

Spirituality in a Medical-Rehabilitation Hospital in the Urban Midwest of the United States¹

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Abstract

Medical-rehabilitation institutes and hospitals treat survivors of major illnesses, accidental injuries, and domestic or urban violence. Patients are not hospitalized in hopes of a cure, but rather to learn how to adapt to permanent, major bodily change. They learn a whole set of cultural rules governing the conduct of changed bodies. Discourse on spirituality and religion plays an important role in everyday life of this social universe shared by staff and patients, raising questions about whether staff and patient needs are addressed in ways facilitating patient re-entry into family and community life. One finding is that, in contrast to acute care hospital life, visits by a patient's clergy or lay ministers rarely occurred, but that spirituality is a major staff and patient concern. This paucity of clergy visits and acquaintance visits from patients' congregations or parishes at this critical time in patient life became apparent when a Protestant minister was admitted to the brain injury unit and congregation members visited him daily. His visitors then extended their visits to other patients on the unit who were lonely or who had no visitors. This article also looks at staff reaction to patients' declarations of spiritual rebirth that patients in interviews claim to have experienced during the medical-rehabilitation process.

Introduction

During the six- to twenty-week period when post-acute care patients reside in a medical-rehabilitation hospital, patients encounter a plethora of ongoing cultural factors present within such an institute's social universe that are an integral part of patient and staff work and life. For instance, medical rehabilitation is one specialty where patient activity in treatment is required and regarded as work. Cultural factors directly and indirectly affect what happens during a patient's stay and, ultimately, a patient's successful survival after discharge. This article reports ethnographic results of studying what I call the The Body Shop hospital (Pawlowski 2001) and identifies salient aspects of spirituality and religious life as experienced by patients and staffers.

An Intimate Picture

Several recurrent elements emerged from a content analysis of 88 interview transcripts and field notes to provide an intimate picture of this institution's patient and staff life. The study included an examination of texts found in archival material from the institute's history collection. Personal papers, publications, and other documents all contributed to the study. Also analyzed was a three-year daily log from a meditation room that staffers and patients filled with

scribbled comments, prayers, and prayer requests.

Emergent were the following:

1. the common experience of both patient treatment and staff work as a growth and maturation process;
2. the intrusion of urban social problems into staff and patient life;
3. the significance of medical, occupational, and organizational work and treatment routines as social rituals that give structure, meaning, and coherence to staff work and life; and
4. the role of spirituality and religion as an important aspect of the lives of patients and staffers.

This article examines only this fourth element, the spirituality of religious life. I found that medical, occupational, and organizational work routines and rituals give structure, meaning, and coherence to cooperative efforts of patient and staff working and living together. The element of spirituality is particularly striking because of how it emerged. Spirituality was not included in the study's broad specific aims lest it presumably detract from the prime medical and occupational focus of a Body Shop portrait. Questions about spirituality and religious life were not incorporated into interview protocols, and yet study participants seemed to inter-

ject spirituality into interviews and informal discussions whenever possible.

Anthropological holism supports the importance of this article. Spirituality of course is part of a holistic approach, especially in a setting where individuals are dealing with often radically life-altering events. Spirituality is what the participants and data showed so strongly. Academics it seems, and I obviously include myself here, often miss important variables in our research designs.

Spirituality: Operational Definition

In the context of this article, the term *spirituality* will be operationally defined to include actions or discourse concerning relationships with a deity or supernatural greater power. These actions or discourse include prayers, the topics of praying, and study participants' expressions of moral or ethical concerns. The term spirituality, for the purposes of this article, also includes religious and philosophical questions as raised by study participants. In interviews and other spontaneously and naturally occurring discourse, they reflect on their own or others' actions and motivations that they perceived to be an unquestioned or unchallenged part of daily Body Shop staff and patient work life.

Spirituality emerged in the context of patients and medical-rehabilitation staffers finding, comprehending, and articulating meanings for the life-altering events or illnesses that bring patients to rehabilitation. Spirituality emerged during the interview process as patients and staffers offered reflections on lessons they felt they learned in the course of their shared daily life. Among these was the view that patient activity is physical work, that it involves learning to physically adapt to a changed body, and that life in such a place means working while watching one's peers work, be they fellow patients or paid co-workers. Both patients and staffers work along side one another in common areas such as gyms or nursing stations where staffers and patients engage in easy, informal conversation. Here lines separating patients and staffers blur in pursuit of a common goal.

Openly and freely, staffers frequently spoke about their work lives and the personal changes they, too, felt they had undergone once they

began working in a rehabilitation setting. This staff discourse was remarkably similar to the manner in which their patients talked about the personal changes they felt had occurred in their lives as they were working during this uncertain period of preparation and cultural re-orientation for their new lives. Both patients and staffers spoke of medical-rehabilitation work as a time of rebirth, and as a God-given second chance to reform from past indiscretions.

The Body Shop's Cultural History

The ethnographic fieldwork that is the basis for this article occurred from 1993 through 1995 in an eight-story, urban medical-rehabilitation hospital, or institute, as these establishments are traditionally identified. Throughout this article the institute is called *The Body Shop* in order to preserve the confidentiality of patients, staffers, their families and all study participants.

The Body Shop was founded in 1951 with the active participation of a group of local and regional health department officials. At the height of a major polio epidemic, this group recruited the region's leading philanthropists and industry leaders to build a special rehabilitation facility to serve young adults now recovering after lengthy confinement in iron lungs. As these polio patients recovered, many needed to relearn to walk and to perform other basic life tasks. To provide a setting for this work, Body Shop founders used a pre-existing, small but highly regarded, holistic physical therapy institution as a model. Leading polio physicians, nurses, physical therapists, and expert craftsmen fashioned braces. Rehabilitation theory at the time required recovering patients to reside in institutes such as The Body Shop during recovery, usually for six months or longer. During this time, they underwent arduous, eight-hour days filled with physical and occupational therapy during which they learned to use braces and assistive devices invented and custom made by Body Shop staff. Records and personal recollections revealed that many Body Shop staff pioneered in what would become known as the field of *orthotics*, the specialty of treating ineffective muscles, bones, and joints with braces. These specialists were also polio survivors who continued to work at The Body Shop until retirement.

The goal of The Body Shop at the time of the polio epidemic was to return as many individuals as possible to their home communities where they could live and possibly rejoin the workforce.

After the polio epidemic subsided, The Body Shop and institutes like it adapted over time to meet changing needs of urban populations seeking help with new types of disabilities incurred in work, recreational, and traffic-related accidents. Research and financial pressures cut patient stays to days and weeks instead of months. Suburban hospitals built their own small but profitable multi-purpose rehabilitation units that complied with regulations determined by Medicare, Medicaid, and private insurance corporations. In competition, The Body Shop further cut patient stays.

Although at the time of the study it was licensed for 155 beds, the daily patient census showed that The Body Shop was consistently below capacity, usually averaging 100 patients or less. Higher admission rates occurred during the warmer weather months when rates peak for boating injuries and other outdoor sports accidents and from instances of urban violence. Informally, in-patient nursing staff often wryly commented that they could gauge how much overtime they would work in the weeks and months to come by watching the evening television news reports. Still, the daily census continued to fail to meet expectations. And by the time of the follow-up period described below, underpopulated portions of units were closed and darkened. Patients were discharged, and nurses and aides laid off.

Patients, whose average stay at the time of the study was approximately 19 days, were admitted to one of four specialty units—spinal cord; brain injury; stroke / geriatrics; and amputations, which included hip or knee replacements. The Body Shop also admitted patients requiring long-term hospitalizations for major illnesses including cancer. At the time of the study, The Body Shop annually admitted a total of 2,000 in-patients to its urban site while also serving an additional 7,505 out-patients at this and its two distant but expanding suburban satellites. The urban site alone employed a paid staff of 600 (Smith 1994), including 15 board-certified physiatrists, who are physicians special-

izing in physical medicine and rehabilitation. In addition, a volunteer corps of 250 unpaid workers donated 22,000 hours of service annually (*Body Shop Annual Report*, June 1995).

The Body Shop has changed. During the study, Body Shop administrators laid the groundwork for much needed facility upgrades, such as eliminating unpopular and impersonal polio-era four to six bed wards in favor of double rooms. The number of private rooms grew. Some traditional hospital patient rooms were converted to apartment-like suites to give patients near discharge a chance to practice, with help and supervision, for the reality of life on their own once again. These badly needed changes began at the study's end, when the patient population was declining. It would be five years before major construction and renovation occurred.

Methodology

This study grew out of an NIH-funded pre-doctoral training fellowship in physical medicine and rehabilitation designed to train social scientists and allied health professionals in research methods in medical rehabilitation. The National Institutes of Health (NIH) granted special permission for an anthropologist to participate in the program, and both The Body Shop and the National Institutes of Health approved an ethnographic study as the research activity. Following the approval of Wayne State University's Human Investigation Committee and Institutional Review Board, fieldwork commenced in 1993 and endured through 1995.

The approved research design and methodology included informal participant observations in semi-public, pass-through areas such as waiting rooms, communal recreation rooms, and open physical and occupational therapy areas. Also, I as the researcher took copious notes while attending weekly lectures, Grand Rounds, staff training functions, and seminars held for all medical staff, allied health professionals, and those serving internships and residencies. Because it is a teaching institution affiliated with a major medical center and university, attendance at these scheduled events was mandatory for many interns, residents and students. This cohort of professionals in training resembled patients in that the time they spent at The

Body Shop meant that, together with the patients, they engaged in a joint apprenticeship. The mix blended the work setting's socialization and learning processes that are required prior to both the individual patient's and the professional's entry into lives that would be new and different from what they had once known.

Life at The Body Shop for its own staff as well as any related allied health professional staff working in its home medical center included a unique obligation. In addition to work and educational requirements, all staff were asked via public address system announcements to accept invitations to attend a variety of late afternoon and evening recreational therapy activities with patients and their families that included informational and outreach sessions and publicity events. Supervisors told staffers that their presence showed support for patients. These events became part of a parallel cycle of mandatory hospital, unit, and departmental programs and meetings that began and ended with a celebratory Rehabilitation Week at the start of the academic year each fall. Consequently, attendance at staff and patient events was included as part of my research activities along with participation in the medical staff activities such as Journal Club and weekly Research Department seminars. The final research design also included two periods of structured observations during afternoon and night shifts on the Spinal Cord and Brain Injury Units to supplement informal ongoing observations on both of those units.

Besides the plethora of observational notes, field notes, and archival data, the study yielded a total of 88 interviews. Specifically there were 52 tape-recorded interviews of patients and staffers conducted during a two-year period of ethnographic study that began in 1993 and ended in October 1995. This original interview population included 28 full or part time staffers (54 percent), three retirees (6 percent), five former patients who regularly volunteered time and services (10 percent), and 16 patients (30 percent). In the following six months, from November 1995 through May 1996, Body Shop administrators allowed further interviews of staff during scheduled appointments. These interviews allowed the study to focus on staff. When they were completed, the interview population

included the full array of occupations found at The Body Shop. At the highest hierarchical level, The Body Shop's chief executive officer (CEO) as well as other managers allowed a "study-up" focus that included rank and file personnel down to the housekeeping aides and attendants at the lowest employee levels. Staff occupations in the study population included all management and supervisory levels, physicians, administrators, secretarial and unit clerks, rank and file nurses and physical, occupational, and psychological therapists. These 36 interviews concluded the research. In all, the 88 staff interviews contained an inventory of 64 staff (73 percent), three retirees (3 percent), five former-patient volunteers (6 percent), and the 16 patients (18 percent). Signed, informed consent was obtained from all participants in specific observations or interviews at all times.

Defining Medical Rehabilitation and Its Patient Population

Medical rehabilitation is the one medical specialty that attempts to offset physical and cognitive changes in bodily function by teaching patients how to care for their new bodies and by retraining patients to use those altered bodies in new and different ways, incorporating, when needed, assistive devices or artificial limbs. Patients enter medical rehabilitation in- or out-patient programs after discharge from acute care hospitals to learn to adapt to bodily changes caused by debilitating illness, strokes, amputations, accidental injury, or urban or domestic violence. Staff with acute care experience prior to Body Shop work reported that potential rehabilitation patients were often a carefully screened and constituted a selected "chosen few." This situation could have added a mythical quality to the spiritual context of a place where both staff and patients might have considered themselves as a select group.

Unlike other biomedical specialties, medical rehabilitation promises no cures. Instead, the task of medical rehabilitation is to assist patients who must relearn simple, basic life skills: swallowing, eating, speaking, sitting, toileting, dressing, and walking. J. Madorsky and Corbett Madorsky (1995:61) explain that rehabilitation retrains, educates, and empowers people with

newly acquired disabilities to develop expertise in the use and care of their bodies—a task that no other medical specialty focuses on in this manner.

In the brief time spent in acute settings, especially with insurance-mandated shortened stays seeing patients discharged “quicker and sicker,” patients and their families have little chance to address the reality of the irreversibility of bodily or cognitive changes. Nursing and allied health staff report that, in their experience while working in other rehabilitation units and institutes as well as The Body Shop, they encounter many patients, regardless of injury, who believe that they will walk out of rehabilitation on their own, fully restored. True, some patients defy all odds and astonish staff with their achievements. But staff must help most patients and their families realize that a good outcome actually means nothing more than full acceptance and adaptation to their new bodily and cultural status.

During the comparatively longer stays, some insurance plans still allow for the medical rehabilitation process. Here patients have the luxury of the time, special facilities and services of trained staff to help them learn to adapt to physical changes. They often make needed psychological and cultural shifts of self-perception that will facilitate their survival after discharge into family and community life. In short, rehabilitation treats the effects on both body and psyche of the types of injury, chronic conditions, and disabilities that Sue Estroff characterizes (1993) as “I am” conditions. These are conditions that are highly disruptive of, and often involved with, cognition and the perceived self. Rehabilitation, then, is a period of time when, as Sue Estroff says, patients and their real or fictive kin may re-construct their world around the new reality of quadriplegia, paraplegia, or the irreplaceable loss of cognitive function.

During this time period, the very nature of inpatient medical rehabilitation work of patients, staff, and supportive family or significant others fosters self-assessment and deep personal reflection. In rehabilitation, all pretenses are stripped away or left behind. Patients, in the presence of others with similar conditions, confront the tangible reality of their basic beliefs

and values about their bodies and ability levels as well as beliefs about their social universe.

The Moral Mandate of Rehabilitation

The idea of rehabilitation resonates with basic philosophical ideals prevalent in Western culture (Scherer 1993; Murphy 1987). These include notions about the potential for individual development and change (Stein 1979) and resistance in the face of adversity (Stein 1979). They also include the ethos of individual achievement and mobility (Gritzer and Arluke 1985; Murphy 1987; Scheer and Luborsky 1991; Luborsky and Pawlowski manuscript) and the concept of body as a repairable machine (Hobbes 1950; Sahlin 1976, 1995; Scherer 1993).

The dark side of this moral mandate is a negative view of the disabled body dating back to the Greek philosophers Plato and Aristotle. The chronically ill, infirm, and disabled are perceived, like females, to be something less than fully human. Augustine says so repeatedly in his much-cited work, *City of God*. Disability can be seen as evidence of God's punishment for evil, and therefore as evidence of an individual's sin or guilt. (Goffman 1986; Pagels 1989; 1994).

Medical Routines as Social Rituals

The backdrop or cultural context of spirituality in this highly specialized setting, then, includes both cultural pressure and a spiritually laden moral mandate to undergo rehabilitation before reentering family and community life. This cultural pressure is coupled with the religion-like culture of scientific medicine and inpatient medical facilities that utilize daily medical routines operating as institutional social rituals utilized to maintain patient-staff work order. On in-patient units in a rehabilitation institute just as in an acute care hospital, medical routines provide a ritual context that contain, encapsulate, and define patient-staff interaction (Mattingly 1998). Staff members report a sense of unchanging timelessness and continuity that marks their work world. One nurse, ending a 16 hour shift said, “You loose track of the real world here. On patient floors, it feels like time outside of ordinary time. It's just like when you are in church.”

In-patient unit life is punctuated by highly

stylized interactions surrounding structured and prescribed cycles of work routines such as nurses and aides waking, washing and otherwise preparing patients for the day's cycle. Life for patients consists of schedules filled with a progression of feeding groups or treatments and psychological, occupational and physical therapies. In addition, aides' and nurses' processions into wards and rooms to take and record vital signs, to turn the paralyzed to prevent bedsores, and to toilet others mark time's passage more than any clock.

These interactions are a part of a repeated cycle of fixed social actions fitting Rappaport's definition of ritual as a set of words and actions, performed in exact sequence, not encoded by the performer (Rappaport, 1979). Added to this definition might be a verbalized or other acknowledgment by the performer of the ritual aspects of this behavior. One night shift nurse's comments show the power of these actions as ritual:

Some of what we do when we take vital signs could be changed or streamlined. We've tried, but we've never been able to make those changes. Nurses want to do things in a certain way. And they get upset if we ask them to change.

In this context small, ordinary aspects of life assume greater symbolic importance than they would if these actions occurred in any other setting. Also, there is an unspoken agenda that may help explain nurses' compliance with hospital rules. The rituals' meaning involves a "do-as-I-do" repetitious demonstration and giving of examples to patients to reinforce nurses' expectations that patients comply with demands that the unit and medical rehabilitation process exacts from patients. For example, there are demands for attendance at therapies, participation in unit and institutional social life, and continued interactions with staff during which new social rules and roles (with staff who may also be learning new rules and roles) are tested and rehearsed throughout a patient's stay.

Nurses, doctors, and aides teach compliance to institutional rituals by using and adhering to an unquestioned canon of institutional and social rituals. Additionally, staff may, by their own mental and physical compliance and sub-

mission to a hospital's or institute's rituals and subroutines, provide patients with their own bodily example, their own model that allows patients to learn the meaning and rewards of compliance. Patients' own casual participant observation of staff work and life is thus used to teach patients the meaning of compliance and importance of submission and adherence to a new way of life. Once released from rehabilitation, though, patient independence will include adherence to a regimen of treatment honed during instruction in body care designed to enhance future quality of life. Non-compliance could mean less than the quality of life that could be achieved through compliance.

Highly ritualized behaviors, matched with similar communication patterns between patients and staff that have been studied by anthropological linguists, are evident as each shift transfers responsibility for its charges to their colleagues on subsequent shifts, the next links in a care chain, during the ritual known as *report*. Report is an inter-shift staff meeting usually held in a conference-type room in the rear of the nursing station and only attended by nurses and aides. This round table, closed-door discussion includes transmission of information that is not always recorded in medical records and can incorporate a nurse's or aide's views on a patient's progress or lack thereof, and of the non-routine details and tales of unit life including relationships with family members or physicians. Following report, each new batch of nurses and aides repeats in detail their predecessors' actions, that is, they take and record vital signs, administer medications, conduct bowel and bladder training, procure supplies and medications, assist with meals and—on assigned days—permit or supervise patient showers or baths.

Staff Spirituality

This highly ritualized setting nurtures, in some patients and staff, a distinct sense of spirituality. Unlike acute care hospitals, no structure exists to accommodate customary flocks of priests, rabbis, and ministers who descend on hospital-bound patients. In fact, during field work, clergy visits were so rare or unusual that their absence was not readily apparent. In acute care hospitals, on the other hand, pastoral visits

are such a part of the day-to-day routine that admissions departments print out patient lists indicating consenting patients' religious preference and room numbers for use by visiting clergy. At no time during field work was such a list ever in evidence. This striking contrast, and the realization that a routine important in similar institutions was missing, only became apparent when a male Protestant minister was admitted to the brain injury unit following an accident in which the minister was permanently injured while saving a passerby's life.

Each evening after supper, steady streams of members of his congregation trickled onto the unit, showering him with gifts and treats. Within a few days, though, congregation members also began bringing fresh fruit and other small, allowable treats approved by the nurses to other patients, especially those whose families were exhausted and no longer came for a daily visit. A small choir put on an enthusiastic, informal performance of gospel songs in the dining room for all patients and staff one evening during visiting hours.

Instead of seeming pleased, however, unit nursing staff reacted in a manner unexpected to me. Nurses behaved in nearly the same fashion as they had on other evenings when a supervisor ordered them to perform chores in addition to their normal duties, or on another occasion to stay and work late without overtime pay. Unit nurses and aides remained stiff and aloof during the concert and later as the congregation visitors fanned out to see neglected patients. It was almost as if staffers were angry about the attention their charges were receiving. Some staffers retreated to the nursing station chart room, with their faces and bodies turned away from the activity, ignoring food laid out for them. No slices of cake or tidbits slipped back to the chart room this night.

When asked why the staff seemed so unhappy, one aide explained that she felt her co-workers were upset because it reminded her and the other staff of another side to patient evening and weekend visiting hours. Over time, the aide explained, unit staff cared for many elderly patients. According to the aide, later confirmed by a nurse, time and again during the late afternoon and evening hours when visitors are

expected, elderly patients remain alone. According to the nurse and aide, patients often cried when nurses and aides on duty came to tend to them. According to the staff, the elderly patients complained that when they had been healthier and physically able, they spent years contributing money and hours of volunteer work and time to their churches and congregations. These elderly patients, who were often widows, the aide reported, in turn then were often neglected by their church during their Body Shop stay when they needed help and encouragement. Many never had visitors from their churches—although one occupational therapist reported working with a church group that did take an active role in some patients' therapies. According to the aides and unit nurses, they felt that some patients are often forgotten by ministers and congregation members once they have survived a crisis, been discharged from acute care, and entered rehabilitation. Seeing this congregation's visits and lavish attention on other patients thus upset some of the unit staff who recalled the time that they had spent, and would spend in the weeks to come, with less fortunate and lonelier patients.

Rituals and Spirituality in the Social Universe of the Staff

Evidence of staff concerns about issues related to spirituality continually appears in public events and places. Unit, departmental, and Grand Round discussions address ethical issues on a regular basis, usually at the request of staff. Fundamentalist Christian religious brochures are openly displayed in lobbies and waiting rooms, found at tables in the cafeteria and patient lounges, and are replenished on a regular basis by anonymous staff. Nursing and dietary aides liberally sprinkle informal conversations during meals or bodily care with religious and scriptural references, mentions of faith and the efficacy of prayers, and belief in a loving and caring God. Not all patients welcome this kind of discourse. Some patients seemed to view this as unwelcome evangelization or preaching and an intrusion into a private area of self that patients would prefer remain undisturbed. The result was deteriorating patient-staff communication leading to friction and conflict that occa-

sionally resulted in a patient's premature discharge. One patient, for instance, openly regarded by staff as uncooperative and hostile, reported her annoyance and complaints about the religious talk of staffers. This patient said:

I am going to get kicked out of my psychology group therapy session for saying this, but I am sick of hearing about religion. I am tired of hearing that 'God loves me.' Every word they say is: "God loves you. God's going to take care of you." And I think, "Why didn't he? What am I doing here if God loves me and is taking care of me? I am ready to walk out of group therapy because it's hard to deal with some one else's spirituality and values when you have your own problems."

There were exceptions to the absence of clergy. Throughout field work, each Sunday morning two young, African American women volunteers arrived at the Body Shop to preside over an hour-long nondenominational service that was open to all. The service was held in one of the large, bright and airy patient dining rooms, often in the Brain Injury Unit. These two ministering women left when their service ended. The service itself consisted of scripture reading, commentary, songs, and personal stories from the ministers and the patients. As if to illustrate the integration of medical and spiritual rituals dominating staff life, the unstoppable medical rituals overran even this brief service. The steady stream of nurses and aides that usually ran through patient rooms was diverted, now continuing its trickling flow in and out of the dining room service as they administered medications, tubal feedings, measured and recorded patients' vital signs while patients prayed or sang.

Also, The Body Shop employed an elderly nun as chaplain during the Monday-through-Friday work week. She worked the day and part of some afternoon shifts and maintained an office and a non-denominational prayer and meditation room that was open while she was in the building. Sister reported that her goal was to visit each patient at least once during his or her stay. However, Sister Chaplain usually left the building shortly after the 5 p.m. when dinner trays were delivered to the patient floors unless there was an administration or medical staff

reception, Board of Directors meeting, or other formal event. Her leaving at 5 p.m. meant that she was not there during nights and on the weekends. The needs of patients nearing their discharge who were prepared for home leaves and those of the remaining, newly admitted and unsettled patients fell on the shoulders of a different group of nurses and aides who may have never had contact with Sister Chaplain. This group of staff worked the busy afternoon and skeletal night nursing shifts. In interviews, Sister Chaplain said that she recalled holding lengthy telephone conversations with patients in crisis at night only four or five times per year in her 16 years of work at the Body Shop.

Much of Sister Chaplain's time and energy was devoted to ministering to staff rather than to patients. This ministerial tactic is regarded as an innovative and much-needed approach to meeting staff needs for personal and spiritual support in work that can be emotionally draining. Working in an unstructured position, Sister Chaplain was free to sit on employee activity committees and administrative boards, often as a staff advocate in this non-union facility. She spoke at New Staff Orientation, at Resident Orientation, administrative functions, and at those activities planned to reduce staff stress.

Describing her work, Sister Chaplain reported in interviews with me that her routine is to start her daily morning rounds first by talking to top level administrators and their staff, as they are located in offices on the building's uppermost floors. Next, she travels down through the building's lower floors and hierarchical levels, talking to physicians, secretaries, therapists and then to patients in gyms and hallways and sometimes to aides. She stops at nursing stations on in-patient units not just to find out the room numbers of patients requesting a ministerial visit, but also to talk to unit staff about their personal needs and concerns, their illnesses, and the problems they face in and out of the workplace.

Given the inevitable emergency (Emergency Code Blue when someone is at immediate risk of dying), Sister Chaplain hovers in the hall waiting to see what her role in this crisis will be. However, as a United States Catholic nun, she adheres to her church's institutional rules and cannot

administer Last Rites or hear sacramental confessions. Still, she encourages and consoles staff in resuscitation attempts before accompanying patient and family to the emergency room of the adjacent acute care trauma center and hospital.

Sister Chaplain said that she defines her job as serving both as a guide and as a witness to individual patient's and staffer's search for inner faith, regardless of their affiliation to a religious group. She reported seeing anguish in church-going patients and their families as they fought to come to terms with their physical changes. Sister reported that these patients and their family members often told her that they felt betrayed by God, by circumstances, and by resultant bodily failure. They asked her, sometimes repeatedly: "Why me?" "Why the accident?" "Why the stroke?" "Why the illness?" After all, Sister Chaplain reported, the patients and their families told her that they went to church regularly. They said that they lived a good life before their traumatic accident or illness. Only now, instead of the good fortune and peace they felt they deserved as a reward for faithfulness to God, they found themselves facing uncertain and painful futures.

According to Sister Chaplain, she frequently observed male patients and members of specific ethnic groups. These were ones whose world and religious views of disability, illness, and injury were such that they as patients were almost frozen into inaction and unable to take part in any of the recommended therapies or treatments offered to them. Uncooperative patients are usually quickly discharged to make room for compliant patients who are willing to work. On occasion, reluctant patients could be seen sitting head down and motionless in wheelchairs in the hallways outside their rooms, parked there by staff hoping that they would participate in therapy after watching staff and other patients, and listening to their hopeful talk. But these individuals had been well taught, in the context of their denomination's religious instruction, that sickness and illness were signs of their own sinfulness and of God's punishment—even when they were innocent, so to speak, and had done nothing wrong to contribute to their injury. Sister also reported counseling patients who told her they were injured in drug or alcohol related

activities or because they acted recklessly or engaged in high risk behavior. In rehabilitation, these patients had to cope with guilt layered atop physical problems.

Reflecting on encounters with patients, Sister Chaplain said,

Patients say to me that they have never spent this much time alone with themselves, thinking about their bodies or their souls. My contention is that if you accept your body, you accept your whole being that God created you as. You might not like the way that some of it looks. I have to look at my face and say: I am me. I am the face of God. Nobody else has that image of God. You see, that's how the face of God is revealed.

Sister Chaplain's observation that rehabilitation is a time of reflection is borne out in all of the patient interviews that occurred during my study. Patients spoke about how they felt that God was giving them a second chance to correct some of the things that they had done wrong in their lives. These patients reported feeling that now that they had been given a rare second chance and could end old patterns of alcohol or drug abuse or stop engaging in the recklessness and risky behavior that had so affected their lives.

On the other hand, one doctor, a unit head, discounted patients' conversion stories and claims of reform because every day he treats, on one unit, both perpetrators and victims of violence, including some repeater survivors of street violence. In addition, like other staffers, he has heard through news reports and from individuals, of the sad fate of some former patients. He has few illusions about conversion stories, saying:

I don't trust people who say, "Now my life is different." People who say that they are going to use rehabilitation as an opportunity to change their life ... there is too much for them to learn when they leave. ... I'm not impressed by people who have an epiphany while they are here and then claim to look at the world in a new light. It just doesn't happen that way. But we do have people who draw strength from their religion while they are here.

My final interviews were on the Brain Injury Unit and may confirm this doctor's opinions. Late in the research, at a point when I had nearly stopped gathering data, one of the night nurses suggested that I pay attention to what was going on with three young adult patients on the Brain Injury Unit. The three often spent a considerable amount of time together after dinner. One patient was an 18-year-old woman who, later in a taped interview, told me how she ran away from a foster home for single mothers with a friend. That night, the pair ended their day at a drug house. The young women decided to spend the night there because they had nowhere else to go. After the two fell asleep, the house was attacked. The patient's friend and all but one other person in the house were killed. Wounded and left for dead, this young woman crawled out of a broken window and escaped with her life.

On the unit, after many counseling sessions, she said she wanted to go home to once again care for the baby she had left behind. She talked for a long time. On the audiotape, in a high-pitched, excited voice, she talks repeatedly about how she feels that God saved her. All seems well, and the recurrent theme in the final portions of the interview is her hope and firm intent to change, to take advantage of this so-called second chance.

The next morning after our interview, I went to ask her a follow-up question. But she was gone. On her white metal night-stand, her small treasures and pictures still sat waiting. New clothes criss-crossed her unmade bed and hung in her open closet. She had run away from the Body Shop, not by walking out a door with her belongings, but by jumping off a second floor patio balcony with nothing but the clothes on her back and nowhere to go. Her friend said that she ran off because she did not want to return to foster care. Although she might not have wanted to return to foster care and she still may have wanted to care for her baby, her irresponsible behavior seemingly precluded the latter. Demonstrated responsibility would presumably be the agent of change.

That night, I interviewed the woman she befriended on the unit, Angie (not her real name). This would be my last patient interview. Angie said she did not want to end up like her

friend, out on the streets running with no hope and no help and no one to turn to and no place to go. In her interview, Angie also talked about her own three small children, aged eight and six years, and five months. Angie said that she was admitted to The Body Shop because she had been beaten with a baseball bat, robbed, and left for dead. Someone found her and called the police, so she survived. Angie emerged from a coma after six days in an acute care hospital, and said that she felt that God had spared her life so that she could return home and care for her children. She spoke at length about how she felt that Body Shop nursing and counseling staff taught her to love herself, to save herself, so that she, in turn, could return home and to love and care for her children once again.

My fellowship and on-site field work ended a few days later, before Angie's discharge. After all those long talks, we had a cheerful and hopeful good-bye. I packed up the books, notes, interview tapes and other material from my cabinets and desk in the corner of a large physical therapy laboratory on that Brain Injury Unit that had been my workplace for 50 to 60 hours a week for the past two years. A month later, I began a final comprehensive round of follow-up staff interviews. After one appointment, a nurse I knew saw me in a hallway and invited me to stop by for a visit. Before leaving the building, I stopped at the Brain Injury Unit nursing station to chat with some of the nurses who had befriended me during my research stay. After talking for a time, one nurse pulled me aside and asked

Do you remember the very last woman you interviewed before you left? Angie? Did you hear? She didn't make it. She was found dead in the middle of a vacant lot. Drug overdose, I hear.

Apparently, at least in Angie's case, the doctor was correct in his assessment of the unlikelihood of spiritual rebirth and change.

Conclusions

Anthropologists need to examine questions raised by patients and staffers in in-patient institutions, such as I studied, and in the more common out-patient rehabilitation hospitals and institutes as well as in veterans' hospitals. Erving

Goffman (1986), Robert Murphy (1987), and Sue Estroff (1993), document some of the issues related to development of self in hospitals and institutions. But much more work needs to be done to examine the social universe and experiences of those whose work centers on socializing people with disabilities in hopeful preparation for a fulfilling life in the community. Researchers need to study the way in which spirituality grows in such institutions and is expressed in this distinctive setting that may, in fact, be largely neglected by organized religious groups. Religious groups also need to examine their relationships with their once active members during the rehabilitation process.

I detect that a distinctive spirituality is emerging in these places where staffers work with patients struggling to learn acceptance of new bodies and new selves. I would argue that the spirituality of disability and rehabilitation staffers serves to compensate for the lack of an adequate, wholesome theological view of the body. Organized religion continues to stigmatize people with disabilities to neglect those who may not be able to again serve and run the churches and congregations as they did in the past. These helpers are now in need of help.

Additional research by anthropologists would be useful. Specifically, anthropologists could examine clinical pastoral ministries and how those who voluntarily or as paid staff affect patient care. Anthropologists could examine and question chaplains' and ministers' roles in hospital staff work and life and in the occupational and organizational culture of rehabilitation hospitals and institutes. And they could look into the theology that staff in places like the Body Shop bring to their work.

A developing theology may be emerging from and centered around the distinct, lived experience of people with new physical disabilities. Is this happening in the lives of patients and staffers who participate in medical rehabilitation experiences? My study shows the need for more research. Is there a theology or spirituality evidencing itself in the lived experience and social universe of those who study, work with, and learn from the growing population of people with disabilities and chronic illnesses undergoing the medical rehabilitation process? ○

Notes

1. This article examining spirituality and religious life in an urban medical-rehabilitation hospital, euphemistically called *The Body Shop*, is based on data drawn from 88 formal and informal interviews in addition to observations conducted during a two and one-half year ethnographic study. The hospital is in the midwest of the United States, and the study was funded by the National Institutes of Health (NIH). Fieldwork took place from 1993 to 1995 under NIH Medical Rehabilitation Research Training Grant 5732-HD-07421-02. The Thomas C. Rumble Fellowships Program of Wayne State University funded additional interviewing and initial analysis. The Dissertation Grants Program of the Michigan Blue Cross—Blue Shield Foundation, by way of Grant 230-SAP/96, and the U.S. Health and Human Services Agency for Health Care Policy and Research, by way of Dissertation Grant 1-R03-HS-09603-1, funded the final analysis and report writing.

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