

Part I

Echoes of Anger

The heart is not simply suspended in a body but in a culture, a place, a time. We are all aware of the traditional risk factors for coronary disease that are physically related—obesity, high cholesterol, hypertension, smoking, diabetes, a sedentary lifestyle. But these factors may fail to identify 50 percent of patients with coronary disease. We now know that diseases of the heart can also be caused by other, more subtle factors such as isolation, depression, and hostility that have to do with not only how we live but how we experience our lives.

There are recent studies suggesting that hostility, in particular, may be more predictive of coronary disease than more traditional factors such as smoking and high cholesterol. Researchers have found that heart attacks, angina, or other symptoms of coronary disease occurred much more often among men who measured as hostile on a personality test than in

those who had more conventional risk factors. Indeed, the only such measurement that predicted heart disease risk more accurately than hostility was low levels of HDL, or “good,” cholesterol.¹

In 1959, Drs. Meyer Friedman and Ray Rosenman famously reported that individuals who exhibited type A behavior—the same rushed, competitive, deadline-driven type of personality I happen to have—displayed a higher risk for having a heart attack.² Later studies have found that it is not this personality type per se but rather certain elements of it, such as cynicism and hostility, that are risk factors most associated with increased cardiovascular risk. We understand intuitively that overt hostility is dangerous. When a driver full of road rage suddenly appears in our rearview window, we gladly let him pass, distancing ourselves from his anger.

But why exactly is hostility so toxic to the heart?

Feelings of hostility—along with mild to moderate depression—in healthy men have also been shown to raise levels of a protein, IL-6, a maker of inflammation that may be involved in the process that causes arterial thickening.³

People with high hostility levels have more pronounced heart-rate responses and blood pressures when placed in anger-provoking situations. They also are more likely to engage in risky behaviors, such as smoking, overeating, and not exercising.⁴

Stress hormones such as cortisol and epinephrine are maximized in situations where people feel anger and little control over their life circumstances, resulting in higher cholesterol and blood sugar levels.

There is also evidence that people who are furious at the world are more likely to develop atrial fibrillation, a possibly dangerous heartbeat abnormality.⁵

From the body's point of view, a hostile or angry thought registers as a ringing bell, warning the body to ready itself for a fight. To prepare for action, the heartbeat quickens; muscles tense; stress hormones are released; vision and hearing become more acute and focused; the whole body contracts. These reactions typically fade once a person no longer feels threatened. But an angry person may carry these reactions within him as his daily state, a cauldron of chronic rage.

Suppressed emotions, or ones we are unconscious of, don't just simmer on the back burner indefinitely; they eventually manifest themselves on a physical level and are reflected in our bodies as physical symptoms. And if you lift up the veil of hostility and anger, in my experience, you usually find some kind of emotional pain.

Just like the heart, the relationship between a patient and a doctor exists within a cultural context. And in our culture at the present moment, the model is too much technology and not enough time. Therapeutic relationships with empathic family physicians have often been replaced with rushed, impersonal encounters with technicians and machines. One of my patients came to see me after having a physical so swift and cursory that the physician didn't even listen to his heart. Another told me how her father had been told by his physician that he had prostate cancer while the doctor was turned the other way, rushing to fill out an insurance form.

“Could you take a moment and look at my father when you tell him he has cancer,” she said to the doctor.

In spite of studies that have long reported that doctors who attend to what their patients tell them have improved clinical outcomes, the constant complaint in patient satisfaction surveys is “My doctor doesn’t listen to me!” One oft-cited study reports that doctors, on average, interrupt patients only eighteen seconds after they begin to talk.⁶

The pressure on physicians to see increased numbers of patients has resulted in the brief time a patient and physician have together being dominated by technical areas and physical symptoms, depriving patients of the opportunity to recount their full story, which may have important and complex emotional content.

If a physician is allocated 17.9 minutes (the average length of a managed care office visit)⁷ with a patient and the clock is ticking, she’s not going to dawdle to ask searching questions or take the time to delve into the deeper reasons a patient may have come to see her—which may not be divulged initially. The system encourages her to listen until a diagnostic knowledge tree springs into her mind, saying, “A leaky valve! An aortic aneurysm,” then to lapse into automatic, ordering tests and procedures based on this rapid recognition.

Patients aren’t alone in finding the quality of medical treatment disturbing. “If I’m not fast, I’m fired,” a doctor friend told me after receiving complaints about the short amount of time she was allotted for patients’ yearly physicals.

Physicians also have much to gain in terms of satisfaction

through better communication. According to Mack Lipkin, founding president of the American Academy on Physician and Patient, “There’s an epidemic of burnout,” with a high turnover of doctors in health plans. “The most significant factor in physician satisfaction is the patient encounter. Physicians with better skills have better quality patient encounters and are more satisfied and less likely to burn out.”⁸

The inability—or unwillingness—of doctors to fully communicate with patients has far-reaching implications—from an inability to gather information, to the ordering of wasteful tests, to a failure to engage patients in their own healing.

I know the statistics well—the eighteen-second interruption, the 17.9-minute visit—they were statistics I struggled daily to keep out of my own practice and life.

A confluence of these issues converged in my patient Russ, a forty-six-year-old man with severe coronary artery disease who came to see me one summer morning.

A handsome almond-skinned man, he entered my office at Scripps haltingly, his head hung low, flanked by his wife and adolescent son, who hovered anxiously around him like satellites.

With his flowing white hair and solemn face, he looked like a wounded prince in a funeral frieze. His face was particularly striking, both noble and devastated. I thought I detected a hint of Native American blood in his high cheekbones, but he hadn’t noted any nationality on his paperwork.

The family entered the office on a still breeze of dread. This wasn’t surprising. I’m often the doctor of last resort, the

one patients are sent to when there's little hope—or when their physicians have given up.

But I don't believe in death sentences; I've seen too many people who've lived when their doctors have written them off, and too many others who've died without clear medical causes.

Once they sat down, Russ said, "I just want you to know that I'm only here because my wife forced me."

"Okay," I said tentatively, thinking, *What an opening!*

But this was better than his second line: "My life's finished," he went on. "The doctors say I should put my affairs in order."

Russ's terse tone and tight face told me how diminished he'd been by his heart disease and his doctors' bleak prognosis. His spirit seemed shattered, and he radiated a deep distress.

It was clear that he was presenting me with his body, but only reluctantly and under duress, because he considered it already defeated. *Dead Man Walking*. This was the image that swept through me.

On paper, Russ's cardiac situation wasn't optimistic. At forty-six, he had severe coronary artery disease and had already been denied a heart transplant. Although he'd undergone a coronary bypass a year earlier, many of the grafts had already begun to fail. His triglyceride and cholesterol levels were high, and he continued to suffer from angina, mainly connected with stress.

However, people don't live on paper. A heart can't possibly be fathomed simply through catheterization readings or

cholesterol levels. These may have been Russ's external data, the test results that could be stuffed in the manila folder on my desk, but as I have learned over the years, the deep stories carved into the hearts of patients can be told only by them.

As the interview progressed, it was clear that Russ planned to keep himself under wraps. Whenever I prompted him to talk, he averted his stony face and let his wife speak instead.

A tiny woman with a worried face, she showed no reluctance about recounting all of her husband's limitations. "We've been broke ever since his bypass," she told me, twisting a Kleenex. "It's impossible to make it on disability. Russ can't even install our air conditioner anymore."

I'd already noticed Russ's fists, clenched in his lap, and as his wife continued her complaints, I saw them clench even tighter. This guy was as rigid as steel.

I knew it was going to be challenging to break through to Russ, but I tried all my usual methods: I told him about cases similar to his that I'd successfully treated; I asked him searching questions; I engaged his family. But as we continued talking, I still hadn't gotten a handle on him, and I'd elicited only the most meager collection of personal facts beyond what were already in my file: that he had once been a day laborer who installed heaters and air conditioners, that he had a black belt in karate, and that his heart disease had left him housebound, unemployed, and struggling to survive on disability.

His identity had been based on being physically strong and capable. He could no longer work, walk, or exercise without ex-

periencing angina, a temporary decrease of oxygen to the heart muscle signaling that the muscle isn't receiving enough blood.

I tell my patients that angina is their heart speaking to them, saying, "Pay attention!"

Every person experiences angina in a different fashion. One person may notice chest tightness when he's walking up a hill. Another a tightness in her back as she makes a bed or a jaw ache when jogging.

Russ's angina was trying to tell him something, but deciphering the message of the heart can be as difficult as understanding a foreign language. I felt Russ's heart was crying out in some sharp, specific way, but what was it saying?

As a cardiologist, I find that my hardest task isn't performing an angioplasty or inserting a stent into a blocked artery. In fact, these procedures are a breeze compared with the job I had in front of me, trying to instill hope in this frozen mountain of a man.

I continued to search Russ's face, looking for a point of entry, but the blinds were drawn. All my questions were answered by one-word answers. He wouldn't meet my eyes. How was I ever going to get through to this guy?

After reviewing his test results, I discussed my plan to stent his arteries in order to increase blood flow to his heart.

"I've had many patients like you who have found real relief from angina after having their artery opened." I drew a diagram to illustrate how the stent would scaffold open the blockage. "Afterward, we can look at ways you can change your life to help reverse your heart disease."

Russ absorbed all this in his inscrutable way and, in the end, reluctantly agreed to the stent procedure. But I suspected this was chiefly because his wife and son had begged him, rather than because of anything I'd said. It was clear from his demeanor that he had little belief that it would help.

He didn't trust doctors, and who could blame him? They had done the unpardonable: taken his hope and snuffed it out.

On the morning of Russ's surgery, I noticed his wife and son huddled together in the waiting room over cups of coffee. The waiting room is the most terrifying spot in the hospital: family and loved ones sitting with tattered, out-of-date magazines while the fate of their loved ones is decided in the parallel universe of the operating room.

The stent procedure was one I'd done so many times over the years that it had become my specialty. And with a 99 percent success rate, I felt confident of a successful outcome for Russ.

"You're going to feel better after this," I reassured Russ as he was wheeled into the cath lab, but all I got from him was a dubious nod.

About two hours into the procedure, an extremely rare but major complication occurred. To my disbelief, Russ's vessel ruptured and a fresh lake of blood began spreading inside his chest. This was the worst possible occurrence, and one that happens in less than 1 percent.

"Oh no!" I whispered, and the surgery nurse looked up at me in alarm.

I worked to stop the bleeding, but to no avail.

“I think Dr. Morgan’s on call; would you page him?” I asked the nurse after a few more minutes.

I was frantically trying everything I could think of to stop the flow when the heart surgeon rushed in and looked at Russ’s chart.

“This isn’t good, Mimi,” he murmured. “You know he’s not a candidate for bypass. What are you going to do?”

“I hoped you’d have some bright idea.”

“Sorry,” he said as he returned to his rounds. It was true that Russ’s vessels were small and his chances of surviving emergency bypass surgery were slim. We needed to come up with another solution. While my hands kept busy, I directed my frantic mind to textbook cases I’d read about, anecdotes I’d heard, but none of them applied to the situation here.

The next time I looked up, two hours had passed and I still hadn’t made any headway. How long could I keep going with this? I wondered. I was concerned about Russ, not about tiring myself. I was so flooded with adrenaline that my own heart was banging in my chest. I noticed that Russ had begun moving his legs, which was dangerous, given the site of his catheter insertion. “I’m dizzy, Doc,” he murmured. “I’m having chest pain.”

In the next few minutes, his blood pressure steadily dropped; he was beginning to die right in front of my eyes. I couldn’t have him writhing around on the table while I desperately tried to stop his bleeding, so I finally called in the anesthesiologist and had him completely sedated.

“Hang in there, everything’s going to be okay. We’ve got

to work on you some more,” I murmured to Russ as he went under, but I realized I wasn’t speaking so much to him as to myself.

I imagined walking out into that waiting room and giving Russ’s wife and son that awful look that conveys that a loved one has died. But the image broke apart; I couldn’t visualize it. There was no way I was going to enact that scene. I had to fix this somehow.

I used every trick I’d ever heard of, but I simply couldn’t seal off Russ’s vessel. Approaching the fifth hour, I was woozy with fatigue when out of the blue I thought of something that I’d never used before and haven’t used since: gel foam, a clotting agent that is sometimes used to block blood flow from an oozing vessel.

As I squirted the gel foam into the artery, I was amazed to see the bleeding stop.

I blinked to make sure I wasn’t hallucinating.

“Did you see that?”

The nurse was as exhilarated as I was. Russ’s blood pressure returned to normal, and we successfully completed the procedure.

Later, when I went into the recovery room, I walked up to Russ’s gurney and stood looking down at him, lying there with closed eyes.

The anesthesia had relaxed his features, so that I could see glimpses of another face embedded in the man’s—a younger, more vulnerable version of Russ.

Standing there, I flashed back to my own first hospitaliza-

tion as a girl of ten—how nauseous I'd been from the anesthesia, how miserable and alone I felt, still bruised from the loss of my mother. I'd been comforted by a nurse who'd swooped in like an angel and fussed over me, tucking me in with warm blankets. She hadn't done anything particular, but the quality of her attention to me in that moment had been deeply comforting.

I was wishing that I could convey this same feeling to Russ when he opened his eyes and looked up at me, and I saw, inexplicably, that I had.

Something had passed between us in those bloody hours, something I couldn't properly quantify or explain in my surgical notes. It was a miracle that he had survived.

On our follow-up visit the next week, Russ had a different quality. He stood straighter; his eyes were brighter; he seemed infused with an *aliveness*.

I asked all the usual questions.

"How do you feel?"

"Different."

"Better?"

He seemed embarrassed to admit it.

"Yes."

He took off his shirt, and I listened to his heart. Although the small vessel that we had attempted to stent had closed, his angina was under better control. But he was still clearly weak and out of shape.

As I turned away and began filling out his chart, I heard the low murmur of his voice speaking to me.

"I'm a member of the Blackfeet tribe," he said. "My ances-

tors were one of the first tribes to begin moving west. We traveled in small bands—usually about twenty people—but we came together for rituals and trade. We were buffalo hunters.”

I stopped in my tracks. Russ had a sonorous, melodic voice that I’d never heard in his terse replies to me in the past. In fact, I’d never heard him say so many words since we’d met. I put down my pen and turned toward him, afraid to break the spell.

“The most sacred event of our year was the sun dance, when we gathered together to fulfill vows assuring abundance of buffalo and the well-being of our tribe.

“We were able to resist intrusion by white settlers until late in the nineteenth century. It was a great devastation to us when the buffalo were driven almost to extinction. My tribe was forced to be totally dependent upon the government Indian agency in order to survive. . . .”

Why is he telling me all this? the clinical part of me wondered. What does this have to do with his heart problems? My eye wandered to the clock; I had already run far over my allotted time with him, but I resisted the urge to interrupt.

As Russ continued speaking, my nurse stuck her head into the doorway and gave me a quizzical look. I was running way over. But I gave her a nod that meant I wanted us to be left alone. Then I did something I hadn’t done since medical school. I turned off my scientist’s mind, the rushed, skeptical, two-minute mind that was muttering in the background.

I put down my instruments and prescription pad, and I let my patient talk.

Our culture has its roots in a storytelling tradition.

There is something in us that yearns to tell the stories of our lives, and have them listened to in return. Research shows that in the act of deep listening and responding, a therapeutic exchange takes places, one that may help heal emotional and psychic wounds.⁹

In medicine, this kind of exchange is especially potent, since historically it is through the telling and receiving of stories that a diagnosis is found. Before angiograms and echocardiograms, this was how healers spent much of their time.

The role of listener was one I had perfected long ago as a girl in Brooklyn with my grandmother. We had a private ritual that required certain conditions—her apartment being empty except for the two of us, her involvement in some methodical kitchen task, my placement at the kitchen table over my schoolbooks.

There was something about this scene—my position as a serious student on a clear table, unencumbered by the chores that had once stymied her own ambitions, had the effect of opening a door in her, ushering forth long stories of her own thwarted Italian girlhood and her frustrations as a bright girl.

Her tale had the predictable plot twist for her place and time—the farm door slammed in the face of her goals, shutting her in with domestic tasks that would prevent her from achieving the education she wanted.

I knew that her telling me these tales was of benefit to both of us, that she was passing something on to me—my heritage as girl of the Guarneri family—and that in her own intu-

itive way she was releasing old angers and frustrations, letting me know that what had been thwarted in her might now be nurtured in me.

And by heeding her, I felt that I was helping something inside her heal. This was a pact between us, the listener and the speaker. I was on my way to being an English major and was already attuned to the structure of stories—the plot, the climax—and I saw that the resolution of my grandmother’s story, the great denouement, just might be me.

This listener role was one mightily discouraged during the rush of medical training. In every hospital where I worked, there was always someone dying alone—usually an elderly female—who was pining for someone to talk to and to whom I found myself gravitating. That is, until some supervisor pulled me away.

“If she’s not yours, you can’t spend the time” was the general refrain. The belief that a doctor’s attention was a finite thing, like money in the bank, which might run out if you spent too much of it, was a common one.

Burned-out doctors were thrown up as cautionary models of what could happen if you cared too much.

The brisk surface approach was what was recommended. Gliding across the slick top layer of the clinical. Implicit in this advice was that you had to save deep emotions to spend on your own loved ones.

It was because of this that early on, I decided my patients would be my family.

The lure of listening began tugging at me again once I

began to practice and saw the hunger of patients to be perceived as more than a list of numbers, the results of an echocardiogram or catheterization, but as a compilation of unique stories and experiences that would help me comprehend them if I would only take the time.

The night after Russ's visit, I was so keyed up I couldn't sleep.

I got up and turned on my computer and searched several Native American sites. In one article I read about *duyukta*—a Native American term for harmony and balance.

I read: "Separation within oneself, from one's family/clan, one's community, from the earth—these are causes of disharmony and disease."¹⁰

I thought of Russ's fists, that stony face.

He was furious, I realized.

A once-strong, proud man, he'd lost all the old connections that had given his life meaning. He'd found himself diminished and alienated, in physical distress, with nowhere to go and no people to go to.

In the midst of a Western culture that stressed individuality over clan or community, Russ was adrift, divorced from the wisdom of his heritage.

Dead man walking, a silently furious man, rendered helpless by heart disease.

This was the theme of the story he'd told me.

Had I treated Russ earlier in my career, this might have been the end of our story, not the beginning. He would have been part of the assembly line of patients who had moved

through my office, whose arteries I'd opened without teaching them how to open their lives and hearts.

Russ would have gone back to his apartment and continued his diet of pork, potatoes, and Coca-Cola. He would have continued bottling up his frustrations, and his vessels would have inexorably closed again.

I would have dealt with his heart and dutifully ignored the rest.

But I'd changed—my patients had changed me. They had shown me the importance of the heart's biography. They had taught me that coronary disease is physical, spiritual, and emotional. And that there could be a bridge between the conventional world of modern medicine and the type of healing known as alternative medicine.

The Healing Hearts Program that I directed at Scripps had been designed as that kind of bridge to help heart patients change their lives, and I wanted Russ to enter it.

At our next appointment, I told him, "I've done everything I can for you; now the ball's in your court. I need you to do everything you can to keep your arteries open. I need you to eat differently, exercise, decrease your weight, and learn ways to reduce your stress. But I also need you to think differently, to believe you will get well, to *want* to get well again."

I gave him the glossy brochure for our Healing Hearts Program, laid out at the foot of the Pacific. Customarily, this was all I had to show a patient for him to eagerly sign on. But Russ's reaction was contrary. As he leafed through the brochure, I saw the old shadows fall across his face.

“I don’t know about this,” he said.

“Why, what’s the problem?”

“I’m just not sure.”

“Russ . . .”

He looked up at me, and the shadows disappeared.

“I don’t have enough money for a hotel room in La Jolla,” he told me.

I looked past him out my office window at the ocean; as a displaced New Yorker, I still half expected to see a brick wall or a rubble-filled parking lot. The Pacific, right there in front of me, was still an unexpected thrill.

How far was I willing to go with this guy? I asked myself. Now that he was on the brink of real change, how much was I going to do?

The bonds and barriers between patient and doctor had been drilled into me since medical school.

My training told me that I was the doctor and Russ the patient, that he was sick and I was well, that I had the answers and he the questions. I’d been taught that the two of us should remain strictly apart, with me imparting wisdom and Russ the obedient and passive recipient.

But this arrangement wasn’t working. I had learned as much from my patients as I’d ever gleaned from journal articles or textbooks, and it was not going to work by my being cool and detached and remaining on my side of some invisible barrier.

“I’ve got space in my house,” I heard myself saying, to my own surprise. “You and your family can stay there.”

That night I lay awake, agonizing over my decision, examining it from endless points of view. Would my colleagues find my behavior unprofessional? Would I feel uncomfortable having friends over with Russ and his family milling around? What if my dogs didn't like them?

My concerns were valid—it was a challenge having Russ and his family up close and personal during that first weekend in the heart program. I had to remind myself to be suitably dressed before wandering out to the kitchen or sashaying out of the shower. And even if I wanted to, I was no longer able to hide behind the authority of my white coat.

I was a regular woman now, standing in her kitchen, wearing her flip-flops, feeding her dogs, and making her salads. I had to hold my tongue when I saw Russ's son go out to their car to sneak in the bright red cans of Coke that his father was supposed to be avoiding. This was his path, not mine.

Russ benefited from all the components of our Healing Hearts Program, from yoga and meditation to vegetarian cooking classes, but the support groups and counseling were among the most important.

Our heart program couldn't provide Russ with his lost tribe, but the support group he entered may have been the next best option. I found myself hesitating by the glass doors to catch sight of his profile during these sessions. I couldn't tell what he was saying, only that he was saying it.

As I looked in at him, a verse from childhood Bible school floated into my head.

“Everything is shown up by being exposed to the light,” St.

Paul said, “and whatever is exposed to the light itself becomes light.”

Research has documented the healing power of confiding in others. James W. Pennebaker’s research on the correlation between suppressing our stories and illness, on the one hand, and telling our stories and increased health, on the other, is especially compelling and well researched.¹¹ As Russ himself later said: “Nothing got better for me until I began to talk about it.”

Group support is a central part of Dean Ornish’s heart disease reversal program, a model for ours. According to Ornish, not only do support groups help participants let down walls, express feelings, and learn to listen compassionately, but group members also motivate one another to sustain lifestyle changes, such as exercise, diet modification, and smoking cessation.¹²

In California, the shift from spring to summer is subtle but monumental, and during this period, something profound also shifted in Russ.

As he continued the program, his cholesterol and triglyceride levels improved, and for the first time in years he was able to walk without chest pain.

As his physical condition improved, I watched that tight, stoic face continue to soften as his suppressed anger finally emerged. Under his shell of toughness was a bruised, tender man, full of hurts and frustrations that he finally felt free to express.

Group counseling also changed the dynamic of his family life. Where Russ had once sat, ill and immobile, the center of the universe, there was suddenly movement again. He no longer needed to control his family through his heart disease,

because it was no longer controlling him. His wife and son were unlocked from their static positions as protectors and guardians of his ill health.

His wife, in particular, who'd spent her days devoted to his care, had her life back. In counseling herself, she was now able to go out in the world without worrying that Russ would collapse at home. Their son even developed healthier eating habits and exhibited less fear that his father was going to die.

But the deepest indicators of Russ's success weren't his lowered cholesterol and triglyceride levels, but what I found him working on one afternoon—an intricate, many-threaded web with red beads woven into its center.

“What's this?” I asked him.

“A dreamcatcher, to ward off nightmares. We believe bad dreams become entangled in the sinews and threads. You hang it near where you sleep. This one's for you.”

He handed it to me, and I held it up in my hand. And then I saw that the table behind me was covered with these intricate ornaments.

This creative side of Russ had been submerged deep under his illness; now his works of art hang throughout our offices at Scripps, a reminder of the great energy that had been locked inside.

Another day I entered one of the offices and found Russ sitting off in the corner with a young woman coworker.

“What's going on?” I asked the group leader.

“Russ is giving Gena a kokopelli.”

“What's that?”

“For fertility—she’s having a hard time getting pregnant. It’s very powerful. Mary Jo and Dan claim he’s already helped them conceive.”

I backed out of the room—I wasn’t exactly in the market to have my own fertility increased.

This is not to say that Russ’s physical condition hasn’t required continued medical intervention—it has. But now, seven stents and over seven years later, when I wake some nights worried about him, I see his dreamcatcher in the corner of my bedroom, and I remember that Russ advanced far beyond my technological fixes. He’s found his own way.

Anthropologist David Maybury-Lewis says that individuals in a tribal society grow up in a defined world where people know their place and their relationship to others. In our modern Western culture, however, we grow up in a seemingly limitless world where we are often adrift and terribly alone.

I believe that this was what Russ’s heart had been trying to tell him—that without community, clan, or a connection to his spirit, he and his heart were floundering.

As a spokesman for the medical technology company that helped fund our heart center, Russ has found a role that’s helped keep him alive and vital nearly a decade after his doctors had given up on him.

He has stood in front of packed audiences across the country telling the story of how he lost his way, then found it again, one of the most ancient of tales.

And the audiences fulfill their part of the bargain. They give Russ what he wants—what we all want: They *listen*.

