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THE CATHOLIC HOSPITAL: Past, Present and Future

ROBERT W. O'CONNOR, M.D.

The Catholic Church has been replaced gradually in those areas where, for centuries, she was the vital force and constant pioneer. Long before the word underprivileged had become the coin of the social service realm, she had recognized the need of the masses for food, good health and education and had done a great deal about it. For love of God and her brothers in Christ, she founded the great teaching and nursing orders. From these bright jewels of her crown came the schools, hospitals and asylums, which inspired the governments of the world to follow her example. But, as government grew more enlightened and its existence more firmly based on popular election, it entered these fields with massive programs which soon outstripped the abilities and resources of church-related facilities and private philanthropies to compete. While the power to tax did not become the power to destroy, it certainly became the power to supplant in the fields of education and other social services.

The Catholic hospital took roots in the same soil of compassion for those deprived of a basic human need that nurtured Catholic schools and other institutions of public welfare. However, from the beginning, and even more so of recent years, its development followed a different path. It reached out to all races and creeds with a concern that did not

distinguish black from white or believer from non-believer.

Those receiving its merciful care found no barrier, imaginary or otherwise, to accepting its help in their distress. As the hospital grew in complexity, the medical care became the responsibility of professionals. It was often the case that those administering the medical assistance did not share the religious convictions of the hospital's owners. While the hospital maintained its spiritual purpose, the performance of its mission became increasingly technical. Because their services were of high caliber and available to all, philanthropies and government have extended to most Catholic hospitals a good measure of support. The end results are hospitals, still church owned, who offer roughly one-fourth of the care given in voluntary, private institutions in this nation. But, church schools used to offer a large proportion of the education given in some lands, and the orphans and the aged used to look first to Catholic hands. This is no longer the case, and it is with this in mind that we must examine the position of the Catholic hospital.

From its simple beginning as a work of mercy with the most meager of physical resources, the hospital has become a modern center of applied biological sciences, educational source for doctors, nurses, technologists and other paramedical

personnel and an important employer in its community. Where its very existence depended on alms in the past, it is now virtually a public utility purchasing goods and services of an amazing variety and paying for them from an auditor's nightmare of pre-pay per diem, Welfare reimbursements, direct payments and a host of other sources of varying degrees of adequacy. Struggling to retain its perspective as a dedicated mission to the sick, it has grown into a large corporate enterprise with all the problems of a major employer and a provider of a vital necessity. Viewed with this in mind, it is not surprising that any hospital, Catholic or otherwise, has to search constantly for the best direction in which to steer itself to avoid the shoals of fiscal disaster and the rocks of substandard medical care: hazards dreaded by all in this social service now grown to industry status.

The health industry, already one of the major segments of our economy, is also one of the greatest resources this country has constructed. In 1966, total expenditures for health care of all kinds were estimated at six per cent of the gross national product, above forty billions that year and still in a steep rise. This has to be a matter of preeminent national concern. Now that Social Security, through the Department of Health, Education and Welfare, is on the scene, government participation with all that it implies, is really at the grass roots level. The goal of a rising health standard for every level of society, which the past and present admin-

istrations have set about achieving, has already brought vast changes in medical activities of every type.

Considering this determination to achieve an unprecedented health level and the expenditures it will require, is it foreseeable that health is growing too important to be entrusted to those who have spent their lives in the war on disease and suffering? Like another kind of war, has it grown "too important to be left in the hands of the Generals"? If this attitude should prevail, and can one seriously doubt that it will, where is the Catholic hospital going to be called upon to serve in the years ahead? Is there a real justification for the existence of church-owned and religious-sponsored institutions within the framework of this nation's health system? If there is, can we demonstrate it to the satisfaction of government and the public? What changes must we make in structure and function to be full partners in the medical organization, as it will exist in the future? Given the imagination to see the new role to be assigned us, have we the determination to make the sacrifices to be called for at administrative and trustee levels, and to demand sacrifices and the full cooperation of all those who administer the care? If Catholic and other private hospitals are to survive in the mainstream of American medicine, they have to be able to answer in the affirmative; otherwise, they will be by-passed and left to wither away, victims of their own short-sightedness. And the answer has to come not alone from the trustees and advisory boards. It has to come with equal determination

from the medical staff and everyone else who can contribute to a goal of unexcelled and constantly improving medical care. The Catholic community must participate much more in the support of its hospitals.

The Catholic hospital is so integral a part of the health care system that no question of its immediate future need be raised. The problem is the long term. How well it is met will depend on how we anticipate the changes in the entire medical care system that are coming. We must place our hospitals in a position to receive and make maximum use of the financial support, regardless of how it is called, that will be necessary if government goals are to be achieved.

First, it would seem that the private hospital should need no justification. But why a Catholic hospital? Government hospitals are as well, or better equipped, to render the same medical service. Their awareness of medical progress and their role in research and education is impressive; indeed we are greatly in their debt for their contributions of the past and there are surely more to come. Our reason for being must lie in our ability to perform the same necessary services with the same degree of competence, but to perform them in a setting wherein the patient retains his personality as a brother in Christ. The pathology we seek to alleviate will respond to the same treatment in any environment, but the whole person must respond to the warmth of affection that he should find in the Catholic hospital. To the extent that psychological factors influence the processes of and recovery from

illness, we have a very real contribution to make. If a sense of identity, of individuality, is so sought after by the well in this confusing time, surely the introspection which illness and suffering bring with them make the sick even more prone to such desires. If we can help their fulfillment, our presence is certainly justified in the health industry.

The demonstration of this justification will have to be found in the fruits of our care. Patients who experience these things will hopefully, in whatever way and to whatever degree possible, respond by support of the Catholic hospital through their preference for its services. Agencies of government establishing standards for hospital operation will find the delivery of high quality care containing this intangible, if they look for it, and we shall point it out if they so need. In this day of psychosomatic medicine, there can be no sensible reason to abandon any form of medical care that is so oriented to the spirit as well as the flesh.

Big problems will arise from the changes which a medical care system now in the throes of a rebirth is going to demand of private hospitals and their staffs. The social and economic forces which have changed so many facets of our lives are beginning only belatedly to be felt at the level of medicine. What has been a long accepted way of life for much of commerce and industry who have found themselves unwilling or reluctant partners of government is just beginning in the complex national health care operation. But, the computer and the miracle drugs were equally the children of necessity in

man's progress; medical care legislation will come to be accepted as another. The important thing is how we anticipate the coming needs and prepare to meet them.

The announced goal of more and better medical care and the accepted fact of a physician, health worker shortage are not going to make the task any easier. There can only be one answer—more effective use of the resources at hand. To this end private hospitals must take stock of how they can utilize the time of their staff members to greatest advantage. Every device of mechanical or electronic nature which will enable the doctor to spend his time with his medical chores and free him of clerical-secretarial duties, must be employed. The committee assignment, grown almost to unbearable proportion, must be cut back to the minimum. To this end, a class of medical management must be recruited and trained to do everything that does not require a definitive medical judgment. Paramedical personnel must be trained and developed in ways not previously found acceptable to do things that will need doing but which will not get done otherwise, because the doctor will not have the time. To permit this, the courts will have to re-evaluate the entire concept of medico-legal responsibilities.

To keep the doctor dispensing his medical skills with maximum efficiency, the erection of medical office buildings adjacent to, or as an integral part of the hospital will be a necessity. The doctor will then spend his entire day in this one location, seeing those patients whom he must attend personally, and supervising

the paramedical workers who render the care he prescribes for others. A communication system within the hospital office complex to supply rapid information will be essential as doctors and beds grow scarcer, and treatment delays, over and above their medical undesirability, become operational problems. Some of these ideas are already under development and well on the way to reality. The private hospital must be alert to the advantages of such resolutions and be prompt to put them to use.

To do this in an effective manner, a long range plan is essential. This long range plan should free itself from certain preconceived notions. One of these is that the hospital is the end of the medical line. Instead, the "port of entry" idea has to be developed. Another concept that needs modifying is that of beds; for too long, we have measured hospital potential by numbers. For this we must substitute the medical center concept, which implies that the entire spectrum of health services is available in the one geographic location.

The center will of course require adequate numbers of nursing beds—but in the interest of cost they will have to be of widely different type. Self-care admission beds for the patients requiring hospitalization but minimum support; acute emergency beds, medical or surgical; intensive care beds for medical and surgical illnesses; post acute beds for the patient needing continued but lower level of care, will make up the hospital core. To this will be added extended care beds where real rehabilitation possibility remains.

A nursing home in close proximity to the hospital is another essential to insure a continuing interest in the chronically ill. Finally, Catholic hospitals would be returning to their historic mission to establish as an integral part of their facility, beds for those whose illness has passed beyond the possibility of cure. The growth of out-patient and emergency service will undoubtedly increase and the necessary staffing of these areas will require new concepts as the numbers of house staffs in Catholic hospitals remain minimal, and the practicing physician the only one available for these services. These are some of the areas in which imaginative solutions can pay dividends in terms of public service and good will.

There are going to be start-up costs involved in all of these things, and other costs not readily recoverable on a day to day basis. The problem of money will be an important one. The rapid advances and variety of technical approaches to diagnosis and treatment make rising costs of all health services inevitable. The growth of these and newer services will be dependent on available funds. To secure support for the greater outlays required, a long range plan of hospital growth and development should be available, in sufficient detail to permit cost estimates, approximate dates of construction or renovation and provision for services that will be required in the next few years, rather than correction of today's outstanding deficiency. Such long range planning, developed with the cooperation of the medical staff, can be integrated with those of the regional hospital planning boards if

such are available. They will be concrete evidence of the need for grants, subsidies or low cost loans to bring these projects into being, in addition to demonstrating that we have vision and direction.

The last question remains. Given the imagination to see the new role—do we have the determination to see it through at whatever cost to our individual authority and complacency? All hospitals will be scrutinized as they have been by various agencies in the past. This examination is not necessarily harmful and, from the information obtained, future plans for the care in each community will develop. Comparisons will undoubtedly be made and the Catholic hospitals which are in larger urban centers will invite the first comparisons. There is an urgency to their position which may not exist in smaller communities, where the Catholic hospital is the major or only hospital facility. But the accumulation of statistics on every level of medical care, through the data processing under way in Social Security will eventuate in yardsticks by which any hospital can and will be judged. If not today, tomorrow they will all be subject to the same kind of analysis in depth of all aspects of their medical and fiscal operations.

The fiscal operations, vital as they are, must be left to another discussion. There is surely enough know-how in Catholic hospitals or other church institutions with an able and eager laity to be called on as needed, to work out the mechanics of the money to be required. Funds will be available to those who demon-

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strate their ability to use them to secure a full measure of public good.

The medical operation can be separated, for discussion purposes only, into three broad activities, i.e., clinical patient service, medical education and research. Clinical patient service has been the dominant concern of virtually all Catholic hospitals and it is generally of a high caliber, and the maximum effort of staff and administration have been directed toward maintaining or improving it.

Turning to education and research, a somewhat different situation exists. For most of our hospitals these have been areas in which, for whatever reason, lesser efforts have been made. The end result finds us in the rear-guard in these phases, with a few notable exceptions. And it is in precisely these areas that our great effort must be made.

The task of education of new workers in the medical vineyard has not been neglected by any means. Nursing schools and schools for medical technologists are present in many of our hospitals and do a creditable work, but once again, change is abroad and the degree program grows in importance. Our hospitals must initiate or participate fully in such educational programs in the near future.

Education of physicians is now considered in two interrelated but distinct ways. The lifetime learning program for the practicing doctor is going to receive greater emphasis and support from medical schools and the government treasury. A working program of this kind will be necessary to all hospitals; again some have anticipated this need and have excellent programs already in operation.

The second category of physician education is the intern-resident training program. It is increasingly clear that his formal education will soon be under the direction of the medical schools. For the hospital having it or wishing to initiate it, closer ties with medical schools are the only answer available. The implications and requirements involved are beyond this present discussion.

In research we cannot claim any consistent effort for the vast majority of our hospitals, again for reasons not to be enumerated. But, the progressive hospital will have to participate in some manner, probably in the field of application of present knowledge. Many facts of great medical significance still remain unrecognized or unapplied to clinical medicine. Their application would be a substantial contribution, and could be achieved without the tremendous cost and problems of basic research. In these areas, medical education and research, it is imperative that we rethink our past attitudes and strike out on some new approaches. An advantage in our favor is the frequent existence of several Catholic hospitals and related health facilities such as nursing homes in a community. Since all of these share in the church's mission of improving man's ability to better serve his God by restoring or preserving his health, they start from a unifying principle. It remains for us to realize the full potential of this unity and to develop all those improvements which may grow out of it.

The mechanisms could be many and each area might have individual circumstances dictating a varying approach but a broad outline might be as follows.

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A meeting of the medical minds of the various institutions through any forum available, is a requisite. The Catholic Physicians' Guild would be an excellent avenue. This group could set about accumulating information on all Catholic-sponsored health facilities in its area. The potential of each, particularly for medical education and research, could be determined. The exploration of physical plant, medical staff, existing educational programs, research efforts under way and many other facets of modern medical care would surely yield information not presently available. Where indicated, mutual aid programs could be set up, and conceivably in some areas, programs of advanced specialty training worthy of full medical school support could be organized among the various institutions.

To hasten such programs and to develop this apostolate which has lain fallow too long, Diocesan recognition of the unique and tremendous responsibilities carried by its health operations is urgently needed. In some areas recognition has been given, but in others the lack of sense of sharing in this mission is truly amazing. Here leadership is urgently needed. The church in renewal is speaking out on social problems with a clear voice. For those who hold responsibility for the conduct of its affairs at every level they must hear and act. The full range of talents which rest in our clergy and our laity must be brought to bear on our individual and collective hospital-health care plans.

As called for by Dr. Ebert, Dean of Harvard Medical School, interviewed in the *Boston Globe*, April 23, 1966, there must be a marriage of medicine and social science to yield the dramatic advances that have come from the union of medicine and the physical sciences. He calls upon the medical school to take the initiative and reach out to make this a reality.

Most Catholic hospitals could profit from some premarital counseling. It is time that the central organization, Diocesan authority, reached out to those who labor in the social services; come to know the grave problems they face today, and help them prepare for the larger ones to come. The survival of the Catholic hospital will be dependent on how well it can adapt to its new life as an integral part of a national health organization, already being forged to carry this nation to its potential of the healthiest on earth. It cannot hope to go it alone, however.

The adaptation will be much more rapid and effective if, at the local levels, we can begin a sharing of our facilities and scarce medical talents as well as the facilities and talents of institutions of education and social service. The leadership vacuum in health services must be filled and filled quickly from our own ranks before it is filled for us.

We have the potential among many able Catholic hospital administrators and trustees, staff physicians

and capable social service personnel already enlisted in our cause. But the direction and encouragement needed to submerge purely local concerns and focus on the goal of a community wide health program will have to come from outside of most of our institutions. Given this kind of leadership, the church institutions of health care and all social services can flourish in ways we cannot now envision. The alternative to this kind of Diocesan leadership will be a continuation of isolated efforts and frag-

mentation of resources which the community will not tolerate and cannot afford.

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