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Responding to Faith

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Abstract

In the context illness, faith may offer a profound source of resolve, courage, and hope. And yet, there are health situations where faith may challenge us. Faith, after all, may compel decision makers, cast doubt on relationships, or supersede expert clinical judgement. While faith may be near the center of a meaningful life for many, as a phenomenon it is multifaceted. The aim of this paper is to explore faith as it may arise and be sustained in clinical practice drawing creatively on the biblical story of Abraham and Isaac. Healthcare providers need to be able to respond to situations where faith is expressed by a patient or their family, even if they are of little faith. Responding to faith is all the more critical in intensive care environments where patients, families, and healthcare providers navigate the limits of surgical interventions and medical technologies.

Keywords

Ethics, faith, medicine, religion, spirituality

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To one who has faith, no explanation is necessary.
To one without faith, no explanation is possible.
- Thomas Aquinas

To have faith is to trust yourself in the water. When
you swim you don't grab hold of the water,
because if you do you will sink and drown. Instead
you relax, and float.
- Alan Watts

what a tremendous paradox faith is, a paradox which is
capable of transforming a murder into a holy act well-pleasing
to God, a paradox which gives Isaac back to Abraham, which
no thought can master, because faith begins precisely there
where thinking leaves off.
- Søren Kierkegaard

For those who work in intensive care, there is perhaps no more challenging situation than caring for an ill patient whose decision maker does not recognize or does not accept that a severe condition makes further medical intervention futile (Piroska et al., 2022). Instead, they may hold on to an unsupportable promise of *faith* (Mendola & Bock, 2015). By futile, I refer to those circumstances across the lifespan where medicine has reached its limits: a newborn is so congenitally malformed that no operation or medical intervention will make a positive outcome of intensive care possible; a child or adolescent's body is so beset with malignancy that it is unresponsive to chemotherapy, radiation, or other life-extending measure; or, an adult has suffered from such severe brain injury that recovery towards a conscious existence is impossible. In these situations, faith may become the inducement to a surety of belief, against all manner of medical knowledge and reason, that a different and positive outcome from what is foreseeable will occur.

This is not to devalue faith. Among healthcare providers, faith is recognized as a source of strength, courage, and hope for patients and their families (Holloway, 2025; Post et al., 2000; Zhou, 2025). To diminish, come against, or otherwise level faith, whether it is or is not expressive of a religion, is foreseeably harmful. In comparison, there is literature that recognizes that healthcare providers themselves, and the healthcare institutions in which they practice, should invest in or otherwise support religious-spiritual dimensions of life (Ott, 2010; Saad & de Medeiros, 2016; Uzun et al., 2024). Said more plainly, "faith indeed matters to medicine" (Levin, 2018, p.291). Illness, after all, affects not only the body, but also may stir social, personal, and existential unrest. People may have spiritual needs both at the beginnings as well as their endings of life (Balboni et al., 2022). Learning about and respecting an individual's values, beliefs, and spirituality may support the building and sustaining of a caring relationship (Post et al., 2000; Puchalski & Romer, 2000).

And yet, there is value in exploring faith as a distinct, albeit often related, phenomenon to spirituality and religion. Faith, after all, is a power phenomenon. It has the potential to afford a hopeless hope for a positive outcome of a negative situation in a way of denying what is a medical reality to challenge healthcare providers (Rosoff, 2019). With contemporary intensive care technologies, some ill patients while failing to improve can be sustained in a state of life without living. They dwell in an illness of enduring chronicity. Healthcare providers may use language such as medically fragile, clinically complex, or quite simply "stuck" to describe them (Henderson et al., 2017). On occasion, it may become clear there is a slow trend towards death; the situation eventually will come to a natural resolution. Still, at times, healthcare providers may discern that the pain, distress, and other burdens of continuing intensive care are too much to wait for such an outcome (El Khoury, 2025; Green, 2013). They are not just prolonging dying; they are prolonging suffering as the patient is unlikely to ever leave the intensive care environment. In such circumstances, faith may become an obstacle, a barrier, or otherwise a difficulty that the team needs to navigate if it so-called conflicts. But what does it mean to navigate the faith that patients, families, or other responsible parties may hold? How should a provider work through situations where faith appears to compromise responsible decision making? When should they intervene when faith seems poorly placed? What limits should faith be afforded?

Healthcare providers need to be able to respond to situations where faith is expressed by a patient and/or their family, even if they are of a lot or of a little faith. They may know from experience that faith is a powerful disposition that may have dispositional effects if it displaces and disposes the usual ways of dealing with things. Regrettably, the health literature is scant when it comes specifically to faith as a phenomenon. So, there is value in considering questions of faith: How should we understand faith? How is faith manifested in human existence? Does religious faith differ from nonreligious faith? What are the normative senses of faith? What is conveyed in such idioms as a show of "good," "bad," or "neutral" faith? How should faith be approached when it appears as a "friend" or "foe" in clinical practice? While not being a religious person myself, I recognize faith may be a source of strength for a patient and/or their family, yet also a potential challenge in ethical decision-making. Healthcare provides need a nuanced understanding of faith phenomena. The aim of this paper is not to conflict the relation of medicine and faith, but instead to point phenomenologically to faith as it may possibly appear experientially in healthcare contexts.

Drawing Faith Apart from Religion

Would it help to know what faith is rooted in? Sometimes we look for a religion behind faith (Rosoff ,2019; Turner, 2003). Religion, after all, is seemingly easier to speak of, to categorize and conceptualize. We can specify many different religions: Bahá'í, Buddhism, Christianity, Confucianism, Hinduism, Islam, Jainism, Judaism, Paganism, Shintoism, Sikh, Secular Humanism, Taoism, and the list goes on. Religion may be regarded as the ordered belief and worship of a god (a supernatural being, spirit, divinity, the sacred, or otherwise) (Oxford English Dictionary, 2024). Such believing and worshipping are unified by systems of values, convictions, rules, and ceremonies that may be variously practiced depending on an individual's orthodoxy. Following, scripture, books, and other texts have been written on religion to support those who wish to become learned in religion.

However, faith as a phenomenon cannot be reduced to religion. Just as religion is not a prerequisite for faith; nor is the converse true. Those who identify as atheist, agnostic, or quite simply secular may experience faith; and one may know a great deal about religion without experiencing faith. It is as if faith as a phenomenon may be drawn apart from religion. A person can question their religion without losing their faith. Conversely, an individual may go through the motions of practicing a religion without having faith.

And yet, we can speak of religion as supporting someone to find their faith. We recognize that some use the words faith and religion interchangeably, blending in the notion of spirituality (Levin, 2018). We also may appreciate that the history of medicine includes religion: originally, in many parts of the world, practitioners of medicine and religion were one and the same (Koenig, 2012). It is only in modern times that it would appear religion and medicine have parted ways. There is also a history of faith healing, which implies faith in itself may have power independent of any religion (Post et al.,2000). While some religions identify unique faith leaders, some faith leaders serve multiple or no particular religion. We may also recognize that there are certain qualities of particular religious faiths whereby the faith is conditioned by the religion. And yet, we may wonder whether there is a unique meaning to faith that transcends any one religion or lack thereof. Can the language of the meaning of faith provide some clarity?

On the Language of Faith

As a starting point, we can look to etymological sources to orient us to the meaning of *faith.* From Latin *fidere,* "to trust," and Old French *feid, foi,* "belief, trust, confidence, pledge," the term faith, as it is used to name human experience, appears rooted in trust and related notions (Online Etymology Dictionary, n.d.). It was only in subsequent centuries that faith was used to refer to "assent of the mind to the truth of a statement for which there is incomplete evidence," and, particularly, oriented towards "belief in religious matters" (Online Etymology Dictionary, n.d.). We may wonder: Is faith a special example of trust, or is the converse true? How does faith as trust relate to belief, confidence, and pledge?

Consider trust: Can I trust you to be there? Can I trust you not to leave when things get hard? Can I trust you with a secret? Can I trust you with our new car? Can I trust you with our children? Can I trust you till death do us part? Can I trust you to be faithful? Do I trust myself? Trust is a weighty five-letter word.

Otto Friedrich Bollnow (1962) points out an important possible relational difference in confidence and trust. I can have confidence in someone's ability to do something (e.g., a surgeon to perform an operation, a mechanic to fix my car, a plumber to plumb, or some other individual with technical expertise to complete a task). This confidence is based on their evidential skills, knowledge, reputation, and qualifications. However, in spite of my confidence in a healthcare provider's knowledge and ability, I may not necessarily trust this person. Conversely, I may trust a physician or nurse with my newborn child, but I may question whether they are knowledgeable or skilled enough to deal with their medical problem. So, I can have confidence in someone without trusting them, or trust someone without being confident in their ability. While one may have a rational basis for trusting another, people can also blindly trust another. This believing quality of trust is not necessarily shared with confidence. So, while the terms confidence and trust are not always

clearly separated, it would seem that, in general, trust is relational, expressive of our feeling of the ethical character of the other person, while confidence is something that we may actually assure in another person. In this sense, we may express our trust through pledges, vows, or other covenants.

Generally, it is accepted that the meaning of a concept lies in its usage (Hellman, 2024). So, concept-analysis consists of studying how certain concepts occur in everyday discourses and how the usages of concepts differ from one another. Still, we need to be careful in ascribing any singular meaning to a concept or otherwise deconstructing-reconstructing linguistic meaning. No one has sole ownership of language; people are free to use the word faith to describe trust, resoluteness, confidence, hope, desire, or any other meanings founded in their experiences. In this way, the terminology does not matter much except that we must not accept one word as a simple substitute for another as far as an explanation of its meaning.

If we orient faith towards trust, we trust that the other person is faithful and can be relied upon. And, if we have faith in them, we do not feel constrained or compelled to look for evidence of their veracity. Faith dwells in my relation with them. There is no trust without a faith which we have toward a person who has trust in us. Trust demands a response. The problem for a confused, distressed, and possibly traumatized patient or family is that they may bewilder feelings of confidence and trust in the medical professionals who are in charge of caring for them or their loved one. They may want to feel confident in healthcare providers or may trust that they will do what is best for them. However, when we talk about faith, this same sense of trusting belief may occur not only in the absence of evidence (as in a “leap of faith” or “blind faith”) but also in the face of evidence to the contrary (as in “unshaken faith” or “unwavering faith”).

My reason for pointing to the language of faith is ultimately to show a meaning of human experience that transcends, yet is still somewhat related to, trust and confidence and related notions. And, my reason for focusing on the meaning of faith is that in medical practice, healthcare providers encounter dispositions in patients and/or their families that can make it impossible to engage in responsible decision making with respect to the nature and seriousness of an illness. In these situations, faith may become something that stands in the way of medical practice. Again, I say this all with admonition recognizing that faith can also be positive for individuals faced with illness. For example, within intensive care, faith may support individuals to make sense of challenging situations as a source of comfort, acceptance, hope, and meaning (Holston ,2015; Milstein, 2003; Rosenbaum et al., 2011). The point, therefore, is not to disavow faith, but to consider how we may respond to the trust of faith.

In the above epigraphs, I quoted Kierkegaard (2014): "faith begins precisely there where thinking leaves off” (p. 82). And as Derrida (1995) writes, “Responsibility and faith go together, however paradoxical that might seem to some, and both should, in the same movement, exceed mastery and knowledge” (p. 6). Later, Derrida writes on faith as absolute responsibility and absolute passion, “Our faith is not assured, because faith can never be, it must never be a certainty” (p. 80). Derrida regards faith here from the position of epistemology which does not allow for certainty. For Kierkegaard and Derrida, it would seem that faith is something that we cannot speak or write about, at least in rationalizing terms. It resists conceptualization and categorization in its transcendence. Yes, we can *experience* faith. But trying to explain “what faith is” in itself is a futile endeavor. We

can only try to show it. We may turn to the biblical story of Abraham and Isaac to dig into the archeology of faith.

Abraham as a Figure and the Silence of Faith

In Scripture, Abraham, the Hebrew patriarch, is the person who embodied a pure faith. So much so, he is revered by monotheistic religions such as Judaism, Christianity, and Islam. It is his unshakable faith and duty to God that is acclaimed and heroized. In opposition to doubt, his faith is what God-fearing believers ought to aspire to as a theological virtue. The account of Abraham that most people are familiar with is from the Hebrew Bible Genesis 22, recognizing that the narrative is told somewhat differently in the Qur'an. Abraham is a central figure in the book of Genesis. His stories revolve around themes such as origins, posterity, land, obedience, and promise.

Let us retell the story: Abraham had left the place of his birth and traveled to a new land at the behest of God. From Abraham's covenant with God, he and his wife Sarah, despite being elderly in age, had been blessed with the birth of a son, Isaac. It is after these things, during the time of Isaac's youth, that we read:

> And it came to pass after these things, that God did tempt Abraham, and said unto him, Abraham: and he said, Behold, *here* I *am*.
> (*King James Bible,* 1769/2008, Genesis. 22:1-2)

In this manner, God calls on Abraham by name. And, in response to the call of God, Abraham answers devotedly, without hesitation, before even knowing the task: "Behold, *here* I *am.*"

> And he said, Take now thy son, thine only *son* Isaac, whom thou lovest, and get thee into the land of Moriah; and offer him there for a burnt offering upon one of the mountains which I will tell thee.
> (*King James Bible,* 1769/2008, Genesis. 22:1-2)

God calls on Abraham to sacrifice his son. Illustrative of his faith, there is no questioning of God's directive. There are no words written to express a sense of reflection, consideration, meditation, doubting, debate, negotiation, or otherwise. Instead, there is solely action scripted.

> And Abraham rose up early in the morning, and saddled his ass, and took two of his young men with him, and Isaac his son, and clave the wood for the burnt offering, and rose up, and went unto the place of which God had told him.
> (*King James Bible,* 1769/2008, Genesis. 22:3)

It is truly a remarkable faith, a pure faith, whereby Abraham submits, obeys, and follows God's demand. And, in the verses that follow, when Abraham's son Isaac questions, "where *is* the lamb for a burnt offering?", we may read Abraham's devotion as assuring, "My son, God will provide himself a lamb" (*King James Bible*,1769/2008, Genesis. 22:7-8).

> And they came to the place which God had told him of; and Abraham built an altar there, and laid the wood in order, and bound Isaac his son, and laid him on the altar upon the wood.
>
> And Abraham stretched forth his hand, and took the knife to slay his son.
> (*King James Bible,* 1769/2008, Genesis. 22:1-2)

From this account of binding of Isaac, Abraham is completely prepared to carry out the sacrifice of his son—his faith is unwavering. But this violent, deliberate, and methodical act of extraordinary faith is interrupted:

> And the angel of the LORD called unto him out of heaven, and said, Abraham, Abraham: and he said, Here *am* I.
>
> And he said, Lay not thine hand upon the lad, neither do thou anything unto him: for now I know that thou fearest God, seeing thou hast not withheld thy son, thine only *son* from me.
> (*King James Bible,* 1769/2008, Genesis. 22:9-12)

And so, we read that the sacrifice was forestalled in the final moments by an Angel's intervention, by God's mercy. Many questions may be asked here: What kind of God would ask for this? Why put Abraham and his child through such an ordeal? Was God commanding a child sacrifice? How do we make sense of such a story in the context of Scripture? While these are all weighty questions, for this paper I am concerned with: How do we understand such an extraordinary faith?

The challenge is that the parable of Abraham and Isaac as recounted in Genesis is "silent" about a great many details. Abraham does not speak to anyone about what he had been told to do. He does not confide in his wife Sarah nor does he tell his son Isaac. He speaks to no one. More so, the Bible does not tell us how Abraham experienced the command of sacrifice. Did he experience shock, distress, and pain? Was he pensive and withdrawn? Did he accept God's request with or without doubt, suspicion, hesitation, or compassion? Did he experience having a choice, or otherwise experience the possibility of making a decision? Was his faith blind? Or did he perceive a future that ultimately had purpose and meaning? What outcome did he foresee as a result of the sacrifice?

Nowadays, surely, we would condemn Abraham: I feel quite comfortable saying that if Abraham were a parent in a newborn or pediatric intensive care unit, his child would be apprehended if the nurses, doctors, or other staff became aware of his intent to sacrifice his child with a knife on a mountain because a voice supposedly told him to do so. To imagine otherwise is absurd. After all, healthcare providers regard responsible choices as those that place a child's "best interest" foremost (Kelly et al., 2012; März, 2022). Such an understanding of best interest is not necessarily a consequential weighing of interests but rather one where a child's well-being, comfort, or other "good" is fore-fronted in their minds (Bester, 2019). In this sense, faith in duty to God cannot exceed ethical responsibility to the child. But we should also acknowledge that in newborn or pediatric intensive care, other less graphic yet still consequential sacrifices are made with respect to children's suffering for the sake of their families—such as continuing intensive care so parents have more time to come to terms with a decision, for family members to spend more time with

their children around the time of their death, or to satisfy a sense of everything having been tried (Brierley et al., 2013; Robinson et al., 2006; Rosenbaum et al., 2011).

Returning to Abraham and Isaac, we may say that this passage of the Bible is vague. And it is this lack of clarity in the Bible that presents the opportunity to creatively re-tell and re-interpret Abraham's sacrifice to explore human phenomena. For example, Søren Kierkegaard, in *Fear and Trembling,* and Jacques Derrida, in *The Gift of Death,* turn to this parable. Both attend ever so carefully to those moments preceding and following the sacrifice, developing elaborations and embellishments of the primary Bible account, to speculatively explore notions of ethics, responsibility, and faith. Truly, each author offers a book-length study of an account that in the Bible occupies scarcely more than a page. It is also important to acknowledge that a more hermeneutic reading of this passage is possible considerate to the broader context of Scripture (whereby the Bible is understood as a unified story that leads to Jesus, prophetic reenactment, and so forth).

Expressions of the faith of Abraham are also found in countless works of art. Just performing an Internet search reveals paintings by Caravaggio, Rembrandt, Pieter Lastman, Andrea del Sarto, Marc Chagall, and Federico Bencovich, to name a few. While various artistic aspects can be attended to as far as technique and style, light and darkness, symbolism and iconography, and so forth, what I am drawn to is how the eyes of Abraham appear. Perhaps in Caravaggio it is an acknowledged sadness as Abraham is becoming aware of what he had almost done, while in Rembrandt it is expressed as relief from not having to act. In the works of some artists, Abraham's eyes are distant and hollow, and in still others, they express grief, suffering, and pain. It would seem that artists appreciate various aspects of faith.

As a physician in newborn intensive care, I know that I recognize different expressions of faith in the faces of parents whose children for whom I have cared. I am aware that as doctors, nurses, social workers, or other healthcare professionals we need to have insight into faith experiences. We need to be able to respond to them, particularly in those situations whereby faith seemingly comes at odds with a reasonable path forward—situations where decision making is needed, and healthcare providers differ in their opinion with a parent and/or surrogate decision maker regarding the appropriate path forward. Remembering the story of Abraham and Isaac, let us read into common expressions of faith spoken in critical care: *"It is against our faith. We cannot stop," "My family says I need to have faith. They told me not to believe the doctors," and "I believe they will survive this. I have faith."* From this reading, we should acknowledge that interpretations of epigrams are tentative if not speculative, yet do provide an opportunity to explore different interpretations of faith experiences. In this way, such interpretations are incomplete yet offer a starting point for further reflection on the phenomenality of faith.

Faith as Guidance: "It is against our faith. We cannot stop."

Faith may serve to provide context, guidance, or obligation. In this way, it may serve an important role in personal moral reasoning (Turner, 2003). And in such a horizon of understanding, at times, medical decisions can be against, in opposition to, not permitted by, or otherwise outside a person's faith. For example, despite overwhelming medical evidence and advice about an eventual outcome, some parents insist on everything being done for their child in a belief that their religion would

expect nothing less; they cannot condone any decision or action that would result in death (Brierley et al., 2011). Said differently, for some, matters of life and death are considered to be faith decisions, whether ascribed to God or other entity.

Imaginably, we may interpret the "silence" in Genesis 22 as expressive that Abraham must follow God's directive, even if he feels pain, distress, and anguish as he is commanded to sacrifice his son. For Abraham, this is a true sacrifice in the sense that he is offering something of ultimate value—his son—given his commitment. Regardless, he is bound by his faith. Abraham has no choice but to follow God's command. And so, we witness his actions.

How individuals experience faith that shapes, constrains, or otherwise directs their choices varies. Differing religious traditions have differing faith directives, even if similarly named, and within a single religion, people differ. For example, so-called spiritual experiences of prayer, the sacred, solicitude, revelation, and so forth are subjective and may vary across and within religions (Katz, 1978; Pike, 1992). Central to Judaism, Christianity, and Islam are the Decalogue, the Ten Commandments, and the Sayings respectively, each consisting of prohibitions and prescriptions such as "thou shalt not kill" and "honor thy father and mother." Faith can be experienced as a felt need to abide by these directives and prohibitions. To violate one's faith may result in experiences of guilt, transgression, and sin. Here, faith is the experience of one's actions being seen before the eyes of God, one's community, or what binds a person as accountable, whether religious or not. Alternatively, experiences of the sacred inhere in wonderment, beauty, and revelation.

In many such situations, consultation with community members, elders, faith leaders, or other sources of doctrinal knowledge or directives of faith may support the navigation of difficult healthcare decision making (Brierley et al., 2011). After all, it is recognized that those with life experience generally contribute not only knowledge but also wisdom of faith phenomena (Murdoch, 1985). That said, not all are willing to engage with others to explore their own views, interpretations, and/or tenets when it comes to their faith (Brierley et al., 2011). The possibility of impasse exists. From this understanding of faith, healthcare providers need to be aware of the beliefs and values of their patients as they may attempt to navigate difficult decisions in a way to respect them (Saad & de Medeiros, 2016). Faith systems—whether they are sourced in religious doctrines, cultural traditions, or elsewhere—may inform their experiences of faith and provide moral guidance. They may direct or even restrict people in their actions as they prescribe or proscribe behaviors.

Faith as a Belief: "My family says I need to have faith. They told me not to believe the doctors."

Sometimes in healthcare, we talk about faith as a commodity, as something that may be earned, gained, or lost. We recognize that some patients intuitively seem to believe in the healthcare system: they have confidence, trust, and perhaps even faith that healthcare providers will do everything they can. While others, as the result of personal or community experiences of abuse, exploitation, trauma, racism, and so forth, have distrust when it comes to interacting with healthcare providers. Such faith is founded in relationships, somewhat akin to an experience of trust. Expressions such as "Put your faith in God" may also be read to express this meaning.

We can imagine the look of Abraham in this different sense of faith as expressing acquiescence and consignment. Abraham believes in God. Like a trusted friend, Abraham trusts the motives of God. While he may converse with God, to question what is to be achieved, he ultimately does have faith in Him. In this sense, Abraham is not confined or forced by his faith. His decision to sacrifice Isaac is founded in his faith as a trusting belief. God, like his faith, is with him.

In a past interview, Emmanuel Levinas said, "Faith is not a question of the existence or non-existence of God. It is believing that love without reward is valuable." (1988, p. 177). Love here is not voluptuous, carnal, or erotic; but rather, conveys the profound proximity of this relation that transcends lover and beloved. Said differently, a "love without reward" expresses fidelity. It is a relation without the expectation of reciprocity, exchange, or contract. Without reward, it is a relation which allows faith as faithfulness: a believing in an other, and that this other acts *for* me. For Levinas, alterity founds such a faith, in spite of myself, yet from myself. And we may appreciate for many "the influence of the fundamental values undergirded by faith remain as strong as ever as a way to interpret the uninterpretable and impart meaning to the seemingly meaningless." (Rosoff, 2019, p. 120). This may be understood as faith as a belief.

Healthcare providers may reflect: How do they relate to their patients? What value do they place on their perspectives? Are they fundamentally receptive to their patients' unique understanding of their situation? These questions can become pointed: What have I done deserving of my patients' trust? How have I been present to them during their times of need? Am I a visible presence at the bedside? Have I made an effort to get to know them, their values and beliefs? Do I express concern in my talking to them? What is my relationship with them?

We are not entitled to the faith of our patients by virtue of our schooling, position, or credentials. Qualifications support confidence yet provide no guarantee of trust. Instead, we must practice in such a way to express our fiduciary relationship. Here, this understanding of faith is founded in meaningful conversations with our patients and their families. In such conversations, we support talk on what patients and their families regard as meaningful, ask and encourage questions, reflect back on what we hear, and show genuine compassion, understanding, and empathy. This does not mean we need to become our patients' friends; but instead, recognize that we do have a relationship with them which may or may not be composed of trust.

Healthcare providers need to also recognize that even if they have established a relationship of trust with patients and those others present at the bedside, there is often a much larger community that is outside of this relationship. Other community members may tell patients and/or their families that they should carry on, not give up, and so forth. Some of these are "communities of faith." There are also those stories of when healthcare providers were wrong: "Doctors told my sister that her baby would not survive and he is now 5 years old. He is thriving." "Have faith!" they say. In such situations, as healthcare providers, there is value to maintaining the focus on our relationships with our patients and their families, to support them in their decisions, recognizing that opportunities for future decisions will present themselves.

Faith as Unconscious of Itself: "I believe they will survive this. I have faith."

We can understand faith as conditioning our very consciousness of the world. As Gabriel Marcel writes,

> [Faith] cannot figure in experience, since it entirely commands and transcends experience. If I am in some ways led to regard it as outside myself, it appears to my consciousness still more essentially as being within myself, more inward to me than I can be to myself, I who invoke or assert it. (1949, p. 210)

In this passage, Marcel shows the uniqueness of faith yet also its ambiguity. In a way, we all live in a constant state of faith whereby our conduct expresses an unquestioning belief in our own existence. On a fundamental level, we do not doubt our existence in the world. Sure, we can question "Is any of this real?" but such questioning is abstract from our intuitive knowing that we exist in the world. In this sense, we are unconscious of our faith to the extent that it is beyond questioning.

Some parents, families, or other decision makers seem to have an unquestionable belief that their loved one will improve or otherwise survive. At times, this faith may be inexplicit: "I just believe it!" Other times, it may reflect a higher power: "It's God's will." It would seem that they cannot accept an alternative because a difference is foreign to an underlying hope or optimism of their faith. We can imagine these parents, somewhat like Abraham journeying to the land of Moriah without concern, questioning, or trepidation, are living their child's story with faith that everything will turn out "ok" in the end. This Abraham is so pure in his faith, so complete, that he does not question God's command regardless of how tormenting and objectionable the notion of sacrificing one's child may be. Here, faith conditions his very conscience existence.

Now, such an understanding of faith founded in religion may be specified as that which "instructs us that the world is a mysterious place with a possibly transcendent dimension to reality, and it organizes our perception of and response to such accordingly" (Levin, 2018, p. 274). And yet, while it can be argued that we have ethical responsibilities to respect the faith beliefs of others as aspects of their autonomy, we also need to underscore that such beliefs cannot justify—and hence should not compel—nonbeneficial or potentially harmful medical interventions without clinical merit (Rosoff, 2019). This means that as healthcare providers we recognize that medicine has its limits, and yet we should also not belittle, shun, or otherwise dismiss the faith that is often born from hope, love, and care.

Faith in and Beyond Medicine

In this text, I have approached the concept of faith as reflected in the above epigrams. But as a healthcare provider, I also may want to acknowledge that faith may be part of our practice as physicians, nurses, respiratory therapists, and so forth (Bartlett, 2014). We practice with the faith that our analgesic and sedative medications truly support our patients to be comfortable and calm. We practice with a faith that our individual patient diagnoses reflect those seen in the broader medical literature. We practice with a faith that our medical and surgical interventions have beneficial effects for our patients. Now, it can be argued that there is a profound difference here in

the sense that this functional faith in clinical practices has an evidence-base to it, but experiences of divine nature, conversion, miracles, or otherwise can also be confirmatory of faith (so-called "restorative of faith" or otherwise resolving a "crisis of faith").

Those of faith have written about receptivity, response, fidelity, and commitment. I again quote Marcel,

> But there is something else no less important. As the soul approaches more nearly to faith, and becomes more conscious of the transcendence of her object, she perceives more and more clearly that she is utterly incapable of producing this faith, of spinning it of her own substance. For she knows herself, she realises more and more clearly her own weakness, impotence and instability; and thus she is led to a discovery. The faith of hers can only be an adherence, or, more exactly, a response. Adherence to what? Response to what? It is hard to put into words. To an impalpable and silent invitation which fills her, or, to say it in another way, which puts pressure upon her without constraining her. The pressure is not irresistible: if it were, faith would no longer be faith. Faith is only possible to a free creature, that is, a creature who has been given the mysterious and awful power of withholding herself.
> (Marcel, 1949, pp. 211-212)

Marcel aims to draw out and explicate an experiential understanding of faith, to show faith, as a genuine communion. From invitation to response, faith is an inexplicable choice. And yet, as a choice, we may wonder whether its appearance is as a choice that has already been made or one that still stands open for the choosing. Jean-Luc Marion suggests that all we can have is "faith in faith", meaning an open stance towards the source of our faith, a responding to a call (2002, p. 124). Following, we can talk about faith as "revelation" and "affirmation" recognizing that people may variably connect experiences of presence, hope, intersubjectivity, or other life meaning to their faith. We should be cautious in generalizing faith experiences.

Finally, it should also be highlighted that people are not necessarily static in their faith. As John Henry Newman writes on revelation:

> That earnest desire of it, which religious minds cherish, leads the way to the expectation of it. Those who know nothing of the wounds of the soul, are not led to deal with the question, or to consider its circumstances; but when our attention is roused, then the more steadily we dwell upon it, the more probable does it seem that a revelation has been or will be given to us.
> (Newman, 1979, p. 328)

People experience shifts in their faith: the appearance of the world, whether induced by changes in their own bodily capacities or their perceptions of others' bodily conditions in illness. This is faith as receptivity—openness to the world as subjective and objective reality changes. Healthcare professionals may recognize the value of families and other decision makers to "be there" at the bedside. And they need to acquire understandings of how healthcare may be experienced by them or their loved ones. From being there, families and other decision makers may gain a perspective

that supports decision making. This kind of faith can only be approached by finding common ground.

Concluding Thoughts

I researched this paper with the aim of understanding a particular experience of faith, a *faith* that may make physicians, nurses, or other health professionals shift uncomfortably or otherwise become troubled when it becomes voiced. This is the faith that may compel decision makers, may cast doubt on relationships, or may supersede clinical judgement. As a physician in newborn intensive, I have heard parents of patients utter all number of expressions of faith in situations where we as a healthcare team feel that we are without medical options. The reliance on miracle thoughts, language of faith, and so forth can be challenging to confront (Brierley et al., 2013). This points to the need for understanding, nuance, and tact in circumnavigating conversations and decision-making. Conversation by its nature, after all, implies navigating shared understandings of language, and if the meaning of the words used is foreign, there is limited opportunity for dialogue.

Thinking about my own clinical practice, the unique context of newborn intensive care is that we are dealing with the faith of parents, which, in time, may or may not be shared with their children. Our patients, themselves, do not express their faith; rather, they are subjected to their parents' faith. On reflecting on the story of Abraham and Isaac, we may note that Abraham is both commanded by a heavenly father and also must act as a father himself to Isaac. The ethics of parental responsibility makes a literal reading of this parable all the more difficult to accept. And yet, we need to be aware of the narratives that undergird individual's own spiritual and ethical positions to respond to the patients we serve (Sulmasy, 2013).

Faith is probably the most difficult disposition for newborn intensive care parents to navigate when it conflicts. At times, in frustration, healthcare providers may assume that faith reflects nothing other than the naïveté, credulity, or self-righteousness of parents who stick to their faith rather than be reasonable about the reality of the medical condition of their children. However, I have tried to offer more nuanced and varied understandings of faith. Although I would find it personally very hard to let a newborn suffer because of their parents' faith, I also recognize the power of faith—as individuals turn to their faith in moments of hardship, turmoil, and loss. Ultimately, responding to expressions of faith necessitates patience, understanding, and openness on the part of the healthcare provider. Even if we do not share the faith of our patients, we ought to respect them in their otherness enough to try to understand their perspectives.

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