

## Humanities: Art, Language, and Spirituality in Health Care

Series Editors: Christina M. Puchalski, MD, MS, and Charles G. Sasser, MD

# “Mother MD Intense”: The Need for Intentional Healing



Ann Berger, MSN, MD

National Institutes of Health, Clinical Center, Bethesda, Maryland, USA

Intention guides action. The importance of intention can be recognized in nearly all human endeavors, from daily family interactions to the most spiritual practices of prayer. The challenge with the practice of intention is that it involves not only the conscious thinking level of the mind but also the deeper levels of the heart and spirit. For example, in the Jewish tradition, intention is referred to as “kavanah,” which also can be translated as mindset or “direction of the heart.” Kavanah is holistic, the whole person all at one time. Kavanah is built over a lifetime and is applied in all situations, moment to moment. Kavanah comes from the root word “kivun,” meaning direction. Kavanah refers to the physical: having the legs, body, and face pointed in the correct direction. Kavanah also refers to having proper thoughts and feelings toward prayer-emotion, spiritual direction, and being totally present in the moment. In Judaism, Kavanah initially applied to prayers but is now recognized as applicable to everything one does in life. Kavanah represents direction of the heart, mind, body, and spirit.

Who has intentions that affect healing within the medical system? The key stakeholders include patients, caregivers, family and friends, hospital administrators, pharmaceutical companies, and medical insurance companies. As a palliative care physician who teaches many health care providers in a cure-focused setting, I prioritize the teaching of healing intention throughout our many modalities of integrative medical practice. This teaching cultivates healing intention not only for the patient but also for the learner. I believe that when health care providers use intention with all their actions with patients and families, many difficult situations

can be avoided or minimized. The patient and family will feel heard and understood. This can lead to a difficult situation becoming a healing situation. And ultimately, intention also helps the health care professional herself grow in a positive way and avoid compassion fatigue.

### Case Study of a Difficult Situation

I am a palliative care physician who previously trained as a pediatric oncology advanced practice nurse. I also have been a patient numerous times, with life-threatening conditions including cancer, cardiac arrhythmia, and a still poorly described neuromuscular problem. Having the opportunity over the years to both provide and experience health care—particularly from a palliative care perspective—has granted insights into some of the difficulties that are system-wide.

When my daughter was 22 years old and was working as a newly graduated nurse in pediatric hematology/oncology, my husband and I received the call that all parents dread. “Mom, I recently had a biopsy and it is a melanoma.” In that one moment, our entire world turned upside down. Thereafter, the world felt like it was continuously shifting. The next few weeks were a blur, as I helped coordinate her access to the best care available while simultaneously processing my emotions both as a mother and a health care provider. Fear about mortality for myself had been something I experienced several times, but there is nothing so difficult as fear of the illness or potential death of your child.

Even with my professional insight into health systems, setting up the first appointment with a surgical oncologist took more than two weeks. It took another

---

Address correspondence to: Ann Berger, MSN, MD, National Institutes of Health, Clinical Center, Chief of Pain and Palliative Care, 10 Center Drive, Building 10, Room 21733, Bethesda, MD 20892, USA. E-mail: [aberger@cc.nih.gov](mailto:aberger@cc.nih.gov)

---

Accepted for publication: May 20, 2016.

week to have the actual surgery. This required my husband and me to make two trips across the country. Getting off of the airplane for both those trips was almost surreal. Here we were flying into a city where most families arrive for a happy vacation, but our hearts were breaking and we were terrified. In our first meeting with the surgical oncologist, our daughter had an initial examination and then there was a discussion of the surgery and pathologic staging. My heart sank as the surgeon offered statistics; I knew the prognosis for survival was not 100%. When the surgical oncologist told me that her prognosis was “very good”—I became upset instead of comforted. As both an oncologist and a palliative care physician, I have taken care of innumerable patients with melanoma with advanced disease. Any prognosis less than 100% for my daughter was not “very good” and was not even “good.”

The day before surgery, my daughter was scheduled for a preoperative visit with anesthesia. I had a personal history of serious complications with muscular rigidity and difficulty breathing after three surgeries. My diagnosis, which was likely a genetic disorder, was still not determined and so I was particularly concerned that my daughter could have a similar anesthesia complication or even death. However, the day of the preoperative visit, there was no anesthesiologist who was able to address these concerns. Our anxiety was not addressed, and it only grew leading up to the surgery.

The following day, my husband and I entered the comprehensive cancer center for surgery for our daughter. An anesthesiologist appeared and reassured us that he had trained at an institution familiar with the potential diagnosis and knew how to deal with the differences in anesthesia. He reassured us he would be doing the anesthesia for the surgery. As we were waiting in the pre-surgical area with our daughter, a nurse anesthetist came in and said that he would be doing the anesthesia for our daughter. I immediately became concerned and shared that we had been personally assured by the anesthesiologist familiar with potential complications that he would be the one personally involved with the case. The nurse anesthetist said that the doctor would be “available,” but he would be simultaneously monitoring eight rooms. Clearly, my husband and I felt worried by this news. I requested that no trainees operate on my daughter. Reportedly, when my daughter was finally in the operating room preparing to fall asleep for her surgery, the last thing she remembers the staff saying was, “Your dad seems fairly uptight and your mother is very intense.” Several months later when she went to get her medical records on her chart, it was even written in the permanent record: “Mother MD intense.”

### ***How an Ounce of Intention Can Yield a Pound of Healing for the Difficult Situation***

Every day in hospitals, health care providers are surrounded with patients and families that are seen as “difficult.” Trainees hear “difficult patient” in sign out. Nurses say “difficult patient” to one another after a long shift. Attending physicians have even reported “difficult patient” as a reason for palliative care consults. But is it really that the patient or family is difficult? Or, is it the situation that is difficult? Fiester writes, “Behaviors that saddle a patient with the label ‘difficult’ can be better explained as normal responses to problematic interactions or negative experiences related to the delivery of medical care . . . and fall well within the range of ‘normal’ for individuals faced with significant life stressors . . . .”<sup>1</sup>

Intention is important on both sides: the health care team’s intention and the patient’s intention. When health care providers interact with their patients and families with empathetic intention, they are direct, they look at their hearts with humility and respect, they cerebrally know that not everything can be fixed, and they acknowledge that helping a patient and family during a life-transforming event can actually usher in healing. This healing can and most often does occur even when the situation is difficult.

I also believe that we as health care providers can learn from patients and families. Therefore, part of my vision of advanced palliative care medicine is to learn “best practices” from patients in terms of their use of intention and then develop methods to teach other patients how to use their intention for their own benefit in all phases of the disease trajectory. My research approach has been to study patients with chronic life-threatening illness with the best subjective outcomes (life-transforming positive change) and determine how they used their intention to obtain a highly positive subjective outcome.<sup>2</sup> One of the main research findings has been that intention plays a pivotal role in developing positive subjective outcomes, a role that 1) often comes very early in the patient’s response to life-threatening disease and 2) is both sustained and further strengthened by positive subjective results during treatment and (if fortunate) recovery. Therefore, one difference is that the health care intention is often applied acutely, whereas the patient’s intention can be more continuously applied through treatment and recovery. An additional advantage of engaging the patient’s healing intention is that it can not only result in relief from suffering but can also produce profound personal growth that is suitable to the patient. Because a patient’s intention can be engaged early and sustained over a long time and it involves multiple levels of cognitive function, a seemingly small amount of intention (compared

with the large peril of life-threatening illness) can have a surprisingly decisive effect in subjective outcome—enough to be positively “life transforming” even in the face of mortality. I have not formally studied family caregivers yet; however, clinically I have seen that positive, life-transforming outcomes also can occur for them when health care providers use *kavanah* or intentional healing.

Why is it so difficult for health care providers to use intention to help patients and their families have a positive healing experience? I think to answer this question we need to look at who we, as health care providers, are taking care of: the patient, the family, or ourselves? From the very first interaction, the health care provider needs to begin to gently explore the patient’s path to walk with the patient on the difficult journey ahead. The issues that need to be looked at are the patient’s perception of the disease and its treatment, level of desire for information, and ability to understand cultural and spiritual issues, support systems, goals and anticipated outcomes. The second thing the health care provider needs to look at, using intention, is the family of the patient. They often have the same issues as the patient; however, they may answer each of these inquiries differently. The primary health care provider also needs to look at all the other health care providers on the team and help them understand the patient’s goals and close the gap between patient/family perception and reality, developing a collaborative plan of care with all health care providers and the patient and family.

How do we as health care professionals get more comfortable using intentional healing to help heal patients and families who are in the middle of very difficult situations? A good first step is found when I practice Reiki on a patient. At the outset of the Reiki session, I ask the patient what is their intention of the day. Then, as a health care provider, I set my intention so that it will align with the patient’s intention to help move them toward healing. To do this, it is best to examine our professional and personal feelings/past experiences/beliefs. It is critical to encourage open communication including fears, concerns, and goals from the onset to promote an environment of security. It is critical to trust the openness of both optimistic and realistic goals throughout the disease trajectory, and, most importantly, always communicate with patient and family as we would want to be communicated with.

As health care providers who wish to help patients and families heal during a difficult situation, one should acknowledge personal and professional bias, be cautious about “if you were me” scenarios, avoid being judgmental, and realize that sometimes the best medicine is presence. Presence is an interpersonal process; presence is sensitive, holistic, and intimate. Patients and families demonstrate a need for

and an openness to presence. Clinicians enact it with intention and help turn a difficult situation into a healing situation.

By 2021, my hope is that the research and clinical practice of the process of healing intention have demonstrated: 1) how to understand the role of the different levels of the mind in making healing intention effective; 2) what it is that makes some instances of healing intentions effective (producing strongly beneficial results for the patient and family) while in other instances healing intentions are not very effective; and 3) what caregivers and patients can do in conjunction with engaging their healing intention to support the translation of those intentions into actual benefit. It is also my hope and vision that the health care providers and system can develop intention holistically toward the whole person and the whole care team. In palliative care, one way this is done is to use integrative medicine: patients, families, and health care providers using routines, relationships, and rituals to build and sustain intention over time, permeating the whole health care system. Then intention—*kavanah*—can be applied moment by moment in diverse ways to help in decision making, with every empathetic interaction we have with others and with every therapy we chose to use.

My wish as a nurse, doctor, patient, and family member who has been in many difficult situations is that I will not be seen as “Mother MD intense” but as “Mother MD Intentional.” Every journey I am on is made easier by empathetic health care providers who are practicing medicine with *kavanah*—being concerned, respecting and acknowledging difficult situations, and helping patients, families, and themselves move toward healing and building healing environments. As health care providers, we need to recognize that we are a very important part of a sacred bond with our patients and families. It should always be a privilege to be on a journey with each and every patient and family.

### ***Disclosures and Acknowledgments***

This research received no specific funding/grant from any funding agency in the public, commercial, or not-for-profit sectors. The authors declare no conflicts of interest.

### ***References***

1. Fiester A. The “difficult” patient reconceived: an expanded moral mandate for clinical ethics. *Am J Bioeth* 2012;12:2–7.
2. Skeath P, Norris S, Katheria V, et al. The nature of life-transforming changes among cancer survivors. *Qual Health Res* 2013;23:1155–1167.