



A VIRTUOUS HEALER WHO EXEMPLIFIED
 COMPASSION, KINDNESS AND SYMPATHY



Mother Teresa of Calcutta

(1910–1997)

I never look at the masses as my responsibility. I look only at the individual. I can love only one person at a time. I can feed only one person at a time. Just one, one, one.... The whole work is only a drop in the ocean. But if we don't put the drop in, the ocean would be one drop less.²

—MOTHER TERESA OF CALCUTTA

Mother Teresa of Calcutta, Founder of the Missionaries of Charity, was one person who dug deep into her soul, bringing forth an encompassing sense of compassion for the suffering person. In loving the person entrusted to her care, she radiated the love of Christ.

“Let anyone who comes to you go away feeling better and happier. Every one should see goodness in your face, in your eyes, in your smile.”³

Born in Skopje, Macedonia, on August 26, 1910, Agnes Gonxha was the youngest of the three children of Albanians Nikola and Drana Bojaxhiu. The future advocate for the poorest of the poor did not grow up in poverty, as Nikola ran a successful business. When Nikola died, Drana supported her family by merchandising embroidery and carpets. She was an exemplary woman of faith, who inculcated in her children

social awareness and concern for the needs of others. Drana gathered her children every evening to pray the rosary. She brought her daughters on pilgrimages to the shrine of Our Lady of Cernagore in Montenegro.

Agnes Gonxha was educated in a state-run secondary school in Croatia. Inspired to pursue missionary work in India by the letters of Jesuit priest, Father Anthony Vizjak, she joined the Order of Loreto in Dublin on September 25, 1928, and adopted the name of Saint Thérèse

of Lisieux, patroness of the missions. On May 14, 1937, Sister Teresa took her final vows of poverty, chastity and obedience. Her superiors assigned her to Calcutta to teach at a boarding school run by the congregation. Learning to speak Bengali and Hindi, the young Sister Teresa taught geography and history and later became headmistress of Saint Mary's High School. But working at a privileged private school, an affluent enclave in the midst of widespread poverty, bothered her. On September 10, 1946, aboard a train on the way to Darjeeling in the Himalayas for her annual retreat, the thirty-six-year-old Sister Teresa received what she later referred to as a "call within a call":

I was going to Darjeeling to make my retreat.... It was on that train that I heard the call to give up all and follow Him into the slums—to serve Him in the poorest of the poor. I knew it was His will and I had to follow Him. There was no doubt it was to be His work.... The message was quite clear. I was to leave the convent and work with the poor while living among them. It was an order. I knew where I belonged, but I did not know how to get there.⁴

Granted permission by her superiors, Sister Teresa petitioned the Archbishop of Calcutta for "exclaustration," or the ability to live and carry out her mission outside her congregation while remaining faithful to her religious vows. She felt it was not enough to help the poor from a distance. It was necessary to be among them, to experience their way of life firsthand, thereby understanding and effectively ministering to their needs. She knew well that in order for "Love to be real, it must cost—it must hurt—it must empty us of self."⁵ She requested her spiritual director to bless a sari, a cross and a rosary—the rudimentary and symbolic instruments of the work she envisioned among the homeless and the slum dwellers of Calcutta.

It was a time of turmoil and crisis in colonial India. The British Empire had dragged India into World War II and the sweltering city of Calcutta was inundated by refugees. Under the leadership of Mohandas

Gandhi, the nascent nonviolent resistance movement against the British had gained traction.

Pope Pius XII granted Mother Teresa's petition to work as an excommunicated nun on April 12, 1948. Trading her cherished Loreto habit for the traditional outfit of a poor Bengali (white sari and sandals), Mother Teresa traveled to Patna, where she trained at the hospital of the American Medical Missionary Sisters.

At the Holy Family Hospital, Mother Teresa quickly learned basic medical knowledge and developed nursing skills, such as preparing hospital beds, taking vital signs and administering injections. She learned to deliver babies as well, preparatory to serving the poorest of the poor. Thereafter, she started working in the slum districts and in February 1949 set up her mission in a room of a three-story colonial house. People were drawn to the house at 14 Creek Street and began to help Mother Teresa care for the poor and the sick. Under her direction, volunteers, including some of her students at Saint Mary's school, sought children in the poorest areas of the city and people dying in city streets.

Mother Teresa's centers for the homeless, abandoned men and women, malnourished children, dying HIV patients, lepers and others, spread throughout the world. By the 1990s, such centers of loving care and compassion grew to over six hundred houses in 136 countries.

On her trips abroad, when people asked to join her work in Calcutta, Mother Teresa would graciously invite them to visit Calcutta but advised prospective volunteers to "Find your own Calcutta.... Don't search for God in far lands—he is not there. He is close to you, he is with you. Just keep the lamp burning and you will always see him."⁶

Mother Teresa received the Nobel Peace Prize in 1979. Despite her many accolades and honors, she remained humble and kept her sense of humor. When someone asked her, "What will you do when you are not

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Mother General any more?" She thought for a while, smiled, and said, "I am first-class at cleaning toilets and drains."⁷

Mother Teresa was beatified by Pope John Paul II in October 2003.

QUESTIONS FOR REFLECTION

1. Does the image of Quixote's *Man of La Mancha* still apply to you? Can you still picture yourself jousting imaginary windmills? Or have the passing years encrusted your childhood dreams, blunted your optimism, watered down your idealism?
2. Once upon a time, didn't you dream of eradicating disease, hunger and suffering? Didn't you enter medical or nursing school excited about the prospect of saving lives, changing the world and making a difference?
3. When you graduated, weren't you convinced you had found your life's calling, vocation and mission? Why do you now feel such relief turning off your beeper or cell phone and so much happiness to leave the hospital or the clinic?
4. Have your goals and priorities changed through the years? Do you feel you have paid a heavy price to achieve your goals?

SPIRITUAL EXERCISE

Envision the suffering Christ in the next patient you treat in the hospital or in your clinic. Lay your hands on Christ's battered body, cleanse his wounds and gently take off the crown of thorns. Listen to what he has to say. Comfort him. Observe how that vision may transform the way you care for that particular patient. Write a brief description of that sacred encounter in your diary or spend some time reflecting on the experience.

PRAYER

Eternal Word, only begotten Son of God,
Teach me true generosity.
Teach me to serve you as you deserve.

VIRTUOUS HEALERS

To give without counting the cost,
To fight without heeding the wounds,
To labor without seeking rest,
To sacrifice myself without thought of any reward
Save the knowledge that I have done your will.
Amen.

—Attributed to Saint Ignatius Loyola

notes

- ¹ Michael Collopy, *Works of Love are Works of Peace: Mother Teresa of Calcutta and the Missionaries of Charity* (San Francisco: Ignatius, 1996), p. 35.
- ² Collopy, p. 35.
- ³ Chalika and Le Joly, p. 105.
- ⁴ Roger Royle, *Mother Teresa: A Life in Pictures* (San Francisco: HarperSanFrancisco, 1992), p. 21.
- ⁵ Collopy, p. 30.
- ⁶ Robert Ellsberg, *All Saints: Daily Reflections on Saints, Prophets, and Witnesses of Our Time* (New York: Crossroad, 1997), pp. 393–394.
- ⁷ Chalika and Le Joly, p. 345.

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TOUGH CHOICES IN THE ICU

Integrity, Ethics and Honesty

“In the same way, let your light shine before others, so that they may see your good works and give glory to your Father in heaven.”

—MATTHEW 5:16

People at times complain about physicians “playing God,” the implication being that doctors try to control the levers of life and death. Families of dying patients resent doctors who seem to have little, if any regard, for the far-reaching consequences of their *ex cathedra* decisions.

Yet, in reality, nothing can be further from the truth. It is the rare physician who does not agonize when patients take a turn for the worse. Granted, physicians may fail to sit down (not infrequently due to their hectic schedules) and give families the extra time they need to change gears and begin to accept the painful reality of impending loss. Doctors also find it particularly difficult to face defeat and they dislike lingering when death becomes inevitable—an attitude families may misinterpret as callousness.

Each patient is unique. But the following case may serve to point out the intricacies involved in making decisions in the ICU.

Mr. D was a seventy-eight-year-old retired maintenance man. For decades, he had worked behind the scenes, mainly in hospitals, fixing and keeping machines functional so that doctors and nurses could go about their daily work of saving lives. Mr. D had the highest regard for the medical and nursing professions.

He had survived lung cancer and in his twilight years he enjoyed traveling and visiting his grandchildren. It was during one of these family visits that he fell ill. The doctor south of the border thought he had appendicitis and recommended an operation. Mr. D decided to return to the United States and came to our ER.

He complained of upper and lower abdominal pain so the ER physician ordered a CT scan because he was not sure if Mr. D had appendicitis, a cholecystitis (gallbladder infection), or a pancreatitis (inflammation of the pancreas, the small organ located behind the stomach). I was asked to consult. After examining him and reviewing the CT scan, it looked like his primary problem was biliary, that is, gallstones plugging the gallbladder. He needed an operation.

Mr. D's cardiac history was vague and his EKG was abnormal so I called in our cardiologist to clear him for surgery—to check whether his heart was healthy enough to withstand anesthesia and carry him through major surgery. The cardiologist reviewed the EKG and declared him a high risk for any major operation. Mr. D would have to undergo cardiac stress testing and a battery of tests before he could be cleared to proceed with surgery. If we took the chance, he might die on the operating table.

After explaining the situation to Mr. D and his family and going over different options available, we decided to defer the operation and treat him with broad-spectrum intravenous antibiotics. The goal was to cool down the infection and relieve his pain, while carrying out more definitive cardiac testing.

The antibiotics worked wonderfully for a few days; his white count (an indicator of severity of infection) fell, his fever came down and his abdominal pain lessened. However, the cardiologist could not clear him for surgery; thus, we requested our radiologist to direct a thin catheter into the gallbladder with CT scan guidance so that infected bile could be drained, temporarily avoiding major surgery. Utilizing local anesthesia, the minor procedure would not put him at risk.

The drain worked, and Mr. D improved. But, after a few days, his white count rose and he became acutely ill. Conservative treatment was not good enough; this time he needed an operation, though he certainly could still die on the operating table or soon after surgery. Should we take our chances?

Again, we sat down with Mr. D and his family. Despite the risk of a myocardial infarction which could lead to cardiac arrest, or pulmonary failure which could mean prolonged use of a respirator, surgery was the only option left. For the better part of his life, Mr. D had worked in hospitals. He trusted doctors and nurses. Whatever we thought reasonable was good enough for him, he told his family. God would take care of the rest.

The operation went smoothly. His heart hardly faltered. His blood pressure remained relatively steady. The gallbladder, as we anticipated, was badly infected. In addition, he appeared to harbor terminal ileitis (Crohn's disease) accounting for his lower abdominal pain. Everyone was relieved that the operation was a success. Post-operatively, Mr. D had to be put on a respirator so we could "keep him down" with high doses of sedation and pain medication, minimizing any strain to his delicate heart.

Forty-eight hours after surgery, however, Mr. D got restless and "extubated" himself—he pulled out his endotracheal (windpipe) tube and disconnected himself from the respirator. The ICU intensivist and pulmologist thought of reinserting the tube but Mr. D maintained adequate levels of oxygen and it was better to let him breathe on his own if he were capable.