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What the Physician Wants the Pastor to Know

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When I was first asked to convey a helpful and meaningful message to pastors, who are much more theologically steeped than I, my initial response was to say, "God, no!" Surely those folks are closer to God, by nature of their profession. They already wrestle with the daily mess of caring for members of their flock who are sick, grieving, suffering, lonely, and depressed. They are well-seasoned professionals. None of my insights will be particularly helpful to them. They expertly navigate the entire range of human experience, from the joys of births and weddings to the brokenness of human relationships, illness, and death. I am just an amateur.

Then I realized that this exercise was as much for me and my patients as for the pastors.

On any given day, I toggle with speed and efficiency between joy, frustration, and sorrow. I start the day rejoicing with a patient in the news that her cancer appears to be cured or that he is in remission. Ten minutes later I take a deep breath at the door to the exam room, as I am about to tell a sweet older man that he may just not make it to celebrate that next grandchild's graduation or that if he is around, he will probably be too sick from chemo to make it to that daughter's wedding. Sometimes I struggle to muster up the empathy that I want to have, that I know Jesus would want me to have. Other times I completely fake it and then hope the next cup of coffee will give me more compassion.

I believe that many in medicine undergo multiple mini-traumatic experiences a day. Any provider who has participated in a Code Blue for a cardiac arrest that had a bad outcome will tell you this. We learn early on in training not to forget these experiences but to put them in a storage closet so that we can pull them out and work through them later, when there is more time and fewer patients. That rarely ever happens. The much easier way to cope is to become numb, or worse yet, bitter and cynical. We do not adequately process these experiences, and as a result we often do not grow from them as we could.

I still wrestle with the role emotion should play in my job. Why is it that I can stare an elderly woman directly in the eye and tell her she has six weeks or less to live and not even shed a tear, then get choked up seeing her hold her partner's hand? I surprise myself at what moves me. Patients who are struggling with so much yet take time to ask me about my children. The old farmer who brings me eggs and tomatoes from his summer garden. The daughter who writes a note thanking me for all I did for her deceased father, telling me how blessed he was to have us caring for him. The last patient I see before the holidays who says, "Merry Christmas," recognizing it will likely be her last.

Mixed between tears and the next fifteen-minute appointment is a barrage of messages from nurses, pharmacists, radiology technicians, and social workers. I quickly sift through labs and make decisions about whether to continue treatment that day; whether to continue chemo or reduce the dose; whether to go ahead and order that scan without contrast or just reschedule it; whether to choose a different medicine from the one I had ideally wanted because the out-of-pocket cost for the patient is too high. I wrestle with whether to push just a bit more with treatment in hopes that one more cycle will help or to stop and call in Hospice. If oncologists are honest with you, many will tell you that they divide their time between the fear of overtreating patients and worrying that they did not treat enough.

Decisions, decisions. I occasionally stop and pray that my decisions will be the "correct" ones, that they will somehow reflect God's will. Then I worry that I don't have the time in the day to pray as I should. I am a perfectionist, tirelessly devoted to keeping my patients alive and living well, in a job with a 100% failure rate. Where do I find my purpose in helping people along their journey to becoming dust? How do I balance science and the art of medicine, reason and faith, while remaining faithful to my Creator?

There was a period about a year ago when I was struggling with significant loneliness in my job. I told a counselor that some of my loneliest moments of the week, sadly, were not at work (at least work gave me a clear sense of purpose and direction) but on Saturday mornings during my son's soccer games. Surrounded by other moms and dads who were investment bankers, lawyers, and commercial realtors, I felt like I did not have common ground to interact and have casual Saturday morning conversation with many of them. How could I engage in banter about mergers and acquisitions or the hottest new commercial development in town, when my mind was completely on my sick patient? It felt so foreign to the concerns occupying my bandwidth every day. It is not that I felt my job was more virtuous, I did feel like these folks would never want to understand what my job entails. So I lost interest in them in return. And I lost an opportunity to be a good friend in some cases.

I found myself worrying about patients at many points throughout the weekend, even when I was not on call. In the middle of throwing the football, watching my daughter at a ballet recital, on vacation at the beach, or even in the middle of a run, I would obsessively check charts of patients on my phone through an application linked to the electronic medical record. Much of my worrying and chart stalking is unproductive and self-destructive. Unchecked, it can alienate me from the people right in front of me, even my wife and children. I realize that I have become addicted to checking charts on my phone and I forget how to worry well, in a more productive sense. Some of this is not entirely my fault, but a result of technology making us instantly accessible for any number of patient messages at all times. Our medical training to some degree rewards compulsiveness and worrying. Indeed, the worrying sometimes pays off and may help a patient. Yet in the process of trying to stay

connected to patients when I am not physically there to help them, I threaten to shut out those whom I love the most. I seal myself off from the community around me, when I know God has created us to be in relationship with this community.

Patients ask me nearly every day how long I believe they have to live. My immediate response is that I am not God. Then I go on to offer a medical prediction based on randomized studies. I owe it to them to be realistic, yet sometimes this dashes patients' hopes. That feels out of step with my calling, as hope can be transformative, and I have seen patients live months, even years, longer than expected on hope alone.

One of my closest physician mentors reminded me that my job is not to play God, not to try to predict the future, or write patients' destinies. In my core, I know this is true. Yet everything about modern medical training is geared around trying to be God. We physicians are trained from the beginning to have the right answer, to make the accurate diagnosis and prognosis, to fix the problem, to find the solution that will buy a patient three more months of life. Physicians will begrudgingly admit a mistake to a patient; yet for many, heaven forbid they mention their mistakes to another physician. In the pursuit of perfection, physicians have created a culture of shame around mistakes. They are buried deep within people, where they fester and lead to burnout, depression, and most of all, a profound sense of loneliness. It is not surprising that many physicians do not count other physicians on their short list of close friends whom they can trust. This is a deep shame, because in a sense, only physicians who make these decisions can truly understand the weight that their colleagues feel. If we could just abandon our own sense of pride, or perhaps our deeper sense of shame, we physicians might be able to witness to God's transformative healing power for one another.

Our culture of isolation is exacerbated by the lack of in-person medical conferences and other physician gatherings post COVID. Introverts though many of us may be, physicians find job satisfaction in the camaraderie built around working together to figure a problem out, collaborating, and in the case of trainees, going through a mentally and physically tough training experience together and coming out on the other side. Like many professions, we, as a medical community, have lost some of this sense of collegiality and mutual support over the past three years. With applications on our phone, we can see labs and results quicker than ever before. We communicate now more than ever, but this technology does not always enable us to communicate well. In the midst of a discussion with a patient about transitioning to Hospice, I am likely to be pinged ten to fifteen times about signing chemotherapy orders, approving labs, or scheduling a peer-to-peer review to make my case to a fellow doctor why an insurance company should pay for my patient to undergo a special PET scan. I approach my peer-to-peer review with the insurance physician not as a cordial discussion about the most appropriate care plan, but as a battle to be won. The doctor on the other line becomes the adversary, someone who left patient care and who no longer understands what it is like to take care of real

patients. He or she becomes an enemy to be defeated in my quest to deliver the best care to my patient. I am David, and the insurance company is Goliath. I realize that I am becoming self-righteous, even arrogant, in my pursuit. I try to tone it down, and I give a good Southern "Thank you, sir" when I hang up the phone. The medical system is designed such that it is often more adversarial than collegial, and sadly patients sometimes get caught in the crosshairs.

In the midst of egos and distractions, how do I remind myself to truly listen and minister to the patient who is suffering in front of me? With all the competing demands, how do I place my attention on the patients who need help the most?

I went to seminary right out of college, sensing that perhaps I was called to be a pastor. Midway through my second year, that calling abruptly changed. I began to explore going to medical school, which I had considered initially as an undergraduate. I discovered that if Jesus himself took human flesh and redeemed it, then there was something innately mysterious and holy about the body. I devoted my life to caring for human bodies as "wonderfully and fearfully made" in God's image. I thought of medicine as the most incarnational of callings and felt it was the most tangible way that I could serve God and God's people. That image stayed with me throughout much of my first year of medical school. I remember going through the anatomy lab, studying the cadavers and reflecting on Psalm 139 "you knit me together in my mother's womb." That probably sounds weird, but the intricacies of God's creation amazed me.

By the end of the second year, however, I saw firsthand the innumerable ways that God's human creations fall apart. Whether through random inborn mutations in utero, or wear and tear from years of poor human choices, the body inevitably falls apart. Cancer is perhaps one of the most cruel examples of this. At first, I became frustrated at the relentless progression of cancer, how it could escape detection and then show up in the brain when you least expected it, or how it could blow up and make people deathly ill within weeks. This decay hardly felt consistent with Jesus's mission of redeeming the human body, restoring it to wholeness. I had to reframe my understanding of incarnation. God did not enter into human flesh to make the body the most perfect version of itself. God assumed human form not to erase human pathology, but to redeem it and restore the body to right relationship. This reframing has helped me a great deal as I try to share God's hope with patients who are suffering from cancer.

This reflection is not meant to whine about being overworked, to lament and reminisce about the good old days of medicine, or to blame the massive modern healthcare institution in spite of all its flaws. Despite all their griping about the increasing corporatization of healthcare, physicians are still a privileged lot. My purpose here is meant to ask you as pastors to help Christian physicians (and all other Christian health care providers) to redirect this Advent season. Many physicians struggle with deep loneliness and alienation, both within the medical community

and outside of it. Medical culture has become such that many feel like they are travelling the road alone. Many feel like none of their non-physician friends truly understand their burdens, and so they bury their heads in the sand and do not make the effort to engage in relationship with others. We need to be encouraged to take that chance on people, to seek out a new friend, to reach out in vulnerability to other physicians and providers so that God's beloved community may become real to us again. We need to be reminded that while our friends may not always understand, Jesus certainly does. We must always remember that contrary to the teaching of medical education, our job is not to play God, but to participate in God's loving care and provision for our patients.

We want you to help us reclaim the joy and promise of Christ's coming in our daily work. We need to be reminded that the Christian faith at its core is about right relationship, with God and one another. We are called to find and reclaim that key relational piece of our work as physicians and caregivers. If pastors can model this by creating transformational communities built on authentic relationships, then hopefully we physicians and caregivers can discover again the joy of medicine in our relationships with patients and one another. We ask for help to live into the Advent hope that even where we cannot heal the body, Jesus, the Great Physician, can still make all patients whole.