RECONSIDERATIONS

EXPLORING CHRISTIAN THOUGHT IN THE UNIVERSITY COMMUNITY

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This past year the students in our Undergraduate Seminars on Faith and Vocation have been blessed with wonderful mentors who have been exemplary in their reflection about how their own faith shapes the work that they do. One of these mentors is Dr. Jay Lynch, who is not only a highly regarded oncologist at UFHealth, but also the Dean of Admissions at the College of Medicine and the President of our Board at the CSC. He and his wife Laura remain absolutely central to the continuing ministry of the Study Center. In this essay Jay reflects on how the principles of incarnation and hospitality impact his own work—in the hope that we would consider how these same principles might impact the work that each of us does.

INCARNATION AND HOSPITALITY AS GUIDES FOR PATIENT CARE

James W. Lynch, Jr., M.D.

Consider the following story.

A seventy-five year widow from a central Florida citrus farm (we will call her Anna) notices a lump in her neck. She feels well, is in excellent health, and is still overseeing her farm's fairly extensive operations. She eventually undergoes a biopsy, is told she has a kind of cancer called lymphoma, and is referred to an oncologist for consultation and treatment. Anna then waits four weeks for the appointment and then sits two hours in the waiting room to see the physician. She receives no information about her disease prior to the appointment, which only fuels her anxiety about the diagnosis. While waiting in the office she is offered no water or snacks, nor is she shown any other common courtesy such as an apology for the wait. In fact, the only conversation with a human being prior to seeing the physician is about how she will pay for the visit and treatment because, "Medicare only pays for a percentage of the cost."

> *"While systems are essential, ... no system is going to eliminate the human element or adequately address human needs."*

Enter the physician, who, without introducing herself, tells Anna she needs a bone marrow biopsy and a PET scan and comments that her cancer is very treatable. She explains that the treatment should start right away and will consist of intravenous immunotherapy given weekly for a month with a very good chance of a remission. Anna is never asked about her priorities, family, friends, faith, or goals for therapy. In short, there is no apparent interest in her as an *individual human being* who has just received a diagnosis of cancer. Anna tries to ask questions about the need for treatment, the side effects, and the prognosis, but the distracted physician appears annoyed and gives the impression that the questions indicate a lack of confidence and trust. In response the oncologist tells Anna that she doesn't realize how fortunate she is to have this particular kind of cancer. There are other people in the office with lung and pancreatic cancer who will likely pass away within the year, but the treatment for lymphoma is very tolerable and effective—even for the elderly. Moreover there are a great number of new treatments and therefore she will likely die of something else.

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The physician leaves abruptly in response to her cell phone, and an assistant enters to obtain consent for the procedures and treatment. Anna asks if there is a way she can have a second opinion before agreeing to treatment. The assistant responds, "Well fine, *(which, by the tone, is clearly not fine)* Go right ahead," and she leads the patient to the front desk. Anna then pays with her VISA and exits the office more anxious, confused, and angry than when she arrived and determined to find another facility for her treatment.

"Practicing hospitality ... refers to emulating God the Father, who, in Christ, has not only invited us to be guests in his home but has also adopted us as his own children—an act that might be described as the ultimate act of hospitality."

This story, although an amalgamation taken from several episodes, is very real. The information from the physician about the treatment and prognosis is factually accurate, but the story illustrates that the care of patients involves far more than sterile medical expertise. I wish this were an isolated event, but sadly, experiences such as Anna's occur every day in every kind of medical discipline. As evidence of this, when I ask audiences whether they can relate to this story or ones like it, nearly everyone nods sadly in recognition. I am embarrassed to admit that at times I have been just like this physician and so my critiques are directed as much to myself as to anyone else.

In response to public concerns about the cost and quality of medicine, the disparities of access, and the impersonal nature of healthcare, some propose large-scale, systemic reforms as the solution. Many government and healthcare leaders believe they can design a healthcare system that will guarantee high quality, equitable, cost effective, patient-centered healthcare. This is a lofty and laudable goal, but I am skeptical that such a project will address Anna's experience. While systems are essential, and we need to continue to address systemic issues, no system is going to eliminate the human element or adequately address human needs. To address the needs of real patients like Anna, every member of the healthcare team must give attention to the human needs of patients, no matter what system frames our practices.

When thinking about attending to human needs from a specifically Christian vantage point, I have found a framework suggested by our own Dr. Richard Horner extremely valuable. If we are called to follow Christ in all spheres of life, we can look to the story of Christ and see at least two great principles or modes of ministry at work. These are incarnation and hospitality. Practicing incarnation refers to emulating Christ in leaving his position of privilege to enter our sinful and broken world in order to redeem us and restore our relationship to God, to others, and to creation. So then, as followers of Christ, we too must be willing to cross over into other people's worlds so genuinely that they get the chance to see Christ in us. Practicing hospitality, on the other hand, refers to emulating God the Father, who, in Christ, has not only invited us to be guests in his home but has also adopted us as his own children—an act that might be described as the ultimate act of hospitality. So then we must be willing to welcome others into our world so fully that again they might have the chance to see Christ in us.

Let's think about what it might look like for these two principles to shape the way we practice our various disciplines. I will reflect on their implications for patient care, but you might consider how they apply to the work you do—not only the work for which you may receive payment, but for any and all of the work that you do throughout the week.

When thinking about our calling to be incarnational in healthcare, I conjure up images of days past when physicians made house calls, but I also think of the continuing importance of home care as practiced by nursing and hospice. The principle of incarnation, however, also has much to say to those of us who work within the bricks and mortar of particular institutions, so we do well to ask: what does it mean to enter into the world of the patients we are caring for in our hospitals or offices? When patients come to us, they are often apprehensive, confused, and feeling out of place. Hospitals are pretty scary places. Incarnational practice seeks to bridge the unintentional divide that modern technical medical culture creates between practitioners and their patients.

If incarnational practice means we cross over into the world of our patients, we need to make ourselves genuinely willing to hear their stories. Perhaps the most basic way to begin to do this is simply to pause and listen. Around the turn of the century over 115 years ago, Sir William Osler insisted that we listen carefully to our patients because they are telling us the diagnosis. In today's busy world of healthcare, however we are not doing well at this basic skill. Studies show that physicians interrupt their patients after an average of about 15-20 seconds of talking. Current discussions of theses issues are working to improve this rather unflattering statistic, but whatever the solutions, it seems clear to me that with the time pressures created by busy hospitals and offices, developing into a good listener requires real discipline and determination. Sitting rather than standing, with our eyes directed towards the patient, can be a great start in communicating via body language that we want to give our patients our full attention. As they talk and we listen, we will begin to see how they understand their illness and how it impacts their family, and we will learn many particular ways that they are suffering with fear, pain, or uncertainty.

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We can also "listen" with our eyes. If our patients are hospitalized, it can be very instructive just to notice the items they thought sufficiently important to bring with them for their stay. You may notice photographs, cards, a Bible, a crucifix, or any number of interesting items worth discussing.

Nothing, however, replaces taking the time to ask simple questions about our patients' lives such as, "Where did you grow up and what was your family like?" or, "Tell me about your vocation and hobbies." I often start my medical conversation by asking my patients to tell me their stories leading up to and through their diagnosis. It is not infrequent that I hear, "Really? You want me to tell you the story?" They can't imagine a busy physician actually wanting to hear the "back story." But after we have a conversation and exchange thoughts and ideas for 15-20 minutes, something wonderful begins to happen. We become human to one another. I cannot help but see them as real, unique persons struggling with a disease and they see me as human too—offering to help and hopefully bringing some expertise. In these conversations I often learn whether or not faith is important to them, and I give them space to talk about such things if they so desire.

The truth is that genuine relationships with patients are some of the more life giving and sustaining parts of being a physician. As a delightful consequence of thirty years of medical practice, I have heard innumerable, amazing personal stories and have learned many fun and fascinating facts about our world.

When we turn to think about hospitality in the context of health care, I do not mean to suggest that we need to have our patients visiting and staying in our homes (although a home that is open and welcoming probably goes hand in hand with a

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medical practice that is open and welcoming). I would suggest rather that we think about our professional "homes" and that we imagine ways to make them more hospitable for patients. What we really want to do is create an atmosphere in our institutions that makes patients feel welcome there much as this is possible. Our vocational homes, be they hospitals, offices, or other spaces must be patient centered in more than a cursory way. It should be easy for patients to navigate their way through our medical facilities. Signs offering directions, and real people offering guidance should be plentiful.

> *"Patients need to* BE *well cared for, but they also need to* FEEL *well cared for."*

At our medical school here at the University of Florida we seek to instill a hospitality mentality among our medical students and staff. From the outset we tell our medical school applicants that we have a family atmosphere, which is another way of expressing the idea of hospitality. On their interview days, we let them meet patients, fellow students, and staff right away, and the deep spirit of community is obvious. We point out that we "take care of one another so we can learn, discover, and take care of our patients." By caring for one another we create a culture of caring that becomes a way of being as we go to the bedsides of our patients. Every health system today says it wants to provide patient centered care, but this can be a reality only when a hospitable family culture is established and nurtured within the institution. While this is our ideal, however, it goes without saying that we too often miss the mark, so revisiting and remembering these basic principles must be a natural part of our rhythms of practice.

For our professions to grow in these areas of incarnation and hospitality, I would submit there are two prerequisites. One is an attitude and the other a skill. The attitude can best be summarized by the phrase, "It's not about us, it's about our patients." Before we will ever be able to see ways we as individuals or institutions negatively impact the experience of patients, we must lean against our congenital obsession with ourselves and our agendas. Much more could and should be said about this, but it will have to suffice to acknowledge that this is a lifelong project. The second prerequisite has to do with our skill or ability to communicate. Ever improving communication skills, developed in the practice of medicine, become the means through which so many of our ideals are accomplished. These skills include listening well and speaking in ways our patients can understand without a lot of medical jargon. As Jesus learned and spoke the languages of our world, so we need to speak in the language of our patients.

Incarnation and hospitality, additionally, need to shape not only the way we communicate but also the way we make decisions with patients. Over the years, at least two decision making models have guided the training of physicians. (I will hyperbolize for the sake of effect.) In one telling, physicians are understood to be the experts who know what is medically indicated and who simply tell their patients the right thing to do. According to this method the professional's expert judgment illuminates the path, and the patient is simply to follow the path. The patient's preferences or individuality are overshadowed by the expert recommendations. In the second model patients are thought of as autonomous consumers, and the healthcare system functions more or less like a department store. Medical practitioners become, in effect, the healthcare counter at Macy's, simply selling the customer whatever he or she may want.

Contrast these models with the kind of relationships we have described that are built upon the principles of incarnation and hospitality. Patients do come to us because we have knowledge and skills that they lack, but medical decisions are rarely so straightforward that patients' goals and values have no usefulness in shaping decisions about their helthcare. As we enter our patients' stories and seek to make them welcome in our professional homes, a natural dialogue will take place. We can then help our patients see how their specific values and goals should shape decisions. During these discussions, the wisest strategies usually become self-evident. This model is called "Shared decision making."[1] Trust between patient and practitioner, built upon mutual respect and understanding, becomes all the more critical as the decisions become more complicated and life altering. Sorting through the variety of strategies can be pretty overwhelming to patients and their families at times, so it is not uncommon to have patients ask me, "If this were you or a member of your family, what would you recommend?" I think this is a fair question, and I do my best to answer honestly. During these critical moments, the wonder and joy of medicine comes to life.

One simple summary of these imperatives of our profession is so say, "Patients need to *be* well cared for, but they also need to

feel well cared for." The first has to do with the medical dimension of care and the latter with the human dimension. Putting it another way, the best way to blend the science and art of medicine is by living and practicing incarnational and hospitable care.

We must not, however, be naïve about this calling. Living and practicing incarnational and hospitable patient care will cost us. First, there is the obvious cost of the time this takes as we listen to and converse with our patients and colleagues. Some practitioners say that the time is simply not available, but this is where we need to become creative and live sacrificially. But perhaps more important is the cost of entering into another person's suffering and inviting him or her into our lives. When we show compassion and empathy for those who are ill we will *actually take on* some of their burden. Without the proper care for one another as health care providers, this cost can be considerable over time.[2] Wise practitioners will therefore be attentive to their own health: physical, emotional, and spiritual. We must be open with one another, acknowledging our struggles and looking for ways to love and care for our colleagues.

> *"When we show compassion and empathy for those who are ill we will actually take on some of their burden."*

Speaking again from experience, I have firsthand knowledge of the potential cost. In my struggles with burnout and depression, which I have chronicled elsewhere, I am no stranger to the cost and the need for care from those who love me. These experiences have taught me that I must listen to those who care for me and seek help with humility. That said, I can honestly say that living and working in this way offers the greatest kind of satisfaction and joy possible in this world.

As we follow the example of our Lord, who entered our world to bear our burdens and welcome us into his family, we can rely on his promise to be with us as we reach out to others in his name.

So what became of Anna?[3] Thankfully, we met some four years ago when she came to our offices for that second opinion. We reviewed her records and radiographic studies. We also got to know her as a person learning about her life growing up in rural Florida: the successes and trials of the farm and the loss of her husband. It was clear she had a deep commitment to Christ and trusted in his care in all her life, including her health. As we conversed, it became very clear to both of us that since her lymphoma was causing her no trouble and was a chronic illness, the wisest strategy was for her treatment to be deferred until her condition changed. Today, we are both glad to report, she continues to do well without treatment, and at each visit she catches me up on her health, her family, and her latest agricultural escapades. Patients like Anna remind me that what I do is clearly a calling, a privilege and a joy.

James W. Lynch, Jr.

Notes

1. Michael J. Barry, M.D., and Susan Edgman-Levitan, P.A. *N Engl J Med* 2012; 366:780-781, March 1, 2012 DOI: 10.1056/NEJMp1109283.

2. https://theconversation.com/the-epidemic-of-burnout-depression-and-suicide-in-medicine-one-doctors-story-41800

3. "Anna" has wholeheartedly endorsed this telling of a version of her story in the hope that it will help other patients get the care they need and deserve.

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RECOMMENDED RESOURCE

FINDING LIVELIHOOD: A Progress of Work and Leisure
BY NANCY J. NORDENSON (KALOS PRESS, 2015)

by Betsy Clover, Program Administrator and Alumni Coordinator, Christian Study Center

When I started working with the Study Center last April, one of my first assignments was to scour our library and gather resources we have or should have on the topic of faith and vocation. Our goal was to identify a short list of resources for use as core reading in our Undergraduate Seminars on Faith and Vocation. This search introduced me to *Comment* magazine and to an essay in their "Making the Most of College," Issue (Fall 2010) that made me slow down and listen. Nancy Nordenson's essay, "Spinning and Being Spun," has the voice of experience sharpened by a vivid memory of inexperience, and seasoned by the perspective of someone who approaches life as a learner. When I tried to explain to others what I loved about the essay, the best words I could find were, "It's beautiful."

During the months that followed, I kept going back to this essay, and eventually I used a portion of it in the first entry I wrote for our blog, "CSC Interchange." As we continued our work on the faith and vocation initiative, we were greatly encouraged to receive confirmation that the editor of *Comment*, James K.A. Smith, had agreed to be our speaker for the Summer Institute. Days before I would meet Dr. Smith in person, I got a personal email from Nancy Nordenson. She noticed our use of an excerpt from her essay on our blog, and she offered us a review copy of her new book, *Finding Livelihood*, which includes the essay "Spinning and Being Spun." So this resource comes to you recommended as helpful – not only on the topic of faith and vocation, but also in training the mind to think about all of life with the body, heart and spirit.

The book's prologue expresses what made me slow down to hear her voice when I came across her writing for the first time. Nordenson not only describes the beauty that drew me in, she tells why it sticks with me and serves to bring clarity to my very blurry picture of the intersection of faith and vocation.

> The style of *Finding Livelihood* is lyric, which means there is a nonlinear structure, white space, metaphor, and slant-angle perspective. It is a way of exploring, not a way of explaining. Lyric structure bypasses the default problem-solving logic of self-help books and the chronologic reportage of memoir to more closely mimic the nature of a complex issue that can't be resolved in 10 easy steps but can be seen and understood in new ways when explored from multiple directions. Lyric style finds clues and layers them or braids them together. It uses story, collage, and juxtaposition. It invites you to dwell on its pages, to enter the experience of contemplation. (*Finding Livelihood*, p. 6-7)

In short, her prose is poetic.

Part of the Study Center's philosophy that serves as an anchor to me in my own thinking is the insight that good questions frame meaningful comprehension. Along this same line of thinking comes a bit of wisdom my friend recently shared with me: the opposite of arrogance is curiosity. These principles encourage me to a posture of humility and challenge me to look deeper than surface issues to find the question that will answer other questions. Nancy Nordenson does this through her writing. By approaching the subject of work with lyric style, she invites us all to embrace curiosity, and allow seemingly contradictory realities to shape understanding. She juxtaposes blunt realities of labor in the world with incommunicable sensations of human experience; like stark scientific descriptions of lab work meeting the palpable tenderness of compassionate human interactions, or rush hour traffic alongside the calming effect of hands embracing a mug of hot tea. Her illustrations come from her experience, yet she writes her reflections in a way that deflects focus from herself. In this way, her writing invites people to identify with her in shared experience. From this starting point,

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she continually keeps her reflections in context of a transcendent reality by running creation alongside Creator, temporal together with eternal, and finite next to infinite.

Because her writing is not from an authoritative, prescriptive stance, she invites readers to think about work without reactionary over-correcting – she holds thoughts about how it is and ideas of how it should be in balance, allowing empathy and hope to come through. The entire book comes from an understanding that there is no textbook formula applicable to individuals grappling with livelihood. Other sources inform her writing, but not in a footnoted article, proof text sort of way. She incorporates the Bible, Christian tradition, and liturgy, as well as other works (Thoreau, Michelangelo, Weil, Bonhoeffer, Emerson, and more) in ways that entice those who aren't familiar with them to get to know them.

As a composer explores every angle in working a theme through variations, Nordenson works through a variety of perspectives on the theme of livelihood so that *A Progress of Work and Leisure* is a very helpful subtitle to the book. Each variation is more than a repetition of the theme, it reveals a facet of the theme that would have gone unnoticed without a change in context. Words are not wasted as the theme resurfaces in different light each time, and the cumulative effect of each variation leaves one with the satisfaction of knowing the whole by examining the parts, appreciating the light in contrast with the shadows.

In church recently, as I was laying the project of writing this review before God and asking him to give this effort true substance, I found myself thinking of this book as I sang the recessional hymn.

> I love to tell the story; more wonderful it seems than all the golden fancies of all our golden dreams. I love to tell the story; it did so much for me, and that is just the reason I tell it now to thee. (Text: A. Catherine Hankey, 1866)

Nancy Nordenson tells stories about a life spent working. Her stories are not told as a paradigm for comparison or gilded with idealistic ornamentation. Rather, her storytelling leads readers in a useful exercise. The substance in this book cannot be captured in a take-away quote. It is in the effort of contemplating the story – and I have to admit, as the lines between the author's story and mine and everyone's blurred, my best words are still, "It's beautiful."

Betsy Clover

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