'Meeting' Magda

HOW STORIES CONNECT US TO THE NEEDS OF OTHERS

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Jesus told stories, parables that offered a glimpse of what the reign of God was like. He helped ordinary people like you and me understand what is elusive by comparing heaven with objects we can grasp and hold, like a mustard seed, a net, a pearl.

As I reflect on my ministry in Catholic health care, I am deeply appreciative and humbled by the countless stories of the people I have served and worked with who have revealed the face of God. They have shown how concepts like love and grace, vulnerable and marginalized and even the preferential option for the poor translate into flesh-and-blood encounters.

Without stories to remind us that, fundamentally, we are social beings called to relationship, health care can quickly be reduced to outcomes and margins. And when it comes to working in addictions and mental health, this patient population can especially challenge what we mean by compassion and justice.

Stories have a way of translating cases and events into faces and encounters. Although strategies and performance measures are important dimensions for better *serving the vulnerable*, we also need to keep reflecting on our relationships with the persons we serve — which is more about *being vulnerable*. If that sounds scary, it is. However, from the safety of our reading chairs and through the medium of stories, we have a wonderful opportunity to meet characters, engage our moral imagination and dare to ask ourselves what it means to risk relationship for the sake of the ministry.

I am talking about risking relationship with those who reveal the image of God, and I believe there are none more deserving of our deepest respect than the human beings in our care, or in our employ, who live with addiction and mental illness. That invitation is what calls me to storytelling and what keeps me grounded in Catholic health care.

Long before setting out to write stories, I experienced them. Not just fictional characters I created who could be shared publicly, but personal reflections shaped by memories of serving patients and families. They granted me permission to enter into their sacred space. For example, memories of the immigrant family I befriended who had witnessed peril and piracy on the high seas. They trusted me when they had nothing to their name. Colleagues shared about lifelong journeys with depression — they have taught me about dignity and resiliency. I learned about indescribable pain from those closest to me who knew the weight of empty arms when their expectations of birth were dashed. Perhaps the hardest

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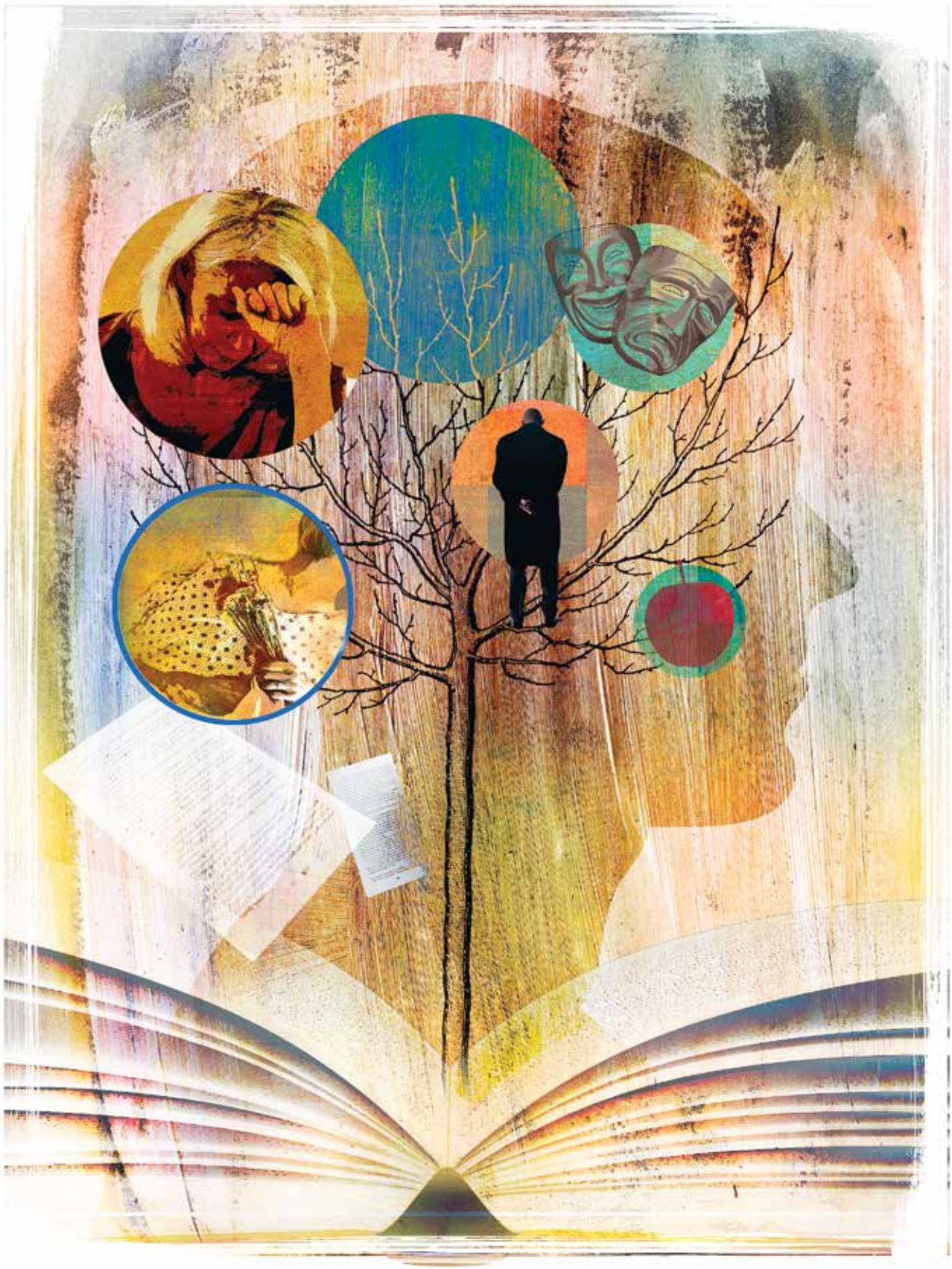

story to tell is the journey of a young man's drug addiction that nearly cost him his life, for that story is my own.

Such rawness can expose both author and reader, not unlike the shared vulnerability in the clinical setting when details in a patient's story elicit a strong reaction in the caregiver. Stories also have a way of affording some insight of what may get in the way of relationship and genuine presence.

'MEETING' MAGDA

I have a busy, full-time ministry in Catholic health care at Covenant Health in Canada, and I have a special passion for our work in addictions and mental health. How I write stories in evenings and on weekends and holidays amazes some people. But it began when I "met" Magda, a character I was compelled to write about to raise awareness and to challenge our health care ministry to do more for invisible people like her.

Magda is one of the many whose needs go unaddressed. She is the character who personified the hollow-set faces and hungry eyes I encountered on work trips to the Downtown Eastside of Vancouver, the poorest postal code in Canada. You have to walk down that community's back alleys and street corners to understand how great is the unmet need to which we are called to respond.

On those trips, we talked with clinicians and researchers and policy analysts who educated us about harm-reduction strategies and trauma-informed care. We learned about creative housing programs, social support programs and the importance of partnering with others to broaden the safety net. We reviewed statistics for overdose death, soft-tissue infections and people leaving hospitals — against medical advice — sometimes because they encountered negative judgment from staff.[1] And most importantly, we listened to people who inject drugs, and we heard their heart-wrenching stories of abandonment and pain.

During this time, Covenant Health was concurrently developing newborn safe havens for our acute care hospitals in Edmonton, and we consulted our colleagues in Vancouver, who established the first such havens in Canada, known as Angel Cradles.

Of course we focus our attention and empathy on the newborn left behind in an Angel Cradle, but do we see the face of abandonment belonging to the parent? What led up to a person abandoning his or her child? What desperation, cycle of abuse and addiction or childhood trauma precedes such an event? What safe haven is possible for those living with addiction and mental illness? That is the story I wanted to tell, and I wanted to make sure every media interview we conducted focused on not just the helpless baby, but on all those at risk of abandonment, which I believe is the greatest moral issue of our time. They are equally deserving of our unconditional help.

In my stories, I invite the reader to see and hear and emotionally connect with our fellow human beings who have been left behind in society. My tales generally revolve around an abandonment theme with a corresponding message of compassion and justice to, I hope, inspire the reader.

As I become more emotionally connected to my fictional characters, and I reflect on the real people who have inspired them, I learn how trauma-informed practices cast so-called drug-seeking behavior in a new light. I understand how many people struggling with addiction are trying to numb almost unimaginable pain, often rooted in such damaged families of origin that they should receive my compassion and understanding, not judgment.[2]

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In humility, I recognize how much judgmental attitude I still harbor. Literature brings readers inside the minds of characters, but not before first probing the conscience of the author, especially when developing the characters unhinges personal and societal attitudes. There remain silent cries around us: 1 in 5 Canadians has had some experience with mental illness in his or her life,

yet enduring stigma prevents people from speaking out and drawing attention to such unattended need. I sense there are many who know too well that it is not fashionable to take off work for a "mental health day," nor does a lifelong journey with depression warrant the same badge of honor as surviving cancer does.

LIVED EXPERIENCE

I write from my lived experience, and, after nearly four decades in Catholic health care, I can tell you I have been challenged, moved and humbled by many good people who have suffered, often alone. Theirs are stories worth telling, and it is indeed an honor to try to give them a voice. For example:

- One colleague publicly disclosed about standing on the edge of a cliff, tempted to jump, when overwhelming depression threatened to take her life. She told her story to help break down the stigma surrounding depression and suicidal ideation.
- Postpartum depression is a serious medical issue that requires skilled professional help, but who will seek out that skilled help when there is societal expectation that a good mother should automatically feel happy, emotionally bonded to the baby and able to cope?
- When a person does comes forward and gets the help they need for facing depression, is he or she lifted up as the embodiment of hope and courage, the way we rightly do with other survivors? Why is one life-threatening illness more publicly recognized than another?
- When there is public acknowledgment of a suicide, why are we more taken aback — or attentive — when it is a celebrity's suicide than, say, an example of the epidemic of youth suicide in Canadian First Nations communities? I may find myself morbidly curious to read the quickly published biography of the celebrity, but I won't bother to learn about, or risk being emotionally affected or morally outraged about what prompted a 10-year-old indigenous girl to take her life. One First Nations chief lamented that we are "losing babies" to suicide.[3] What is the Catholic health care ministry's response to that crisis?
- Or, to make it more personal, what are we to say to the parents who have lost young daughters and sons to suicide? At minimum, we should be asking ourselves to what degree Catholic social teaching regarding the preferential option for the poor is a real driver of our advocacy strategies. Does the value of social justice, as espoused by Covenant Health,[4] make us uncomfortable and force us to ask tough questions? To see the faces of Magda and others? To speak out about the unspoken issues?

Well, it should.

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ASSISTED DEATH AND EUTHANASIA

Let me provide another example about the stigma of suicide that our ministry inadvertently plays a part in perpetuating. For the past few years, Catholic health care in Canada has been challenged by the legalization of voluntary euthanasia and assisted death (called medical assistance in dying, or MAID). This development obviously required defining how our organization and our national ministry colleagues would navigate this unprecedented change in society, remaining both in communion with the church and faithful to our institutional Catholic identity while still being compliant with the law.

So, although we will not provide, facilitate or condone medical assistance in dying, we nevertheless knew that, as a publicly funded institution, there would be people in our care requesting information and, potentially, medical assessment as the law requires, and they might transfer elsewhere to undergo MAID. We looked far ahead, long before the legislation was passed, asked ourselves, "How would we respond?" and prepared Covenant Health's policy for such situations.

I maintain that the most important word in our policy is the first word in the title, *Responding to Requests for Medical Assistance in Dying*.[5] Responding is a movement towards relationship, not just a stance that says, "No, we don't do that here." The response seeks to understand the

underlying reasons for the request and if there might be something else going on in the life of the patient. Responding means being prepared to have a conversation and really listen to a person, even if he or she is pursuing something that is in moral conflict with both our personal and our organization's values. And that can be messy.

I invited our clinicians to imagine how they would respond if a patient in their care asked them to hasten the end of his or her life: "What would you say?"

I asked priests, bishops and seminarians how they would respond if a parishioner contemplating assisted death requested a sacrament or a funeral: "What would you do?"

It can be argued that there is no need for dialogue and that the only response to such a potentially messy, complicated and emotionally challenging conversation is to walk away. But would that mean our church as well as our hospitals are environments that push at-risk people away for lack of understanding? Our work in addictions and mental health challenges us to ask ourselves tough questions about all our institutional attitudes and biases.

STORIES AND MORAL IMAGINATION

One of my characters struggles with seeing her aged parent growing old, his mind clouding with dementia. She is guilt-ridden and exhausted, feeling obligated to spoon-feed her dad each day, wishing she wasn't there. She hears the ticking of the radiator in the care facility room, sounding off her own mounting pressure to stay connected to her dad as his mind disappears a little more each day. She wonders, in that terribly sad and lonely moment, if someone could just end it all. Make his pain, and hers, go away.

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The scene affords the reader a glimpse inside the character's mind, and perhaps inside his or her own, about the temptation of suicide. It is very quickly suppressed. It is taboo. Still, how will I grow in compassion and respond authentically in keeping with the Catholic ethical and moral tradition, if I can't even hear the lament? It would seem to me that authentic Christian response to suffering requires some proximity to Job's dung heap.

I stood, this summer of 2017, with my face pressed close to the pane of glass on the One World Trade Center observation deck in New York City, 100 stories above the memorial site of the original twin towers. I imagined for a moment what it would have been like to jump, as victims did that horrible September day in 2001. To step out into the empty space; to take my life, instinctually fleeing an even more unimaginable death by heat and flame. I could only feel profound compassion for those who were forced to do the unthinkable.

Afterwards, I wondered what unimaginable fear or burden or perceived death would lead one to request a hastened end to life. To imagine what possibly could ever force a 10-year-old child to take her life, or a person struggling alone with postpartum depression to drown herself.

"Is there really such a thing as suicide as a freely chosen act of one's volition?" one character in my novel asks. The character's question made me wonder what a compassionate response might be to a person who has disclosed innermost thoughts of desperation, believing ending life as the only way out of his or her suffering.

A compassionate response definitely would not be to assist in ending his or her life. But I hope I wouldn't just walk away, either. During the lead-up to assisted suicide and voluntary euthanasia legislation in Canada, there were some in public circles suspicious, even judgmental, of what the expected Catholic response might be. That we *would* walk away.

It made me wonder when the weight of lament risks clouding any reason for a person to go on, if a listening, compassionate presence might provide just the shred of hope to make a difference — if only we stay present, without judgment. What if I were to press my face against the glass of his or her soul, asking permission to peer inside?

Time will tell if our ministry will witness a consistent, compassionate and authentic pastoral response regarding the issue of suicide and the issues of suffering and abandonment that can drive people to take their lives. Will we use our voice to speak out with equal conviction about youth suicide in impoverished communities as we

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do regarding the few who choose legalized death? But certainly, there would be no doubt whatsoever in people's minds of what to think of the Catholic hospital or parish if we did anything less.

If fortunate, we may find ourselves in just that right moment when a person living with mental illness or addiction discloses his or her deepest fears and needs. Mostly we can only guess. I suspect often I guess wrong.

Literature affords us insight that helps us grow our capacity for ethical reflection and discernment to probe a little deeper into the human spirit, to really see Magda and the other fictional characters inspired by those who turned to us in need, and to respond graciously from a place of compassion. To engage our moral imaginations of what we can do and what we must do. Our ministry of Catholic health care reminds us that every person we serve with competent care, as a son and daughter of God, has an important story no less worthy of being told, heard and embraced with empathy and love.

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NOTES

1. Ryan McNeil et al., "Hospitals as a 'Risk Environment': An Ethno-Epidemiological Study of Voluntary and Involuntary Discharge from Hospital against Medical Advice among People Who Inject Drugs," *Social Science & Medicine* 105, (2014): 59-66.
2. See, for example, Gabor Maté, *In the Realm of Hungry Ghosts: Close Encounters with Addiction* (Berkeley, California: North Atlantic Books, 2008).
3. Jody Porter, "First Nations Losing 'Babies' to Suicide, Chief Says after 10-Year-Old Dies," CBCNews Thunder Bay, Jan 20, 2016. www.cbc.ca/news/canada/thunder-bay/first-nations-suicide-ontario-youth-1.3410909.
4. To learn more about Covenant Health's values and to read stories highlighting them, see *Lasting Impressions, Many Voices, One Mission: Report to the Community 2017*. www.covenanthealth.ca/media/123409/2017-annualreport-covh.pdf.
5. Covenant Health, "Responding to Requests for Medical Assistance in Dying," *Corporate Policy and Procedure Manual*, September 2017. www.covenanthealth.ca/media/123343/vii-b-440.pdf.

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