Suffering Absence: Hauerwas and the Challenges to Faithful Presence in Contemporary Medical Training

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Abstract

In this essay, the author draws on the theologian Stanley Hauerwas' work to describe the central challenge of the contemporary medical trainee as an inability to be present to suffering patients. While the central challenge to the physician was once the moral resources required for such presence, today it is the temporal and bureaucratic demands bearing upon the contemporary resident preclude even the opportunity for this presence. In order to seek out such spaces when time does become available, the contemporary trainee requires a moral community, as Hauerwas notes "like a church," to remind him or her of the moral commitment to be present to suffering patients even in the midst of such structural challenges.

Summary: Contemporary residents must actively seek out the opportunity to be present to suffering patients and require moral communities to sustain this commitment.

Keywords

Medical education, Moral theology, Resident, Resident/medical student training, Suffering

The Resident's Plight

"Smith in thirteen just passed. Can you go declare her?" Weary, I glance up at the intensive care unit (ICU) nurse caring for this patient, offer a slow nod, and follow her to the room.

The death exam has become an all-too-frequent occurrence for me these past three weeks in the medical intensive care unit (MICU), and one I find particularly challenging to perform on patients I have grown close to, like Ms. Smith. She was a fifty-year old with stage four breast cancer causing a life-threatening infection of her right chest cavity. Her death, once imminent, had arrived.

As the intern on the team given the task of "goals of care" discussions, I knew both Ms. Smith and her two sisters well. We shared conversation about her impending death but also about her life, her work as a teacher, and her faith and eager anticipation of a body that would no longer be wracked by pain.

As we enter the room, Ms. Smith's two sisters greet me with warm hugs and tears. I share their grief, but I am also strangely grateful to be here. During my time in the MICU, these settings void of medical decision-making are often the places where I feel most useful. I am frequently flummoxed by discussion of vasopressors, chest tubes, and organ failure on rounds as I fumble through my presentations. It is in these moments I am grateful to be present because it doesn't take much training to know that sad and lonely people need company.

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I explain the process of declaring death and check for a heartbeat, respirations, and active pupils, all of which are absent. I step back and nod. It's 3:30 a.m. and both the family and I are exhausted. Nevertheless, I experience an overwhelming sense of peace as the family shares a prayer. It is toward the end of this prayer that the senior resident rushes in and whispers in my ear. "We just got two more. I need you to document this death and start working on those notes." I apologize to the family and slink back to my computer, angry and frustrated, but mostly tired.

Residency and the Vocational Tension

It was after this experience with Ms. Smith that I began to sense the tension between my dual professional loyalties as an intern. I yearned to be with sick and suffering patients like Ms. Smith, but tasks involving documentation and other nonclinical duties prevented me from doing so. This drained and demoralized me. I sensed that I was obligated to invest time and energy toward nonclinical responsibilities that were clearly of less importance than, and seemed to afford less benefit to, the sick and hurting patient with whose care I was entrusted.

This fundamental tension precludes presence in the midst of suffering and is central to the disillusionment of medical trainees today. The theologian and bioethicist Stanley Hauerwas, who described the constitutive role of the physician as one offering presence in the midst of pain, helps us to understand this vocational discomfort. He highlights how the most challenging element of medical training is no longer offering such presence, but finding the opportunity to do so. In response to such a problem, it is only a moral community with an emphasis on moral memory—something like the Church—that can form trainees to prioritize presence in the midst of their other obligations.

Hauerwas on Presence and Medicine

As the contemporary practice of medicine continues to evolve, there is increased confusion about the nature of the physician's role. The traditional, Hippocratic vision of medicine focused on the covenantal therapeutic relationship between patient and physician. There is now a legion of professional roles vying for the clinician's time and attention. Medical students are increasingly taught to consider their roles as basic and clinical scientists, quality improvement champions, and social advocates,

among other professional responsibilities. Each of these roles is important in its own way, but the combination also threatens to distract from the primary commitment of the physician to the sick person in front of him or her. As the ethicist Leon Kass (1975) wrote, "When [medicine's] powers were fewer, its purpose was clearer" (p. 12).

Amid this vocational confusion, where can one hope to find a clearer description of the purpose of medicine and the physician's place in it? Stanley Hauerwas offers an account of the physician's role, grounded in the phenomenology of the suffering patient in his essay "Salvation and Health: Why Medicine Needs the Church." Hauerwas argues that the experience of suffering serves as a central problem for humans because it threatens our identity as beings-in-community in two ways. First is the isolation and incommunicability that suffering imposes on the sufferer, for whom pain "creates a history and experience that makes the other just that much more foreign to me. Our pains isolate us from one another as they create worlds that cut us off from one another" (Hauerwas 1986, 76). Second is the discomfort that suffering creates for nonsuffering members of the community, serving as a reminder of others' finitude and vulnerability to their own illness and suffering. Such an embodied reminder in the form of the suffering other may cause us to detest our own "smallness in the face of pain" and consequently to detest the suffering person who brings this smallness into focus (Hauerwas 1986, 80). It is against this background of the problem of suffering that Hauerwas offers the clarity missing for many in contemporary medical training:

"I take [the activity of the physician to be] characterized by the fundamental commitment to be . . . in the presence of those who are in pain" (Hauerwas 1986, 78). Put another way, "The physician's basic pledge is not to cure, but to care through being present to the one in pain." (Hauerwas 1986, 79)

In this claim that stands in stark contrast to the medical world, which often champions an image of the physician as a master diagnostician or salvific interventionist, Hauerwas contends that the physician's role is an irreducibly *moral* rather than a technical one. Such a vision of medicine as moral practice is consistent with the traditional, Hippocratic vision of medicine but is less apparent in an era when medicine is increasingly consists of physician "providers" interfacing with patient "consumers" in a transactional, rather than covenantal, relationship (Eberly and Frush 2019, 421; Blythe and Curlin 2018, 431; Crawshaw, Rogers, and Pellegrino 1995, 1553). The moral vision of medicine which informs the imperative Hauerwas

describes, to care when cure is not possible, resonates even more strongly today in an age of medical progress that promises relief of suffering even as the daily work of the modern physician attests to fact that this promise returns void.

Flowing from Hauerwas' definition of the physician is an account of the morally taxing nature of medical work acting as "... the bridge between the world of the ill and the healthy". In acting as this bridge, Hauerwas observes, "none of us have (*sic*) the resources to see too much pain without the pain hardening us". Consequently, it becomes apparent that "the physician cannot help but to be touched and thus, tainted, by the world of the sick" (Hauerwas 1986, 79).

Hauerwas' prescience is remarkable; his description of this "hardening" process calls to mind the now familiar term "burnout." It is now recognized that a generation of physicians, "tainted," by this world of the sick, faced high rates of depression, anxiety, substance abuse, and low job satisfaction, due in large part to the weight of this moral calling (Rotenstein et al. 2018; Schwenk and Gold 2018).

Yet today, more than thirty years after this essay was written, in light of patient encounters like the one involving Ms. Smith, it is fair to ask whether the task of offering such presence to patients is truly the most pressing one facing this generation of fledgling physicians. Given the temporal and bureaucratic pressures facing the modern resident, might it be that it is not sustaining such presence which proves most difficult, but the lack of opportunity to provide this presence, even to have the opportunity to face this moral challenge, that characterizes the primary difficulty of modern medicine? As my experience with Ms. Smith illustrates, the modern resident may be too often protected from the potential "tainting" Hauerwas references by the computer screen or the heavily annotated patient list, leaving him or her not morally hardened but atrophied and still exhausted.

Search for Presence: The Resident Life

Much has been written about bureaucratic and temporal pressures facing medicine today, particularly for residents (Ishak, Lederer, and Bernstein 2009, 236; Dyrbye et al. 2018, 1114). Here is what a typical day of work looks like for most interns on a generic inpatient rotation. Consider the challenges such a day presents to Hauerwas' vision of the physician as one offering presence in the face of suffering:

The resident arrives at the hospital a few minutes before 6:00 AM, and then checks with the overnight resident about new admissions as well as getting updates on patients from yesterday. At 6:15, the resident finishes, forwards the team pager, and stares at the list of twelve sick patients. It's a list that never grows because it's capped. It never shrinks because as soon as one patient is discharged a new admission fills the spot. The resident sets to work reading the electronic medical record for vital signs and new labs for patients and attempts to scribble down a tentative plan for each patient for the day.

By 7:00, the resident begins to "preround" on these patients, performing a cursory physical exam on each of them. The resident performs this work stealthily and in the dark because the last thing anyone wants is to awaken a hurting and confused patient and face a set of questions that will make it impossible to get to morning conference on time, again.

Morning conference is 7:45–8:30, after which the resident meets with a senior resident and attending physician to round. Rounding presents the best opportunity to offer meaningful presence, but the stress does not allow the mental and emotional energy for that. The primary focus is on making sure not to forget any crucial information that may cause the patient harm and not sounding like a fool in front of superiors. While rounding, the pager on the resident's hip buzzes nonstop, preventing any sustained attention to a given task, much less conversation with a sick and lonely patient.

Rounds finish at 11:00, and the next hour is spent placing consults, putting in orders, discharging patients, and working on notes, all while that pager constantly interrupts. After noon conference, the afternoon is a whirlwind of discharging patients and admitting new ones, reconciling complex lists of home medications, tracking down outside hospital records, following up lab results sent earlier in the day, and praying none of the sick patients decompensates, thereby setting back note-writing even further. The resident signs out at 6 p.m. (if lucky). Perhaps there is time for exercise and to eat something other than spaghetti for dinner. Afterward the resident collapses on the couch, exhausted not by the suffering witnessed but by the fact that the job has left no opportunity for this witness.

Barriers to Presence

In the course of such a day, when the resident functions more like a cortisol-infused task manager than a thoughtful moral agent, two challenges to Hauerwas' call of suffering presence become apparent.

The first is a lack of time for presence. Evidence suggests that the average intern today dedicates more than five times as much working time on medical documentation or reviewing electronic medical records than in direct patient care (Chaiyachati et al. 2019, 760). The forces that make this happen are sometimes subtle, like the hospital that requires large patient-to-resident ratios and daily progress notes to allow for prompt and accurate billing. Such large-scale bureaucratic and financial forces detract from the ability of the resident to care for the patient, creating a moral dilemma that has been implicated as one of the main factors contributing to the recently characterized entities of physician "moral injury" and "moral distress" (Talbot and Dean 2018; Perni 2017, 533). At other times, this tension is made more explicit, such as when documentation of death takes precedence over time spent with a mourning family.

The second challenge is that such a system lacks the ability to identify, and thereby justify, a response to suffering. The only way to arrive at fitting moral responses is articulate the moral issues at hand; Hauerwas himself notes the prior condition of "seeing" and "saying" to acting in any moral dilemma (Hauerwas 2001, 611). The only way to complete the tasks required is a system that has clearly defined problems and solutions. Every good intern has a daily list of tasks with check boxes next to it, boxes that are decidedly binary and leave little room for any gray area. Every presentation and every note has a series of medical problems, the associated plan, and the metrics which indicate whether this plan has proven successful.

Such a system induces a certain moral myopia; there is no room to include an issue like "existential suffering" on a problem list, not just because residents are not trained to view it as a billable medical condition but because its solution does not lend to the clear, efficient measures taken with other hospital problems. There is a mantra in medicine: not to search for a problem when identifying it will not change management. The neglect of suffering is an especially stark example of this.

In the face of these two challenges, the structural barriers to providing presence become more apparent. And even if one were to find time, suffering is not viewed as a problem residents are trained to see; even less is it one that residents would be encouraged to address.

Distraction and Demoralization

The physician who seeks out suffering and bemoans the lack of exposure to it may seem like a voyeur or masochist. Indeed, if Hauerwas is to be believed, presence to suffering entails an unavoidable amount of vicarious moral injury. Ought the modern resident not be thankful for being shielded from such a strain?

This objection is an important one, as it serves to re-center the discussion on the purpose of medicine. Hauerwas himself notes that it is precisely this central challenge of presence to suffering that renders the physician's work meaningful, for just to the degree that suffering may cause the patient to lose communal identity, the physician's refusal to abandon the patient can serve as something of a "bridge" to community. Hauerwas (1986) terms this role a "privilege and burden" borne by the physician:

It is the burden of those who care for the suffering to know how to teach the suffering that they are not thereby excluded from the human community. In this sense medicine's primary role is to bind the suffering and the nonsuffering into the same community. (Hauerwas 1986, 26)

Precluding medical trainees from offering suffering presence may temporarily spare them a weighty burden but also deprives them of the privilege of vocational identity. Environments that fail to respect the importance of this moral call lead to what physician-ethicist Farr Curlin (2008) has termed the literal "de-moralization of medicine," as those entering the guild fail to understand the moral weight of the profession because they don't have time to be present. Rather than the moral "tainting" Hauerwas wrote of which characterized burnout for one generation of physicians, it is the lack of opportunity for such encounter that leads to a lack of fulfillment for this newer generation.

Experiences like the one involving Ms. Smith do not lead to burnout because physicians must care for decompensating patients and pronounce their deaths. Those parts are challenging, but they don't lead to fundamental disillusionment. It is only with the gift of such experiences that the physician garners the moral strength needed to sustain a career in medicine. In an important sense, it is these moral challenges that encourage those in the practice of medicine.

What is truly demoralizing is a sense of inability to respond to the basic desire to be with the sick. This is the impulse that drove so many into medicine originally, what internist and philosopher Jeffrey Bishop

has termed the “call of the suffering other” (Bishop 2011, 288). Too often today, such a call is not heard, drowned out by the sound of an intern typing away at 3 a.m. in the MICU.

The Response of Remembering

If this is correct, the fundamental problem in medicine today is not how to sustain physicians who are daily present to suffering but rather how to teach physicians to choose to be present in spaces of suffering when such a choice is so strongly discouraged. Where, then, can one learn to count this cost? Let us return to Hauerwas.

Hauerwas’ conclusion is that something “very much like a church” is necessary to sustain those in medicine in the face of the moral energy required for suffering presence, a community of people who have ingrained the practice of presence into “the marrow of their habits” (Hauerwas, 1986, 80). For Hauerwas, it is only through a moral community like the Church, with a tradition undergirded by a moral history, a vision of the good, and a theology of suffering that one can be properly supported and trained in the school of moral presence. But what of the modern resident, for whom daily presence is no longer a given, but something that must be actively sought?

Hauerwas characterizes suffering presence as a clear burden to the physician, but he also points out that such a role is a profound privilege. It is likely that many in medicine enter training with some understanding, however inchoate, of this privilege. Yet through residency, they are prone to forget. If it is true that physician trainees desire to be with and care for the suffering, that such encounters may prove enlivening when undertaken with the support of a community like the Church, then there is hope for such a burden to be experienced as privilege. Yet given the forces pulling trainees away from that first step toward presence, such a hope is unrealized.

The task at hand is not teaching but reminding. Medicine still needs the Church to learn how to be present to suffering, and it needs the Church to remind those in medicine of the call to seek these spaces of suffering presence. Significant systematic challenges present an imposing barrier to the ability even to finding time to seek to be with the suffering other. It is also true that as physicians progress in medical training, from intern to senior resident to fellow or attending physician, in certain specialties and practices, discretionary time becomes available. The question is whether those formed by experiences

like the intern day described above can even remember the “call of the suffering other” that drew them to medicine in the first place when such opportunities later arise.

This moral “forgetting” has been well-documented in medical education. Medical training is not only transmission of medical knowledge but is also a form of moral formation: a particular vision of what the good entails and the physician’s place in it (Eberly and Frush 2019, 421). Unfortunately, such moral formation may be more accurately described as deformation, as this training process may train morally deficient rather than virtuous practitioners (Coulehan 2005, 892; Chalmers, Dunngalvinm, and Shorten 2011, 281). Given the “moral regression” that occurs in training, the task for reminding and remembering may prove more important than emphasizing development of a new moral outlook. It is more important to simply not forget (Chalmers, Dunngalvinm, and Shorten 2011, 281).

A moral community with an emphasis on revisiting moral truths time and again is needed to serve to remind the resident who is prone to forgetting the call of presence. Hauerwas notes that the Church, which consists of a body whose fundamental purpose is retelling the same story over and over, is uniquely equipped for such “reminding.” He writes, “Only a people trained in remembering, and remembering as a communal act, their sins and pains can offer a paradigm for sustaining across time a painful memory so that it acts to heal rather than to divide” (Hauerwas 1986, 81).

Despite the weighty call of a traditional view of Hippocratic medicine, contemporary medicine lacks the moral resources necessary. It is thus is reliant on external moral communities, as Hauerwas would term it, “something like a church” to serve this function of moral pedagogy and remembering (Kingham et al. 2007, 40). It is also true that “something like a church”—a Christian ethic that at its core emphasizes the tragic and transformational capacities of suffering, that prioritizes the practice of hospitality toward the sick and suffering, and that recognizes the limits of our abilities as humans to ameliorate such suffering—is necessary to offer a counternarrative to the emphasis on efficiency built into contemporary medical training.

As the Christian bioethicist Allen Verhey wrote, “Jesus did not teach his disciples how to avoid suffering, but how to share it” (Verhey 2003, 136). Fledgling clinicians can only learn how to engage in the practice of hospitality and in the charitable act of sharing of burdens when they are present

to those who deserve this: their patients. They can only be present to suffering in a medical culture that devalues such presence when supported by stronger, truer, and more beautiful community—the Church. Such a reminder is sorely needed in order that trainees might better understand the privilege and burden before them. They may then choose to pursue it boldly, even when tempted at every turn to forget.

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References

- Bishop, Jeffrey P. 2011. *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying*. Notre Dame, IN: University of Notre Dame Press.
- Blythe, Jacob A., and Farr A. Curlin. 2018. "'Just Do Your Job': Technology, Bureaucracy, and the Eclipse of Conscience in Contemporary Medicine." *Theoretical Medicine and Bioethics* 39, no 6: 431–52.
- Chaiyachati, Krisda H., Judy A. Shea, David A. Asch, M. Liu, L. M. Bellini, C. J. Dine, A. L. Sternberg, et al. 2019. "Assessment of Inpatient Time Allocation among First-year Internal Medicine Residents Using Time-motion Observations." *JAMA Internal Medicine* 179, no 6: 760–67.
- Chalmers, Patrica, Audrey Dunngalvin, and George Shorten. 2011. "Reflective Ability and Moral Reasoning in Final Year Medical Students: A Semi-qualitative Cohort Study." *Medical Teacher* 33, no 5: 281–89.
- Coulehan, Jack. 2005. "Viewpoint. Today's Professionalism: Engaging the Mind But Not the Heart." *Academic Medicine* 80, no. 10: 892–98.
- Crawshaw, Ralph, David E. Rogers, and Edmund D. Pellegrino. 1995. "Patient-physician Covenant." *Journal of the American Medical Association* 273, no. 19: 1553.
- Curlin, Farr A. 2008. "Conscience in the Practice of the Health Professions." The President's Council on Bioethics.
- Dyrbye, Liselotte N., Sara E. Burke, Rachel R. Harde- man, J. Herrin, N. M. Wittlin, M. Yeazel, J. F. Dovi- dio, et al. 2018. "Association of Clinical Specialty with Symptoms of Burnout and Career Choice Regret among US Resident Physicians." *Journal of the American Medical Association* 320, no 11: 1114–30.
- Eberly, John B., and Benjamin W. Frush. 2019. "Integrity in Action: Medical Education as a Training in Conscience." *Perspectives in Biology and Medicine* 62, no 3: 414–33.
- Hauerwas, Stanley. 1986. *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church*. Notre Dame, IN: University of Notre Dame Press.
- Hauerwas, Stanley. 2001. *The Hauerwas Reader*. Durham, NC: Duke University Press.
- Ishak, Waguhi W., Sara Lederer, and Carol A. Bernstein. 2009. "Burnout during Residency Training: A Literature Review." *Journal of Graduate Medical Education* 2:236–42.
- Kass, Leon. 1975. "Regarding the End of Medicine and the Pursuit of Health." *Public Interest* 40:11–42.
- Kinghorn, Warren A., M. D. McEvoy, A. Michel, and Michael Balboni. 2007. "Professionalism in Modern Medicine: Does the Emperor Have Any Clothes?" *Academic Medicine* 82, no 1: 40–45.
- Perni, Subha. 2017. "Moral Distress: A Call to Action." *AMA Journal of Ethics* 19, no 6: 533–36.
- Rotenstein, Lisa S., Matthew Torre, Marco A. Ramos, R. C. Rosales, C. Guille, S. Sen, and D. A. Mata. 2018. "Prevalence of Burnout among Physicians: A Systematic Review." *Journal of the American Medical Association* 320:1131–50.
- Schwenk, Thomas L., and Katharine J. Gold. 2018. "Physician Burnout—A Serious Symptom, But of What?" *Journal of the American Medical Association* 320:1109–10.
- Talbot, Simon G., and Wendy Dean. 2018. "Physicians Aren't 'Burning Out. They're Suffering from Moral Injury." *STAT*. Accessed March 29, 2020. <https://www.statnews.com/2018/07/26/physicians-notburning-out-they-are-suffering-moral-injury/>.
- Verhey, Allen D. 2003. *Reading the Bible in the Strange World of Medicine*. Grand Rapids, MI: Wm B. Eerdmans.

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