearnings, a fact that medical school curricula generally ignore. Spiritual growth becomes part of the “unwritten curriculum,” guided by individual encounters with mentors and teachers.

A medical student has many opportunities to form relationships with mentors 7-20 years older. Interns (roughly age 26) residents (about age 27-29) and subspecialty fellows provide substantial one-on-one teaching in the third and fourth years of medical school. Because of their age, the junior and senior faculty who lecture in the classroom and serve as clinical teachers (“attending physicians”) might be seen more as parental figures than mentors. Individual encounters with a teacher in times of intense stress might have positive or negative spiritual consequences, depending on the degree of teacher’s

¹⁶ Some students are older, entering medicine as a second career, but second-career students are much less prevalent than in seminaries.

¹⁷ As described by James W. Fowler, *Becoming Adult, Becoming Christian* (San Francisco: Jossey-Bass, 2000). It would be interesting to explore the various models (Erikson, Levinson, Gilligan, and Fowler) of faith development in this age group at some length, but this would better be done in a separate paper.

¹⁸ *Ibid.*, p. 117.

personal spiritual experience, and the nature of the interaction between student and teacher.

In most medical schools, students spend much of the first two years in the classroom and laboratory, learning the basic sciences of anatomy, biochemistry, cell biology, physiology, microbiology, pharmacology, and pathology in a rigorous, challenging curriculum. The amount of material is overwhelming, and difficult examinations are frequent. Teachers emphasize that science underpins medical decision-making, a concept called “evidence-based medicine.” Students may have occasional lectures on generic “spirituality,”¹⁹ professional behavior, and ethics, as well as opportunities to reflect on these issues in small group discussion sessions. Religious aspects, in the denominational sense, of spiritual and ethical issues would not usually be part of the formal curriculum unless a church group owns and operates the school.

A student’s first contact with a “patient” is in the first week of the first year, when the students meet their cadaver, a person who has donated his or her body to medical science. Most medical schools consider several months of meticulous human cadaver dissection an important aspect of the teaching of anatomy. Some students form a bond with their cadavers, and may report spiritual (even mystical) experiences related to prolonged contact with the deceased person. To provide closure, many schools hold nondenominational cadaver memorial services after the dissection laboratory has ended (See Appendix 1). Some students develop pathologic psychological or spiritual reactions to the anatomy laboratory sessions. The prevalence of “cadaver stories”²⁰ and rare incidents of physical cadaver abuse suggests that the gross anatomy laboratory can

¹⁹ Auguste H. Fortin VI and Katherine Gergen Barnett, “Medical School Curricula in Spirituality and Medicine,” *JAMA* 291, no. 23 (2004), p. 2883.

²⁰ Frederic W. Hafferty, “Cadaver Stories and the Emotional Socialization of Medical Students,” *Journal of Health and Social Behavior* 29, no. 4 (1988).

produce strong reactions for which there may not always be an appropriate outlet. In less severe cases, some students report the need to dehumanize and emotionally detach from the experience. A study of the prevalence of this reaction and its effect on developing relationships with human patients would be instructive, although difficult to conduct. In some schools, chaplains come to the anatomy laboratory to be available for counseling,²¹ but this practice is rare.

In some medical school curricula, first and second year students perform physiological and pharmacological experiments on stray dogs obtained from the local animal shelter. Generally, a laboratory assistant has anesthetized²² the dogs before the students enter the laboratory. At the end of the session, students inject the dog with a combination of chemicals similar to that used for executions by lethal injection, and leave. The laboratory assistant disposes of the deceased animals. Some faculty and students perceive “dog lab” as an important rite of passage, others see it as abhorrent. Some schools now use computer simulations to provide the same learning experience as a live laboratory. The “dog lab” experience places students into a personal ethical crisis – participate, or be dismissed from school. Student reactions vary, ranging from no apparent reaction to detachment, and rarely to animal abuse.

A student’s initial contact with living patients consists of encounters with “standardized patients,” trained actors who provide consistent answers to the questions of a medical history. Instruction in, and experience with, spiritual history taking is not prevalent.²³ In

²¹ Donald G. Shockley, “In Quest of Profound Courtesy: A Chaplain Enters the Anatomy Lab,” *Christian Century* 103, no. 27 (1986).

²² In my own experience, the anesthesia was usually inadequate. More drugs had to be given because the animal was clearly experiencing pain.

²³ In 16 years of clinical teaching at a state medical school, I have never yet had a student present a patient’s spiritual history, although many articles in the medical literature stress the importance of the spiritual history. One resident has done so.

the second year, students practice interviewing and physical diagnosis skills on relatively well patients. Thus, medical students have very little contact with suffering and dying patients in the first two years of school. This approach to medical training has the risk to make physicians into rationalists who are “materialist and physical beings.”²⁴

In the third and fourth years, students begin to apply their basic science knowledge to the care of patients. They spend time working in various medical and surgical specialties, in outpatient clinic settings and in inpatient hospital services. They study the diagnosis and management of human disease while interviewing, examining, and performing technical procedures on human patients. At the same time, they are called upon to maintain and develop their own humanity, sometimes with help from a more mature person, and sometimes not.

In doing so, they begin to experience the “unwritten curriculum” of medical school. They have almost daily opportunities to discern right from wrong, as well as situations in when it is not possible to know what is right. Some make personal and patient-care decisions that prove to be wrong, and they may have little support in dealing with their reactions to this. Students also learn to deal with the ambiguity that what is “right” for one teaching physician is “wrong” for another. Additionally, students provide patients with informed consent for potentially life-threatening medical and surgical procedures, and they deliver bad news to patients and families. They are involved in end-of-life discussions. Students begin to face true ethical and moral dilemmas for which there may be no clear answer. They have the opportunity to interact with chaplains and ethics panels, and they will

²⁴ Anonymous, “Father Joseph: God in a Medical School,” in *Healing Ministries: Conversations on the Spiritual Dimensions of Health Care*, ed. Joseph H. Fichter (New York: Paulist Press, 1986), p. 186.

encounter both positive and negative professional relationships with other medical personnel.

While students may have entered medical school with idealistic goals of alleviating pain and suffering, and saving lives, they now find themselves surrounded by the gamut of human affliction and sometimes find that there is little that they or others can do. While most have the skills to comfort patients and families in distress, they may not realize that they do, or past life experiences²⁵ may make it difficult for them to do so. While a student may have a personal prayer life, and may participate in prayer groups, it can be difficult to lead a patient or family in intercessory prayer because of the concern that others might view resorting to prayer as an abandonment of standard medical treatment. Some withdraw into the realm of academic evidence-based medicine: probabilities and scientific rationalism. In the frenzied pace of school life, involving cycles of intense study and examinations, some brick themselves up in their apartments, as modern anchorites. Other students make time for church attendance, prayer life, Bible study groups, and medical mission trips. In the challenges of medical school, some find opportunities to deepen faith and enhance spiritual and psychological growth and development. Some discover, perhaps for the first time, that they have the *charisma* of physical and spiritual healing.

Clinical pastoral education

Having medical students involved in clinical pastoral education (CPE) is an underutilized option for developing humanistic attitudes and promoting spiritual growth.²⁶ Although CPE is often considered a summer program for divinity students headed towards

²⁵ Perhaps the inevitable death of a patient will force the student to recall the helpless feelings of watching a grandparent, parent, other relative or friend die.

²⁶ David C. Duncombe, Arthur M. Gershkoff, and Robert M. Nelson, "Medical Students in CPE," *Journal of Pastoral Care* 32, no. 3 (1978)

ordination, CPE is also available to committed laypersons. With appropriate physician and chaplain supervision, medical students and CPE students might serve as mentors for each other. The medical student could help the CPE student understand complex medical terminology, procedures, and hospital routines. The CPE student could help the medical student understand the theological basis of ministry to the sick and the spiritual dimensions of illness, injury, and the resulting personal and family crisis.

A few medical students might take an elective CPE unit if it were available. In a report by Duncombe and two medical students,²⁷ one student observed that “listening, offering support and presence, experiencing and reflecting concerns, and praying” seemed to be like “rediscovering attitudes and skills I had not known since childhood.” The other student noted that in the first two years of medical school he had looked “in vain for signs of the compassion and service that are the hallmark of a physician.” In the CPE experience, prayer became “the most intimate, personal and powerful form of ministry.” While there is no literature on the training of medical students to be spiritual directors, and while it would not be appropriate to incorporate formal training in this specialized ministry into a medical curriculum, it seems that these two medical students received direction from their CPE supervisor and offered low-level, brief direction to the patients whom they visited.

Not all students will be able to find elective or vacation time to take a full CPE unit, or a CPE-like course, and not all would have the inclination to do so. Margot Hover reports her experience in using principles of CPE, including verbatims, with medical students.²⁸ Student response was hostile; students called the program, “God Rounds,” and felt that it

²⁷ Ibid.

²⁸ Margot K. Hover, “The Role of CPE in Medical Education,” *Journal of Pastoral Care* 38, no. 3 (1984)

was redundant of earlier classroom work. They observed that as patients they would rather have a competent physician than an empathetic one, and that listening is more of a job for a chaplain than a physician. Yet, she learned that most of their resistance was based on preconceptions, as the course ultimately became a venue for the sharing of feelings of “fear, frustration and helplessness.”

At another medical school, the Department of Pastoral Services offered a CPE-like elective for students, allowing students to function as chaplains, with supervision, for a four-week period.²⁹ There were didactic sessions, class discussions, and presentation of verbatims. Three second-year students enrolled in the elective, afterwards noting that their listening skills had improved, that their understanding of personal “spirituality” had broadened, that the CPE model encouraged learning from one’s mistakes, and that they had a greater understanding of importance of pastoral care and the role of hospital chaplains. Because of their medical training, these students “brought perspectives which the typical seminary trained pastoral trainee lacked.”³⁰ However, CPE is not spiritual direction.

Spiritual direction and health science students

Medical school is an intense physical, intellectual, psychological, and spiritual journey. Since God is the source of all healing, it is particularly important for a student of healing to develop and maintain a profound personal relationship with God. Yet, the intensity of the medical school experience may leave a student feeling alone in a spiritual desert, apparently facing demons, not God. A spiritual “dark night” in which God seems not to be present and active in the student’s life can be particularly painful, mimicking some of

²⁹ Robert L. Sevensky, Myron L. Ebersole, and Paul Derrickson, “Pastoral Care of the Sick: A Clinical Course for Medical Students,” *Journal of Pastoral Care* 39, no. 3 (1985).

³⁰ *Ibid.*, p. 234.

the symptoms of depression. A secular counselor might not be able to identify signs of a dark night, instead recommending therapy for depression. A dark night without guidance and reassurance adds to the intense stress of medical education.

Of course, students do not walk alone. God is always present, but even in a mature person, feeling and recognizing God's continuous presence and support can at times be difficult. Unlike CPE students, medical students do not have assigned spiritual supervisors. However, students find psychological and spiritual support in each other, their mentors, and their faculty. These are generally "spiritual friendships" rather than spiritual direction. Some of these individuals are unaware that in these informal relationships they are functioning as charismatic spiritual directors,³¹ without formal training or being aware of the ethical principles guiding this ministry. Certainly, it would be difficult to find enough trained spiritual directors to serve the needs of a medical school, which might have 800 or more students at a given time. Thus, it would not be possible to offer spiritual direction to all students. Additionally, students come from various faith traditions, some of which might not embrace the concept of spiritual direction, and some are agnostic or atheists. Secular counseling is available, but this is not a faith-based model and it is not appropriate for many situations.

Students have opportunities other than *ad hoc* encounters with untrained persons functioning as low-level directors. If they are part of a religious community, they have the support of the laypersons and clergy in that community, and spiritual direction may be available. For hospital chaplains, pastoral counseling or spiritual direction with an occasional medical student might be a welcomed opportunity, a relief compared to the intensity of duty in the hospital. However, most chaplains are overworked. A medical

³¹ Edwards, pp. 98-99.

school might be located in a city with a monastic community, or a city that has independent directors who would be willing to work with medical students. Churches and monastic communities might offer occasional retreats for medical students. Lastly, there might be spiritual directors and other clergy who would be willing to lead faith-based discussion seminars in areas of interest to students. In such a scenario, it might be possible to use a testing instrument, such as the Holmes-Harvey Spiritual Style Inventory, to help students assess their spiritual style and identify areas of strength and blind spots that warrant focus in the context of direction. Using the results of such testing might serve as a platform for discussing the general principles of “spiritual style” in a group setting.

At an unnamed medical school, a Roman Catholic priest named “Father Joseph” and an “Episcopal minister” direct a “Ministry to Medicine” program to discuss ethical dilemmas in various aspects of medicine. The program is intended to “prepare them to have a humane concern for patients.” The broad nature of this program allows discussion of nearly any spiritual issue related to medicine, and it also gives students an opportunity to explore whether individual sessions with a pastor, including brief spiritual direction, would be spiritually edifying.

Brief spiritual direction

Classic monastic spiritual direction is a long-term, one-on-one process of formation. In some situations, brief, or short-term spiritual direction might be appropriate, taking six or fewer sessions. Duane Bidwell believes that most modern spiritual direction is a short-term experience. He views such sessions as “opportunities to help people learn to listen on their own and with others for God’s presence, without the guidance of a pastor or

chaplain.”³² This model is similar to the “Occasional Direction” model described by Laplace.³³ It is attractive since medical students are busy, can have off-campus clinical rotations, and are only in school for four years. It is dangerous if a student believes that a few direction sessions would qualify the student to lead a group discussion without training as a director and appropriate supervision. It is also hazardous for a student called to mystical experiences with God, since discernment of spirits is a *charisma* that is not quickly learned. Furthermore, since Bidwell’s model is founded on the principles of brief psychotherapy and brief counseling, there is the chance that in crisis intervention these models would prevail over actual spiritual direction.³⁴ Brief spiritual direction also may require premature termination of the director-directee relationship without an opportunity for the director to assist the directee in finding another director. Still, brief direction sessions might teach relaxation, clearing of the mind, and focusing so that true prayer is possible in difficult and chaotic situations. Bidwell’s model is well-suited for pastors and others who want to incorporate low-level, informal spiritual guidance into pastoral care, and who are able to discern situations in which directees need classic spiritual direction or other therapeutic relationships.

Summary

Throughout the four years of medical education, students face multiple situations in which spiritual direction would be helpful, if it were available. Putting Christian spiritual direction into the formal medical education curriculum is impractical for many reasons. However, there are many extracurricular opportunities to introduce medical students to the concept of spiritual direction. These include participation in church groups, retreats,

³² Duane R. Bidwell, *Short-Term Spiritual Guidance* (Minneapolis: Augsburg Fortress, 2004), p. xi.

³³ Jean Laplace, *Preparing for Spiritual Direction*, trans. John C. Guinness (Chicago: Franciscan Herald Press, 1967), pp. 140-143.

³⁴ Bidwell also discusses other “dangers and pitfalls.”

CPE-like electives sponsored by the medical school, and discussion groups like Father Joseph's "Ministry to Medicine" program. These sessions would provide opportunities for Christian students to discuss the unique challenges of the medical education process in a faith-based setting, and chaplains, local clergy, and spiritually mature laypersons could organize them. Discussions in these various contexts might prompt some students to recognize a need for short-term spiritual direction, which ought to be readily available, as well as prompt them to engage in classic direction once their training has completed.

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Appendix 1. A medical student's thanksgiving to Cadaver #9³⁵

Dear Cadaver #9,

It's hard to believe that your remains will soon be cremated and scattered over the ocean. Thank you for donating your body to medicine and for allowing me the opportunity to learn the intricacies of the human body in an unforgettable and highly effective manner. To be honest, even though I have only known you for a year...and our interactions were mostly limited to a tightly controlled setting with five other students at the table...and even though your conversational skills were somewhat non-existent...I feel like you have been a strange sort of friend. Familiarity is a funny thing, and now I think about those dozens of hours spent poring over your organs and vasculature as if it were the Book of Life, and maybe that is not so far from the truth. Strange to think that you have single-handedly shown me that Man is a World Unto Himself, and that your gift has changed my life and hopefully the lives of many others.

Can I call you a friend? Because you have helped me, given selflessly, and never questioned or rebuked us even when we devised the "Resistance Method" to test whether certain white strings were nerves or fascia³⁶ ("if it breaks when you tug it, it was fascia"). Even though you were a strange green color and had a really interesting liver, you smelled familiar and the other cadavers just didn't smell the same. We touched your heart, your lungs, your brain, looked into your face and handled every muscle in your leg. No other human will ever be so open and clear to us, so bravely exposed and for that we are grateful.

The memorial service held at UCSF last week for the cadavers was extremely touching. You would have liked it, I think. Two baskets of white flowers stood at the head of the aisle in our lecture hall, and the first year medical students read poems and written pieces. One of our classmates played a haunting waltz on the fiddle that made my insides ache. The anatomy faculty attended the service, and one of the faculty members read a poem from the New England Journal of Medicine and she cried throughout the recitation. She mentioned how every year, there are new cadavers all unopened and pristine, and a new class of medical students who are all strangers. As the year progresses, the bodies "come apart" and the class "comes together" as the process of dissection slowly instills knowledge into our inexperienced heads. You made all the difference. Thank you.

Sincerely, Stephanie

³⁵ "Stephanie." "Stephanie", (accessed August 17 2008); available from <http://ucsfynapsemed1.blogspot.com/2007/06/cadaver-memorial-service.html>.

³⁶ Fascia is connective tissue that can look like a nerve.