SEEING DOORS

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Many people think that medical doctors have a lot of power, and for the most part, that notion is true. Many also think that a doctors' power is linked with a great degree of freedom, and whether THAT is true or not depends on your perspective. From the patient's perspective, it certainly LOOKS like doctors have lots of freedom. They can come and go as they like, they make all the decisions, people treat them with reverence, and so forth. For example, the consequences for a doctor being late for an appointment are negligible, and folks will usually wait patiently in those little johnny-thingies for them to show up, and typically will not express much displeasure (at least to the doctor's face) when they finally arrive. On the other hand, if you're a patient and you show up late, you often find that your appointment has been cancelled, and you need to come back another day. Power begets freedom.

On the other hand, though, doctors labor under cultural constraints that are quite controlling of both behaviors and emotions. The doctor role is very clearly defined, and the emotional distance and aloofness that many doctors display is a result of incredibly strong norms that the profession creates for what is and what is not "appropriate" behavior. This acculturation process starts as early as medical school, and they even have a name for it – they call it the "hidden curriculum" of medical school. It is not "appropriate" to get emotionally connected to your patients, because it would interfere with your objectivity. It is not "appropriate" to cry in front of a patient, because that would show weakness, and your patient needs you to be strong. It is not "appropriate" to show doubt, because patients need certainty, even if the world is uncertain. And so on and so forth. The problem with the norms is that they sometimes obscure opportunities to effect significant healing, for both patient and doctor.

I was in my early thirties when I met a patient whom I will call "Charlie". One of my liver specialist colleagues called me and said "I have a patient that needs your special expertise". For an expert specialist to call a primary care doctor and say that he needed my "special expertise" was not a good sign. Charlie was my age, and had already been admitted to the hospital twice with hepatitis caused by excessive consumption of alcohol. This was a life threatening illness from which his young and otherwise fit body had miraculously bounced back. At his first visit with me, Charlie had a water bottle filled with what he admitted was vodka. He said that the liver specialist had told him that I was going to help him quit alcohol, and that his life depended on him listening to what I had to say. I asked Charlie what he thought about that, and he demurred. He wasn't exactly sure he wanted to quit, and he pivoted the conversation to all of the losses in his life, primary of which was the death of his father several years earlier. He expressed a lack of control and a lack of anything to live for. He didn't seem so much depressed as he seemed numb.

He also didn't seem like he had hit rock bottom yet, and the possibility of immediate change seemed to me to be low in terms of his alcohol usage.

Thus started a four-year journey for Charlie and me. I referred Charlie to Simone, a young psychologist at our hospital who had an interest and expertise in a new technique for creating behavior change called "motivational interviewing." I connected Charlie with a psychiatrist, and gave him antidepressant medication. I got to know Charlie's mom, with whom he lived, and had long discussions with her as we tried to coordinate our efforts in helping Charlie to quit. I spent long visits and even longer conversations with Charlie on the phone, talking about his past, his life, and talking some about mine, too. I visited Charlie in the hospital during several additional bouts of alcohol-induced hepatitis, one so severe that he landed in intensive care with his kidneys and lungs shutting down. During that visit, I sat with his mom as the ICU doctors laid out all of the technical details of the case. She turned to me and I said; "I think this is it – I don't think he will survive the weekend". But Charlie did. Every time, he bounced back with a miraculous recovery after only a week of no alcohol. Every time, I talked with Charlie about the chance for a new beginning. Every time, Charlie relapsed.

One day, Simone came over to my clinic to talk. She had been working with Charlie for three years, and she wanted to tell me that she felt like she needed to discharge him from her practice. At the Veterans hospital where we worked, there were more patients with alcohol and drug addiction than Simone could physically see, and she needed to triage her services to the patients that she realistically thought she could help. Charlie was not one of those patients. She was in tears as she told me this. She felt like she was abandoning Charlie. I reassured her that I would carry on for the team, because, as the primary care physician, the Veterans hospital protected my time to be there for Charlie. Eventually, I was the only doctor caring for Charlie when he was not in the hospital, as each and every one of the other doctors discharged him from their clinics. At each visit, Charlie asked me whether I would continue to see him, and at each visit, I replied that I would be with him for the duration. I had grown quite fond of Charlie, even though that little doctor voice kept whispering in my ear that I was doing nothing for him, that I was failing Charlie because I could not make him stop drinking.

Charlie died while I was out of town at a meeting. I had given his mother my cell number back when he was in Intensive Care, and she called me to let me know. Since I was out of town, I called Simone and asked if she would go to his funeral and represent our team. She later told me that it was a beautiful ceremony, an end to Charlie's pain, and his family was incredibly grateful for her presence. I felt like a failure. In my mind, Charlie became the prototype for my worst failure as a doctor. I eventually moved on, as most doctors do, and turned my attention back to the patients that were still among the living, thinking that I would just need to try harder with the next one like Charlie.

On the one year anniversary of his death, Charlie's mom called me. She was having a hard day, and she was reaching out to folks who knew Charlie. I froze. The feelings of failure came flooding back. I started to say that I was sorry that I did not do more, that I should have been more forceful with Charlie, that I should have led us in some kind of intervention or something. She immediately reacted with an alternate narrative: "I thought you understood that Charlie's alcoholism was terminal. There was no rock bottom for this, other than his eventual death. Charlie knew that, and thought you did, too." I felt the tears welling in my eyes. She continued: "I just wanted you to know that, despite everything, despite his continued drinking, he talked about how he could always depend on you, how you would not judge him, and how you did not abandon him when everyone else did. I am grateful for that, and wanted you to know it."

It was in that moment that I realized that I was tripping over my job. As doctors, we are trained to cure or prevent, and little else. These usually work fine, except in instances where cure or prevention is not what is needed for healing. If we are to truly be healers in the medical profession, we need to see the opportunities when cure or prevention are irrelevant. It's easy for a primary care or palliative doctor to see such opportunities when a patient has terminal cancer. It's less easy when the situation is not as cut and dry. Charlie had terminal alcohol addiction. Both he and his mother knew this. I, however, did not see it, and even though I was kind and patient-centered with Charlie, I can describe multiple opportunities where I could have made a move to ease Charlie's psychological pain or physical discomfort, but I didn't because I was so focused on getting him to quit. A door opened, and I couldn't see it. It wasn't until a year later, when Charlie's mom described the door that I even realized it was there.

AT THIS POINT, PAUL STEPPED OFF OF THE PULPIT AT BOTH MARKET AND CLOVER AND DESCRIBED WHAT HE LOVES ABOUT EACH BUILDING

Yes, I love this building, AND… I have to ask: Is THIS (pointing to the building) the Unitarian Church of Harrisburg? Are WE the Unitarian Church of Harrisburg? The time is coming when we are going to have to get very clear and specific about what, exactly, constitutes the Unitarian Church of Harrisburg.

It's easy to get locked into a particular mindset. It's LESS easy to take a step back, to ask the hard questions. What does it really MEAN for a doctor to heal? What does it really MEAN to be a member of the Unitarian Church of Harrisburg?

"And we pray, not
for new earth or heaven, but to be
quiet in heart, and in eye,
clear. What we need is here."**

Peace be with us all.

** Quoted from the poem “What We Need is Here” by Wendell Berry, read in its entirety during the call to worship at today’s service.