Published in final edited form as:

Society. 2019 April ; 56(2): 153–157. doi:10.1007/s12115-019-00343-y.

Symposium: Hostility to Hospitality:

Do I Need Mercy to be a Physician?

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[Ed. Note: Dr. Berra delivered the following talk at the Vatican as part of the “2016 Jubilee of Mercy” on September 8, 2016. His event was entitled “Knowledge and Mercy: The Third Mission of the University”. See https://www.lumsa.it/sites/default/files/eventi/2016/XIII_Simposio_depliant_en.pdf and https://www.lumsa.it/sites/default/files/eventi/2016/Simposio2016_Libretto.pdf]

My name is Lorenzo, I am 42, and I work in the Anesthesia and Critical Care Department at the Massachusetts General Hospital in Boston (USA). I would like to propose a premise: While disclosing my Christian identity in my presentation, I do not want to exclude anybody (and I hope I never have). On the contrary, by telling who I am and what happened in my life, I met people (atheists, Hindus, Jews, Muslims, Buddhists) with whom I became real friends and companions on the path that is life. I would like to give examples from my work of how this awareness that I am the first in need of Mercy in order to be a physician.

The title of my presentation is: “Do I need mercy to be a physician?”

This question incorporates other questions: Why become a doctor? Why take care of wounded people (that may have injured innocent people)? Why take care of patients that are dying with “do-not-resuscitate” orders that might be alone, without anybody at their side?) Similar and simpler questions might arise on a daily bases. Why answer a friend who calls on behalf of a friend of a friend who is visiting Boston on vacation and who has a sore throat and is leaving tomorrow to go back to Italy (of course usually these phone calls arrive at midnight and the “friend” has no insurance)? Why answer the “pager” that rings outside regular working hours?

My short answer is - because I am loved in everything that I am. I am forgiven always and again now. Without these real and tangible experiences in my life I would have stopped being a physician, or would have simply been satisfied with what I already had or achieved. I would have not engaged any longer with life. I would have not answered the phone “*after hours*”, or I would have lived trying to forget my mistakes (if that is possible).

I cannot think about my job of being a physician and an investigator, without thinking that I have been saved, literally, that I have been taken by Christ. Going to work is the greatest reminder that I have of this new awareness of myself which allows me to enjoy life, hope, being active, doing research, and taking up new challenges. I discovered that in whatever circumstance I encounter, once there is no desperation, there is no misery that cannot be overcome. To me, my life itself is the greatest demonstration of this discovery.

The inspiration to become a physician came to me when I was a little boy going to see my physician. Dr. Italo Siena, an non-observant Jewish physician, with a long unkempt beard. He was the kind of physician who took care of everybody, adults, children, people well-dressed or not, people with nice perfume or very smelly/stinky people. He could be seen traveling around on weekends or in the evening after long hours in his office seeing patients, with a bag that contained all his medical “instruments”. He was seen leaving the gipsy village, where, small children were prohibited to enter. He was also seen bent over a homeless person in a dark corner.

If someone was very sick or had a very high fever, Dr. Siena was there at the front door at any hour bag in hand, smiling. He would enter the house with a serious face asking questions, listening with his stethoscope, and prescribing medicine. He would depart leaving words of encouragement, and reassuring all that he would return the next day if necessary. After a brief goodbye, and a quick exit out the door, he would be directed to another house, another door, another sick person. In our neighborhood, Dr. Siena visited places nobody could reach. He crossed barriers and walls that nobody ever thought possible to cross. This was incredibly fascinating to me.

The inspiration I received from Dr. Siena became concrete while attending university, during my first year of medicine. I met other students who motivated for their deep sense of friendship and unity among them, they were happy, they were studying with passion, and they enjoyed life. I also wanted this. Their happy faces are still very visible in my mind: Giovanni, Manuel, Nunzio, Andrea, Teresa and many others. The university became the center of my life and, while the days transpired, it was clear to me that I never met people that were so full of life alive. During that time, a question began growing inside of me: “Who are these people? How can they be like that?” One of the students answered this question at the end of a free series of classes organized for new-students: “Guys, we did this course because we are Christians”. It was like a spark. I never thought that Christ could have anything to do with “life”, with the people that I loved and that I was not able to love with my personal interest in medicine. From that moment on, the Christian event became central in my life. I wanted to understand who Christ was. The more I talked about Christ, the more I understood the exceptionality which fascinated me. Slowly there was more light in my life. I was finding that I was the leprous, the blind, the deaf and dumb, or the paralytic of the Gospel. I was like that man who was wasting his gifts living as a wreck. Eventually, I understood the one in need was not the patient, but it was me who was the one in need, and that the Lord had pity on my nothingness. I continue to embrace this revelation in all that I do.

During my fifth year studying medicine my mother was diagnosed with lung cancer. My mother accepted her disease with a saint like intensity and serenity. I was convinced that in the end she would make it and that the disease would be defeated. The cancer seemed to respond to treatment at the beginning, and I was very pleased with her medical and surgical team. “God is on our side ... clearly she will get better,” so I thought. On December 14, 1999 my mother died. I then learned that the goal of medicine is not to prevent death. Life is mysterious: it is ours and not ours at the same time. The time of being sick is a special time, every minute is essential, because it is the time given to the patient and doctor so they can

pursue a human path together, much like the one my mother followed, but I could not. It is essential that physicians pursue this path while accompanying those who suffer and die. Their questions are our questions on existence itself, on the pain of leaving behind loved ones, on the possibility of reconciliation with the many shadows in our hearts that appear to consciousness only at the end of life. If physicians and patients do not pursue this path together, sooner or later we will get stuck, unable to stay with those who suffer. Indeed, as the days passed after my mother's death, my hands began to tremble more and more. Then one night after several months of trembling (meanwhile I was already in my second month of my anesthesia and critical care residency) while placing a central line, I fainted. I was unable to be a physician. I thought I would never be able to work in a hospital again, and would have to choose a different career path. Professor Antonio Pesenti, director of my residency program, but above all a friend, a real friend, proposed that I go to work for two years at the National Institutes of Health in Washington DC to study with his mentor, Dr. Theodor Kolobow. I accepted and moved to Washington, DC without knowing a word of English.

Dr. Kolobow in Washington DC, and later, Dr. Warren Zapol at MGH/Harvard, became my mentors. In different ways, they made major contributions to medicine with their inventions and discoveries in the fields of anesthesia and critical care. Among those, the most notable are: ECMO (extracorporeal membrane oxygenator) and the clinical use of breathing nitric oxide gas. They attracted students from all around the world. These two great professors welcomed me with real generosity (not just words). They opened their homes to me. They treated me like a son, and they never stopped teaching me. Despite the fact that they were not strictly observant (one Christian and the other Jewish) their kind of religiosity, defined as an insatiable human curiosity, with their questions towards the infinite, was and is for me an irreplaceable friendship, and it helped in my faith during these years.

The Case of Uncle Jean

Jean, "Uncle Jean" is a friend of mine. Like many, his story is very troublesome. He has been addicted to heroin for more than 30 years and homeless for many years living in the Boston Common (the Central Park of Boston). He endures extremely cold New England winters by sheltering together with other addicts. He has been in prison many times for different reasons, and suffers with hepatitis C, advanced liver cirrhosis, severe systolic and diastolic heart failure, repeated infections to the lower extremities that has caused a chronic large lymphedema that further limits his ability to walk.

I met Uncle Jean several years ago. He is the uncle of a friend of mine. Every month or two, he would be admitted to the hospital. He would stay for 2–3 weeks due to pneumonia, sepsis, or cardiac failure. He would recover enough to be discharged back to the streets. During each hospitalization I would visit him together with my fellows. We would joke around and call him "Uncle Jean of the lab". Our visits clearly created lots of attention and questions amongst the nurses and physicians taking care of Uncle Jean. I was asked many times with incredulity "Why are you here again?" I would answer: "Jean is a friend of mine." The medical personnel became very suspicious. I was often asked "kindly" whether I was bringing drugs to Jean: Lorenzo - the anesthesia-drug-dealer. Unfortunately, this

suspicion should not be a surprise, because the real drug-dealers in the United States are not only the “El Chapos” of the world, but the hospitals themselves. We, the medical providers are also part of the drug problem. In 2014 alone, 20,000 oxycodone pills disappeared from MGH (<https://www.justice.gov/usao-ma/pr/mgh-pay-23-million-resolve-drug-diversion-allegations>). In years past, anesthesiologists who worked or trained in my department have died from a drug overdose. In 2016, the mortality rate for non-voluntary opioid overdose in Massachusetts was three times the number of deaths for car accidents, and it is the leading cause of accidental deaths of those under 40 years old.

It is clear to me now why my “friendship” with Uncle Jean was perceived as strange. MassHealth, a program similar to Obamacare, thankfully provides healthcare to all. Therefore, Uncle Jean never had to pay for hospitalization, treatments and medications. However, how can a man take all those medications if he is homeless, with no place to go, and lots of challenges while walking? A study conducted by a group of Canadians, led by Robyn Tamblyn et al., shows that approximately 30% of general practitioners’ prescriptions are not filled despite their being free. In the United States these statistics on compliance with medical treatment are even lower. Only about 30% of patients take the medications that are prescribed.

For Jean something totally unexpected was going to happen. In between hospitalizations, Alpha, a saintly friend of mine, was able to host him in the house she directs in Boston (Casa Monte Cassino). The house provides a place at no-cost for children and their families coming from all over the world for treatment in one of the Boston hospitals. While at Casa Monte Cassino something completely unexpected happened. A Chinese youngster with severe burns all over her body, wakes Jean up every morning. “Lorenzo, you would think this kid had enough to do in her life, but she comes to wake me up every morning, and she waits for me. We talk by making gestures”. You see, this child was more powerful than any medicine, or any healthcare reform to re-awaken the heart and soul of Jean. Today, Jean is on a new path. Although difficult, and full of falls and recoveries, he is walking and taking his medications. He is also taking care of his feet. All this was possible because Jean recognized receiving such love that moves one to use tenderness towards oneself.

The Case of Mary

We need to meet the other person where he or she is. This is the case of another patient of mine, Mary. She arrived in the hospital with a post-operative pneumonia after repair of a broken femur. After being extubated, she remained for days in a state of depression. She did not talk, did not eat, she was “on the ground”. The only thing we were able to do was to repeat that it was important, according to our general “guidelines”, for some incentive spirometry, that would have helped her to breathe. One day passed, the second, the third ... and at the fourth or fifth day, during rounds the nurse remarked: “Do you know, Lorenzo, that Mary is a singer?” It was wonderful to see how much compassion nurses feel for their patients! I replied: “Really? Mary, sing to us a song!” Surprised by the request, Mary started to sing a song. I then added “Mary, let’s get out of this room and start singing in the corridor so that others can hear your voice!”. So we did, and at the end of rounding, I said: “Listen Mary, you don’t like to do incentive spirometry but you like to sing. I will prescribe three

songs a day instead?” Mary replied: “Done deal doc!” So I am not against the utility of guidelines, absolutely not. However, such guidelines are for the patient. We cannot “beat” our patients with guidelines.

Charity cannot be delegated to a policy like health-care reform (even if it was an excellent healthcare reform). Whether Jean or Mary, and whether a checklist or guidelines, novel therapies or new techniques, only charity gives oneself back to another. T.S. Eliot said the supreme ideal of the contemporary world is to create a world of automatons: “systems so perfect that no one will need to be good”, which means that charity is unnecessary. As it is structured right now, “*pro-bono*” work is difficult to accomplish in our institution, so, one needs to be clever and build new systems (sometimes on the boundaries with what is allowed by these institutions) to create space for charity. How wonderful to see physicians that work extra-hours seeing patients who may be undocumented immigrants or have no medical insurance, and finding creative ways to obtain medications otherwise difficult to obtain. This is the victory of love for humankind over a system that tries to eliminate charity.

I had just become an attending in the ICU and was rounding with my fellow residents as we arrived at a patient’s door. The patient instead of having a white blanket had a blue one on the regular white hospital sheet, a sign for “*CMO - comfort measures only*”. These are patients for whom medical treatment has been stopped, and the medical team focuses on relieving pain and discomfort (with morphine or similar medications). At the front door, I asked the resident: “How is it going in there?” The resident replied: “Lorenzo, I did not check the patient- he is CMO”. I answered: “Well, let’s go in and see the patient.” With some surprise he asked: “Why?” and I replied, “The patient is breathing.”

Money and Medicine

Let’s talk about something hot - money. Maybe this topic is more relevant in the USA than in Italy. In any case, I thought to say something about this topic because money is a good test. Indeed, often we can agree on everything when we talk about charity, but then, when we talk about money everything changes. Every hospital/organization/country is organized differently. In my hospital, we, the physicians, use the electronic patient chart which includes treatments, interventions, procedures, etc. By doing this, we do part of the process

called “billing”. The bill is sent to the insurance company (or to the patient). The bill will be larger depending on the time spent with the patient (or in the hospital), the procedures and treatments. The money obtained is used to pay for the services given by personnel, divisions, and physicians. At the beginning of my career I was taken aback by how much time was being documented by my colleagues and therefore how much money was being requested of patients and/or insurance companies. I was so surprised that I decided not to bill my patients (in any case they were billed by other physicians for hundreds or thousands of dollars). I raised my concern at one of our ICU meetings. I did not have to wait long for a response. I was called in by my ICU director and received an email: I was to be suspended from working in the ICU until I followed what was decided at the division level. I read the email: *“I share with you that you will not be added to future ICU call schedules until your compliance with billing expectations improves. Lorenzo, we truly value you as a colleague and an important member of the Department. Your strong devotion to your work and many contributions are recognized and appreciated by your colleagues.”*

The following day I was in the operating room and, of course, I felt the pain of the reproach and of the injustice. I was fearful, uncertain, and confused. I asked for the help of my friends and my community. In the meantime, the news quickly reached the nurses, other physicians and therapists. There was an impressive movement of people who supported me. I reassumed my work in the ICU soon after.

What is most striking to me about this episode is that I could have had the best reasons in the world (even though I was also wrong in my positions!), but this was not enough to feel better. I was unable to rid myself of my confusion, and after all I would become the Chief of the “Department of Complaints” (every hospital has at least one -- there are the departments of cardiology, surgery, and... of complaints!). We need to be with somebody, and not alone! To be with somebody at work we can share our hearts, the questions of our hearts, whoever he or she is and wherever he or she is coming from. It is for me the encounter with Pankaj from India, or Ernesto, from Venezuela, or my mentors and colleagues: Pesenti, Kolobow, Zapol, Kacmarek, Bittner and so on. It is necessary to create places of friendship, where the heart and life with all its questions and needs are shared, where I am corrected, loved, and challenged for the real needs of the heart wherever we are. To be alone in those difficult moments is very dangerous, because we can be pulled away from our humanity. The environment of the hospital is often sterile and violent and can really empty the humanity of those people that work in it. To understand the financial implications is very difficult for me, especially in a different environment with different laws. However, I think that opening a dialogue on this topic, on our services and payments and salaries would be something beneficial for everybody.

A Final Provocation

I would like to conclude by reading a piece of the homely of Pope Francis for the canonization of Saint Mother Teresa of Kolkata. In his homely the Pope challenged us, and I would like to propose to everybody again his statement because I think it can be a starting point for all of us: “We are thus called to translate into concrete acts that which we invoke in prayer and profess in faith. There is no alternative to charity: those who put themselves at

the service of others, even when they don't know it, are those who love God (cf. 1 John 3:16–18; James 2:14–18). The Christian life, however, is not merely extending a hand in times of need. If it is just this, it can be, certainly, a lovely expression of human solidarity which offers immediate benefits, but it is sterile because it lacks roots. The task which the Lord gives us, on the contrary, is the vocation to charity in which each of Christ's disciples puts his or her entire life at his service, so to grow each day in love." There is nothing I desire more than placing my entire life at His service, aware of all my betrayals, so to grow each day in love. Thank you.

Biography

Lorenzo Berra, M.D. is associate professor of anesthesia at Harvard Medical School and medical director of respiratory care at Massachusetts General Hospital.