I will never forget the first night I stood alone beside the operating table as the only surgeon in the room. I was beginning my fourth year of residency. Two patients from the same car wreck arrived simultaneously. Both were unstable. Both required urgent laparotomy. The sickest patient went to OR 9 with the attending surgeon. The other patient went with me to OR 6. The preliminaries were the same as ever: exposure, vascular access, betadine prep from neck to knees, suction, blood, and light. For many years I had been around the table as medical student and resident, but this time it was completely different. As I approached the table to make my midline incision, not knowing what I would find beneath the fascia, I remember swallowing hard, summoning the will to quell the tremor in my voice that betrayed the terror I suddenly perceived in the face of the awesome power extended to me by my office. This man needed the peculiar care of the surgeon’s knife, and I was the only one available to wield it.

In that moment, I thought of nothing other than the technical details of the operation, but soon after I wheeled the patient up to the intensive care unit, I realized that this was not the first time I had stepped forward to a table with the same sense of awesome responsibility. Three years earlier, while stepping up to the altar at Trinity Episcopal Cathedral in Pittsburgh to consecrate the elements of bread and wine in my first Eucharist as a newly ordained priest, my experience was almost identical. For years I had been around the altar as acolyte, chorister, seminarian, and deacon, but as the presiding priest, it was completely different.

I was relieved, but not entirely surprised, to discover that in both cases, my training was sufficient for the task. In the operating room, I identified and repaired several tears in the cecal serosa, and the patient made a swift and complete recovery, marked only by a scar that stretches from xyphoid to pubis. At the altar, God was once again faithful to his promise as the
congregation gathered to share a foretaste of the supper of the lamb. In the years since these first experiences, I have grown more accustomed to the weight of responsibility that descends every time I step forward to each table. However, terror is never far away in either context, and I pray that the terror will never disappear entirely.

From my perspective, both the altar and operating room table are holy spaces, because those who dare approach either table encounter something larger than themselves. In what follows, I aim to provide a phenomenological description of the analogies between surgeon and priest, altar and operating room table. Some will likely confirm my observations in the distinct language of their own theological tradition. Others will no doubt find such an analogy far fetched. Yet I hope that even the atheist or the agnostic will recognize in my description a crucial dimension of surgical practice that often eludes expression in the secular idiom that orders our professional discourse. My phenomenology is but one way to articulate the surgeon’s unique privilege and responsibility to provide comfort and cure by piercing the integrity of another’s body. However, regardless of philosophical or theological traditions, I contend that there is something distinctly sacramental and priestly about surgery and surgeons.

HISTORICAL PERSPECTIVES ON THE SURGEON-PRIEST

Although physicians were available in varying capacities in ancient Rome and Athens, the institution of a hospital dedicated to the care of the sick was a distinctly Christian innovation rooted in the monastic virtue and practice of hospitality [1]. Arranged around the monastery were concentric rings of buildings in which the life and work of the monastic community was ordered. The outer ring of buildings served as a hostel in which travelers were received and boarded. The inner ring served as a place where the monastic community could care for the sick, the poor, and the infirm. Monks were frequently familiar with the medicine available at that time, growing medicinal plants on the monastery grounds and applying remedies as indicated. As such, many of the practicing physicians of the Middle Ages were also clergy.

Some physician-priests were prominent in the development of modern European medicine. Niels Stensen (1638-1686), for example, was a physician and a priest who is best known for discovering the parotid gland duct (ductus stenonianus) that bears his name. After distinguishing himself in both anatomy and geology, he converted from Lutheranism to Roman Catholicism, was ordained a priest in 1675, and served as Vicar Apostolic of Hanover and then Bishop of Titiopolis, where he published more than a dozen theological volumes [5].

Political forces in 17th-century England made the combination of medicine and Christian ministry increasingly common. Young clergy of more radical protestant persuasion (e.g., Puritans) were unable to secure appointments within the established Church of England, and, as a result, their ministry depended on alternate sources of income. To serve the needs of these “non-conformist” clergy, many English universities incorporated the study of medicine in the curriculum for divinity students [3]. As a result, one contemporary critic observed that physician-clergy were becoming the “dominant group in the medical profession” [2].

Many of these non-conforming clergy with medical training sought refuge in the British colonies of North America. Samuel Fuller (1580-1633) was the first physician in New England, arriving with the other Puritans on the Mayflower. Later, many of the Methodist circuit riders who evangelized the American frontier practiced medicine to support their ministry. In fact, one of the best selling medical texts in 18th- and 19th-century America, *Primitive Physic*, was written by John Wesley (1703-1791), an Anglican priest and the founder of Methodism [4].

The influence of physician clergy can be traced to the origins of some of the oldest American medical institutions. Aneus Munson (1734-1826) graduated from Yale College in 1753. He was subsequently ordained as a Congregational minister and installed as
pastor of a New Haven church, where he stayed for seven years. He then switched to the practice of medicine, earning renown for his encyclopedic knowledge of materia medica and botanical remedies. He became one of the most respected physicians in Connecticut, playing a critical role in the charter of the Connecticut Medical Society and the New Haven County Medical Association. In 1813, Munson joined three other eminent physicians to found the Institution of Medicine at Yale College — Connecticut’s first medical school.

My own systematic survey of North American seminaries, medical schools, and Episcopal dioceses identified 230 contemporary physician clergy throughout North America, representing every type of medical practice. Psychiatry was over-represented in this group, accounting for a third of the population; the remaining two-thirds were evenly divided between medical and surgical specialties. Although some of these physician clergy left one vocation to pursue the other, most continued to practice both vocations with varying degrees of explicit or implicit integration. Although certainly not common, there are many more physician clergy in practice today than one might imagine, suggesting that the homology between the two professions endures even in the contemporary context.

ANALOGIES BETWEEN ALTAR AND TABLE

Both surgeons and priests utilize and depend on rituals that embody the significance of their work. At the most basic level, the altar and operating room table are both tables with lights. They come in all shapes and sizes and are manufactured from various materials. Some are fancy and some are simple, but in the end, they are both tables. Surgeons will constantly complain about the inadequate candlepower of the lights in the operating room, and a certain kind of priest will quibble over the necessary amount of beeswax in the altar lights, but both surgeon and priest require basic illumination at their respective tables. Both surgeon and priest are concerned about bodies and blood, and both tables encounter, receive, and support bodies in life and death.

To consecrate and sanctify something means to literally “set it apart.” The operating table is sanctified by being set apart within the limited access interior of the hospital, approachable only by the acolytes and clergy of the operating room team. An elaborate ritual of cleanliness and purity has emerged around the operating table that’s not unlike the ritual ablutions that surround altars. There may be strong science to support the antiseptic techniques that reduce surgical site infections, but much of the operating room ritual serves not only sterile technique, but a ritual “setting apart” of the operative field that effectively marks a barrier between the operating room and the world “outside.”

In Christian churches, the altar is stripped bare once a year on the Thursday before Easter, when it is ritually washed while singing the same anthem that is sung as a body is washed in preparation for burial. The operating room table is similarly stripped and washed between each case, though the musical accompaniment to this act is no doubt different. Both surgeon and priest are careful to wash their hands of impurities (moral or bacterial) before approaching their respective tables. Although there are no specified prayers for the scrub sink as there are for the priest’s ablutions, the time spent by surgeons washing hands is often spent in mental and even moral preparation for the work ahead. The surgeon then presides at a complex vesting ritual in which she is gowned and gloved before draping the table in preparation for the specific procedure. Likewise, the priest vests in special clothing (chasuble and stole) before draping the altar with fair linen and spreading out the corporal underneath the chalice and paten that contain the bread and wine. In either context, each action and ritual has a specific practical function: The surgeon’s lap pad and the priest’s purificator are technical items with the identical function of soaking up spills. Yet beyond the practical function, the ritual of all the preparations serves to mark a transition from ordinary to extraordi-
nary time and space. The rituals around the altar and the operating room table mark boundaries around each holy space.

**SURGEONS AND SACRAMENTS**

Priests are ordained with the particular responsibility of administering the sacraments of the Church. Sacraments give physical form to the theology, hope, and promise of the Gospel through the elements of the Eucharist, the waters Baptism, or the oil of Unction. Ideally, the priest’s interpretive role of preaching and pastoral guidance is grounded in the embodied substance of sacramental worship — neither can exist without the other, though the emphasis often shifts with context. Protestants focus on right preaching. Catholics focus on ordered sacraments. These tropes are as tired as the medical stereotype between “thinking” internists and “acting” surgeons, but the stereotypes do identify something distinctly sacramental about the practice of surgery. Surgeons work in flesh and blood. In the same way that bread and wine can convey Gospel promises with a simplicity more profound than the most eloquent sermon, having our arms up to our elbows in blood and guts exposes surgeons to a depth of the human condition encountered nowhere else.

The sacramental theology of the Eucharist is clear about two things. First, although the priest is ordained to consecrate the elements, the sacrament is the product of a joint effort between priest, people, and God. A priest cannot consecrate the sacrament without at least one other person present to share the work. Furthermore, the Eucharistic prayer deliberately invokes the presence and assistance of “that great cloud of witnesses” who have faithfully transmitted the tradition to the contemporary congregation and who, with the priest and congregation, join their voices with “angels, archangels and all the company in heaven who forever proclaim the glory of God.” Second, the sacrament’s efficacy does not depend on the virtues of the priest — the sins (real and imagined) of the priest do not invalidate the grace of the sacrament because the sacramental power originates not in the priest, but in God himself.

Similar observations might be made about the practices of surgeons. Although there is a definite satisfaction and responsibility associated with being the surgeon of record, surgery is truly a team effort between surgeon, patient, anesthesiologist, nurse, scrub tech, and a veritable army of ancillary support staff. Neither the surgeon nor the priest can work alone. And perhaps more than other physicians, surgeons explicitly acknowledge their dependence on a tradition that spans both time and space when they confess that they are “standing on the shoulders of giants.” Furthermore, although proficiency and skill are mandatory for successful surgery, it is increasingly clear to me that efficacy is often beyond the surgeon’s control — the perfect bowel anastomosis leaks despite every effort taken against this risk, whereas the dodgy anastomosis that can’t be made any better heals without a hitch. This is not meant to excuse sloppy technique. Rather, it is a humble (even humiliating) acknowledgment of reality: As much as we know about the science of trauma, wound healing, and molecular physiology, it remains fundamentally miraculous that after cutting away the rectal cancer, the colon actually manages to heal when I staple it back together.

**ANTHROPOLOGY**

Across diverse cultures, anthropologists have observed that the role of shaman, priest, and medicine man is frequently filled by the same individual. This is no mere coincidence. Humans need help weaving the experience of illness into the tapestry of meaning that makes their lives significant. This interpretive role is fundamentally “priestly” in that it locates individual experience in a wider framework of meaning and value. Even in the context of our modern scientific materialism, the phenomenological experience of illness and death continues to expose the finitude that challenges the omnipotence of our rugged individualism. Indeed, the persistent reality of illness and
death betrays the undeniable fact that in the end, humans are not autonomous masters of their own bodies. Physicians of all kinds play a critical role interpreting this reality to their patients, though their success is often limited.

In our secular, scientific culture where even Christian monastic orders have abandoned their distinct vesture in favor of street clothes, it is significant that physicians persist in wearing the flowing white coat that marks them as modern-day priests who live in the cloistered environment of the hospital throughout their arduous initiation into the mysteries of the human body. The chaplain is welcome to attend, but it is the physician who currently presides over life and death.

Contemporary medical education does little to prepare physicians to fill this interpretive role, and many physicians deliberately avoid it. Indeed, I suspect that much of the current fascination with complementary and alternative medicine is an expression of a deep hunger not fed by the current practices of American medicine. The precise nature of this hunger is unclear, but the appeal of complementary and alternative medicine seems to be the philosophical frameworks through which patients make sense of their experience of illness. The attraction of alternative healthcare seems rooted less in its efficacy than in its facility with locating patients within a wider interpretive framework of meaning.

On the other hand, in its success and zeal for effectively treating disease, allopathic medicine has largely abdicated its role as the interpreter of illness in favor of the promise of scientific efficacy. Both patients and physicians have come to believe that sickness and death would be preventable if only we knew enough science. As a result, the reality of sickness is all the more shocking when it disrupts our otherwise orderly lives. Patients and their families often turn to their physicians for guidance in making sense of their suffering, but physicians are not always willing or able to fill this role. As medicine becomes increasingly complex and technical, patient satisfaction may depend increasingly on physicians cultivating their skills for helping patients interpret their illness in meaningful ways. Furthermore, the growing disillusionment of many physicians may stem, in part, from the way modern bureaucratic health care denies and mitigates against this interpretive role by treating physicians merely as interchangeable “providers” of technical services. In other words, patient and physician satisfaction alike may depend on physicians reclaiming a “priestly” aspect of the medical vocation.

CONCLUSIONS

Much has been said about the “god complex” of surgeons, and I would be ashamed if anything I have written here was distorted to support the arrogance of which some surgeons are guilty. Surgeons are no more gods than my fellow all-too-human priests. Yet the point of this extended phenomenology of altar and table is to suggest that there is something priestly about what surgeons do, and that ignoring these analogies may impoverish our professional practice and identity. If actions speak louder than words, the rituals that permeate our surgical practice speak forcefully, even if we surgeons are often unaware of what those rituals communicate. Regardless of each surgeon’s philosophical commitments (sacred or secular), the substance of our work remains both terrifying and awesome. The power with which we are entrusted is easily distorted for less than virtuous ends, and perhaps precisely because that power is so easily distorted, elaborate rituals have emerged (sometimes unintentionally, but never by accident) to protect both surgeon and patient by setting our work apart as in some way holy. The altar and the operating room table are remarkably similar, and I suggest that it is important to recognize the analogy with a respect that theologians might call “fear and trembling.” Furthermore, the role we play in the lives of our patients can often be priestly as they seek guidance in making sense of their illness. Without returning to the heavy-handed paternalism of the past, we have the opportunity to offer the interpretive wisdom we garner through years of practice — wis-
dom that is not merely technical, but deeply shaped by the questions of meaning and value with which our embodied practices force us to contend. To offer such guidance with grace, humility and fortitude is indeed a sacred vocation.

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