TRANSFORMATIONS IN CARE

METAPHORS IN MEDICINE: TOWARD TRANSFORMATION IN CARE

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The first college president I worked for was Sister Lilian. . . . Shortly after becoming president, she was diagnosed at the age of thirty-nine with advanced ovarian cancer, and she spent two of the hardest years of dying that I've ever witnessed . . . . She looked like a Holocaust survivor before she died. She had intestinal obstructions. She was in and out of the hospital. I can remember sitting behind her, kind of offering physical strength as she retched over an emesis basin.

And knowing that I was teaching in our nursing department, she said to me, "Carol, please tell your students when I first got sick, it didn't matter how people treated me because I knew who I was." [She was] President of our college [with a] PhD in Microbiology. [She was] from Worcester, Massachusetts and had all that New England reserve that got trampled over royally the sicker she became. [She was] one of the most gentle, loving, kind human beings I've ever had the good fortune to know. She said, "As I've grown weaker, I've become whatever people make of me." And she said, "If a doctor or nurse walks into my room and treats me like meat on a platter, I become meat."

I wanted to cry. I remember that my profession can take a Lilian and transform her into a slab of meat by virtue of [one's] approach. . . . The more vulnerable people are, the more we become their world of meaning. So, [if someone] interacts with me like [they] don't care [especially] if . . . my days are shorter rather than longer [when] I have questions of meaning and worth, [then] I'm going to feel compromised.[1]

With this story Carol Taylor (PhD, MSN, RN) highlighted one facet of CBHD's 2016 conference theme "Transformations in Care": as she died, Lilian's life was transformed and this transformation was not only caused by her cancer but was facilitated by the medical professionals attending to her.

Transformations in Care

The conference addressed issues that have, are, and will inevitably continue to transform the nature of the medical care offered. For example, Taylor noted that transformations to the medical profession have been brought about by profits, politics, and policies—external factors that shape and guide the practice of medicine.

In his address, Michael Balboni (PhD, ThM, MDiv) discussed similar social forces that drive the contemporary practice of medicine and have transformed it in recent decades: the market economy, bureaucracy, and science. It is helpful to frame these forces as controlling metaphors that offer both a plot and roles to actors. First, the 'market economy' suggests that medical professionals, in exchange for money from customers (i.e., patients), offer the product of service. As a 'bureaucracy,' medical professionals fill the role of efficient data managers, reducing patients to ID numbers—data to be managed. While doctors and nurses should certainly be technically competent, as a controlling metaphor 'science' reduces the practice of medicine to experimentation: medical professionals are the scientists and patients are little more than bodies. The medical profession has not been able to resist these metaphors as they have come to permeate our culture.

Cheyn Onarecker's (MD, MA) opening address not only praised the benefits of advances in medicine but also lamented how the profession has changed. External

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transformations such as those described by Taylor and Balboni have reshaped the ways that care is delivered, which has, at worst, the potential result that these metaphors dehumanize both patients and providers. Vulnerable patients can be "trampled over royally" as customers, ID numbers, or "slabs of meat."[2] But medical professionals, too, are reduced to providers, managers, and scientists. This is far from the ideal where both actors are persons interacting with one another in a meaningful moment of clinical encounter.

This highlights another layer of transformations brought about by these powerful cultural metaphors. Rather than systemic, these transformations are personal and interpersonal. They occur in the patient herself and in those moments when two people encounter one another, when a patient is attended to by the medical professional. For good or ill, these transformations are facilitated by the professionals who interact with the patient. Dr. Taylor's remembrance of Lilian's final days illustrates that persons are transformed in such encounters and that interactions between medical professionals and patients are spaces where one may either be *re*formed or *de*formed—with the stakes as high as the patient's vulnerability.

These two levels of transformation—external and internal—raised a central question discussed throughout the conference: How can Christian medical professionals pursue proper formation—especially amidst the inertia of such social forces?

The Metaphors of Medicine

The medical profession certainly has a rich vocabulary to counter the powerful cultural forces enacted by the metaphors of the market economy, bureaucracy, and science. I would highlight two controlling metaphors mentioned at the conference which, taken together, provide a re-orienting vision of the medical profession. Like the social forces above, these metaphors provide roles for actors to play, which will be explored in turn.

For his part, Balboni offered the controlling metaphor of *suffering*, one that allows us to recover much of our heritage as Christians offering care. The characters of this metaphor play the role of host and guest. "This is the Christian tradition: A hospital is a place [to receive] hospitality." Balboni expanded the metaphor, reviving the roles latent in the metaphor: "the physician is a host and the patient is the guest, a stranger. Patients are patients, those who, in Latin, are suffering and . . . called into the virtue of exercising patience."[3]

Lauris Kaldjian (MD, PhD) responded to Balboni's metaphor with his own, *benefaction*. Kaldjian recounted Karl Barth's reading of the Good Samaritan as a paradigm "that has empowering implications for a Christian doctrine of service in healthcare, a doctrine that should encourage clinicians to abandon all pretense to superiority in the clinician-patient relationship."[4]

Barth's reading "turns the tables on our common notions of giving and receiving and thereby reframes the dynamic of the clinician-patient relationship."[5] Barth goes to great lengths to describe both the role of the suffering person as the representative of Christ who is the benefactor, and the role of the Samaritan as the *receiver* of benefaction. "The afflicted fellow-man offers himself to us *as such*. And *as such* he is actually the representative of Jesus Christ."[6] It is also significant that Barth, through his use of the first person, implies that this is a subjective encounter where *I*, as the one who goes and does likewise (Luke 10:37), am ever the recipient of Christ's gift of mercy through such acts of service. Thus, the suffering person is not someone who *I* serve as a benefactor. Rather, the suffering person is someone who reveals the suffering Christ to *me*. Kaldjian suggested:

Top: Robert D. Orr and Carol Taylor, bottom: Cheyn Onarecker, deliver their plenary addresses at CBHD's 2016 annual summer conference.

> to love my neighbor means to accept her service to me. And that service is to show me in her person my sin and misery and the love of God through Jesus Christ. . . . In short, my neighbor reveals my lostness and in that way he tells me that I can only live by God's grace.[7]

By extending service to the neighbor, *I* see my condition in my neighbor and recognize that Jesus is the only one who can help *me* in my plight. Barth states it thus:

> The wretched fellow-man beside me simply reveals to me in his existence my own misery. For can I see him in the futility and impotence of his attempt to live without at once . . . recognising myself? . . . [I]f I can still see him without seeing myself, then for all the direct sympathy I may have for him, for all the zeal and sacrifice I may perhaps offer him, I have not really seen him. . . . He is still not my neighbor. . . . The neighbor shows me that I myself am a sinner. How can it be otherwise, seeing he stands in Christ's stead, seeing he must always remind me of Him as the Crucified? How can he help but show me, as the reflection of myself, what Christ has taken upon Himself for my sake?[8]

This entails, according to Barth, that the man-left-for-dead does not present the Samaritan (i.e., "me") primarily with a *task* but with an *event*, a Samaritan event. Stated another way, this is not a task to accomplish but an event of the Kingdom to be participated in. Thus, I do not offer acts of service by fulfilling the tasks of caring for my neighbor. Rather, I participate in events where the Kingdom of God comes near by meeting my neighbor's need and seeing in him both my own need and the only one who can alleviate my suffering, namely, Jesus Christ.

For Kaldjian, this empowers "healthcare professionals to see every one of their patients in a new light," namely,

> to abandon any inclination toward the self-inflating belief that we who serve are the benefactors and those we serve are the fortunate recipients of our benefaction. . . . It is only after we appreciate what Christ has done for us that we can appropriately turn our hearts and minds to the task of service as we help our patients, remembering that our patients, if seen rightly, have already been of benefit to us.[9]

Top-right: Kevin T. FitzGerald, top-left: Linda R. Duncan, bottom-right: Michael Balboni, bottom-left: Lauris Kaldjian, deliver their plenary addresses at CBHD's 2016 annual summer conference.

"the distinctive Christian contribution to healing was the element of compassionate care . . . which focused on the sick and particularly on the sick poor."

Playing the Part: The Early Church and Living Metaphor

The theological commitments underlying the metaphors of *suffering* and *benefaction* were deeply held and put into practice by the early church. Indeed, Barth's interpretation of the parable of the Good Samaritan builds upon and expounds early Christian interpretation.[10] Gary Ferngren (PhD) explored this historical perspective in his address, "Christianity and the Rise of Western Medicine."

Ferngren asserted that "the Greeks gave us . . . rational medicine, naturalistic medicine. But the Christian church gave us the elements that make medicine a benefit to those who are really needy, especially those who don't often receive it."[11] After exploring the contributions of Greek medicine in the ancient world, Ferngren then described how Christians adapted this particular philosophy of medicine to their own ideology. "During times of plague . . . the sick and dying were thrown out into the streets—sometimes by members of their own family. . . . Christians by contrast, saw this as an opportunity to provide care for the sick and the dying." Indeed, "the distinctive Christian contribution to healing was the element of compassionate care . . . which focused on the sick and particularly on the sick poor." In Ferngren's estimation, "most historians of hospitals would

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agree that hospitals represented the most significant institutional outworking of Jesus' parable of the Good Samaritan in Western culture. Hospitals were directed to the sick poor. There was no place for them to go other than to the streets."

also a place where the poor or those who had no family could go to receive care while dying. Within one hundred years after Basil's first hospital was founded, there were around one hundred hospitals throughout the Roman Empire.[12]

> ***In sum, "the church created the only organization in the Roman world that systematically cared for its sick."[13] In this way the Church enacted Kingdom events by playing the parts scripted by the metaphors of suffering and benefaction***

Out of Christian care for the poor and dying grew the first hospitals. Basil of Caesarea founded what he called a "poor house" to care for lepers in 370 AD. The "Basileum" (as it is more commonly known) quickly welcomed other poor sufferers. The first hospital in Rome was "founded by a woman, Fabiola, who was a friend of Jerome . . . . As a Christian, she did something that no one else would do: to go out in the streets, pick up the poor and homeless and bring them into her institution." Christian hospitals were

In sum, "the church created the only organization in the Roman world that systematically cared for its sick."[13] In this way the Church enacted Kingdom events by playing the parts scripted by the metaphors of *suffering* and *benefaction*—the parts of patient and caregiver enacted as guest and host and as benefactor and servant. By taking seriously the call to care for the suffering and poor, the early church cemented these metaphors as the historical foundation of the institution of benevolent healthcare.

Top: Gary B. Ferngren, bottom: Paige C. Cunningham, at CBHD's 2016 annual summer conference.

Motivation and Metaphors

But the metaphors of *suffering* and *benefaction* offer much more than an interesting historical perspective of the medical profession. Rather, they offer an ideology that can be reclaimed.

First, it should be noted that, even though some vestige of meaning remains in contemporary semantics of healthcare, these metaphors are "dead" to most contemporary English users. Living metaphors elucidate an unknown thing (A) by a known thing (B). For example, the controlling metaphor, "*Time is money*," indicates that one can understand (A) *time* in the categories with which (B) *money* is understood. So, in contemporary English usage, time is spent and saved, invested and wasted. But metaphors can also die.[14] I suggest that this is the case with some central metaphors of healthcare. The death of metaphors such as *patient* or *hospital* makes space in our collective cognition that is filled with the controlling metaphors of our culture such as *market economy* or *efficiency* or *science*.[15]

Second, though these metaphors are dead, it is significant that the original ideology remains latent within the terms. This latency has potential to vivify the particular ideologies of the Christians who were first compelled to care for those in need of care. Rescripting the roles of patient and caregiver offers motivation to Christian healthcare professionals by providing a robust Christian approach to the practice of medicine. Kaldjian illustrated this with two medical sub-fields especially vulnerable to exhaustion:

> [W]orking in hospice and palliative care is exhausting. But the people who end up working in this kind of area have a sense of purpose or calling that is accompanied by motivations deep enough to sustain them so that in their exhaustion they do not succumb to feelings of depersonalization or lack of accomplishment.[16]

I suggest that reclamation of these metaphors can provide "motivations deep enough to sustain" medical professionals. It is in reclaiming the latent ideology of these metaphors that Christians have an

opportunity to participate in Kingdom events by understanding their primary roles as *host* to the sufferer—the one who can reveal Christ himself.

But we should not make the mistake of thinking that because this ideology is a *Christian* ideology, it requires faith in Christ to participate in the Kingdom events enacted by these individuals. It matters not whether medical professionals are Christians. The scripts of these metaphors, though first employed by Christians, can be enacted by anyone—Christian or not. Barth, in his discussion of the Good Samaritan, notes that

> as the Bible sees it, service of the compassionate neighbour is certainly not restricted to the life of the Church in itself and as such. It is not restricted to those members of the Church who are already called and recognisable as such. It is not restricted to their specific action in this capacity. Humanity as a whole can take part in this service. . . . [E]ven those who do not know that they are doing so, or what they are doing, can assume and exercise the function of a compassionate neighbour.[17]

Moreover, Christians have a significant—even *holy*—responsibility in our coming alongside of fellow medical professionals and patients. For it is in the coming-alongside a sufferer that the Kingdom comes near. Christians, as citizens of that Kingdom, should have eyes to see it coming, willingness to play these parts in these Kingdom events, and even boldness to name it as such.

In Healthcare as It Is in Heaven

As a Kingdom event, the ideology of *sufferer* and *benefaction* threatens the powers of "profits, politics, and policies." But it is also presents a danger to practitioners.

As a biblical scholar, I must continually attend to one particular and dangerous occupational hazard: the temptation to become enamored with the text—whether its beauty, language, history, theology, or even my knowledge of it—while overlooking the God who not only breathed it and teaches and rebukes and corrects and trains in righteousness through it (2 Tim 3:16), but also calls me to submit to him as he does these things in me. The occupational hazard is to approach the text as an object without encountering it as a subject—or—to encounter God in his word and fail to submit to his claim over my life. In my experience the risks increase in proportion to professional competence.[18]

If these distinctly Christian metaphors of *suffering* and *benefaction* are reclaimed by individual healthcare professionals, then Christian medical professionals must attend to a similar hazard. Even when the roles as scripted by these metaphors are played well, one may yet become enamored with other goods such as developing technical efficiency in offering cures and therapeutic interventions, developing scientific expertise, or communicating with careful attention. Such pursuits are good and necessary for professional competence. But they can also provide professionals with a risk: I may fail to see that I am the one in need of transformation and that this transformation is offered in every encounter with a patient. For in every such encounter, I have opportunity to meet the suffering, resurrected, and ascended Christ and in doing so, enact a Kingdom event. Truly, it is in the daily grind of encountering the needy and suffering that I can grow accustomed to these Kingdom events—the normalcy of which threatens to *de*form me. But it is in my participation in such Kingdom events, in my going and doing likewise (Luke 10:37), that I can, by God's grace, be transformed through the consistent, daily encounters with Christ himself.

Indeed, it is when I acknowledge in every encounter with the sufferer that *I* am in need of care that I experience the most significant transformation in care. 

1 Carol Taylor, "Transformations in Health Care for Better or for Worse" (plenary address, The Center for Bioethics & Human Dignity's 2016 Annual Conference, "Transformations in Care," Deerfield, IL, June 17, 2016).

2 Cheyn Onarecker, "Transformations in Care: Framing the Discussion" (plenary address, The Center for Bioethics & Human Dignity's 2016 Annual Conference, "Transformations in Care," Deerfield, IL, June 16, 2016).

3 Michael Balboni, "The Hidden Curriculum and the Future Socialization of Medical Professionals" (plenary address, The Center for Bioethics & Human Dignity's 2016 Annual Conference, "Transformations in Care," Deerfield, IL, June 18, 2016).

4 Lauris Kaldjian, Response to Michael Balboni, "The Hidden Curriculum and the Future Socialization of Medical Professionals" (The Center for Bioethics & Human Dignity's 2016 Annual Conference, "Transformations in Care," Deerfield, IL, June 17, 2016).

5 Kaldjian, "The Hidden Curriculum."

6 Karl Barth, *Church Dogmatics* I/2, (New York: T&T Clark International, 2004), 429, emphasis added.

7 Kaldjian, "The Hidden Curriculum."

8 Barth, *Church Dogmatics* I/2, 431.

9 Kaldjian, "The Hidden Curriculum."

10 Barth states, "The primitive exegesis of the text was fundamentally right" (419)—and this in contrast to the "current exegesis" (from Barth's perspective, of course), which he explores in detail on 417–419.

11 Gary Ferngren, "Christianity and the Rise of Western Medicine" (plenary address, The Center for Bioethics & Human Dignity's 2016 Annual Conference, "Transformations in Care," Deerfield, IL, June 17, 2016).

12 Ferngren noted that what makes these hospitals unique in the ancient world is their philanthropic nature—their care to those in need. This care frequently included only palliative care (such as it was) and a place to die.

13 Ferngren explores this thesis at length in his book, *Medicine and Health Care in Early Christianity* (Baltimore: Johns Hopkins University Press, 2009).

14 I recognize the difficulty of the term d*ead metaphor*. However, the term fits the current discussion in the same way as Lakoff's example of *pedigree*. Etymologically the English term derived from French *pie de grue*, translated as "foot of a crane." *Pedigree* has taken on its own life quite apart from any resemblance of family tree diagrams to crane feet. When using the term, contemporary English users simply do not envision the metaphor rendering it "dead"—which should not be confused with meaningless. Lakoff hopes to complicate the use of the term *dead metaphor* and only approves of its usage in such instances as this, which parallels English terms such as *patient* and *hospital*. (See George Lakoff, "The Death of Dead Metaphor," *Metaphor & Symbolic Activity* 2, no. 2 (1987): 143.)

15 Other terms that could also be pursued along these lines are *nurse* and *therapist*.

16 Kaldjian, "The Hidden Curriculum."

17 Barth, *Church Dogmatics* I/2, 423.

18 This dynamic frequently occurs in the gospels when Jesus is confronted by law-teachers. See for example, Jesus' response to the teacher who understood the scriptures but failed to encounter and submit to God's claim *to his life* in the scriptures in Mark 12:28–40: "You are not far from the Kingdom of God" (34). Indeed, the open-ended ending of parable of the Good Samaritan leaves the reader wondering: "Will this law-teacher 'go and do likewise?'"