The Linacre Quarterly

Volume 54 | Number 3 Article 13

August 1987

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Never before has the United States had as many sisters, brothers and priests prepared and serving as physicians within its boundaries. While the number is still small compared to all physicians, the religious hover close to the several hundred mark and their ranks are growing. The following presents thoughts about this group as persons and physicians and about their apostolic endeavors.

Thinking about the religious physician in society, one thinks of persons with a "double calling". From biblical times, physicians have been accorded a uniquely special place in the human community. Sirach 38:1-8 says:

> Hold the physician in honor, for the physician is essential to you. And God it was who established the physician's profession. From God the doctor has wisdom and the king provides his sustenance. Knowledge makes the doctor distinguished and gives him access to those in authority. God makes the earth yield healing herbs which the prudent person should not neglect.
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> . . . He endows people with the knowledge to glory in his mighty works, through which the doctor eases pain and the druggist prepares medicines; thus God's creative work continues without cease in its efficacy on the surface of the earth.

While licenses were not the order of the day in Old Testament times, clearly the equivalent prevailed. The Old Testament quote exhorts all people to, in effect, obey the physician. It makes no exceptions, nor does it qualify that the physician must exemplify any one or a series of personal virtues before he/she is to be obeyed. The Old Testament simply says that God has gifted a few select of His people with special insights and grasps about healing and makes it the duty of the afflicted person to obey these specially gifted persons.

The Old Testament makes it clear that this special healing power is a very definite talent which God directly and very intentionally placed in the community so that His people could be healed to carry out their part of the covenant between Himself and them. In a very real sense, the physicians of the Old Testament carried a license every bit as real as that carried by the physician of today. Then the licensing authority was God; today in our more complex societal governance forms, the licensing authority is the State on behalf of the people.

The State dispenses many licenses and, in so doing, effectively creates monopolies excluding many from a whole range of activities which would permit them to charge and collect fees. Of this entire range of licenses, the physician alone is given a standing of almost untouchable privilege. There simply is no profession or business or function which has such a broad range of unchallenged discretionary behavior allowed by society. This reflects the physician as viewed in the broad community. For the most part, the physician often feels quite put upon, especially in this day and age, with a plethora of regulation and seemingly endless oppressive burdens of proof. Despite this, in fact objectively, the physician in society, taken individually, still has enormous free reign equaled by few others.

A Weighty Responsibility

Such God-likeness bestowed by society on one of its members carries with it, for that particular individual, a very weighty responsibility, significant enough to periodically overwhelm the individual somewhat.

But for the religious physician, this is only half of the story. The other half is that religious physicians also are fully credentialed members of another group whom recent polls repeatedly showed are perceived as the most trustworthy members of the community—religious and clergy. Despite the periodic maligning dealt out to religion, persons of religion on an individual basis know all too well the role in which they have been placed and the expectations about their actions and performance.

This dual major function makes the religious physician a totally unparalleled minority. Being a tiny minority brings with it all the inattention accorded tiny minorities. There is no system for religious physicians; there is no establishment for them; there is not much precedent for them; there is no thought that such talented and heavily "licensed" persons really have needs. Everyone knows that such superstars are totally self-sufficient, right? Wrong.

The high expectations and sometimes inordinate demands placed upon the doubly religion-licensed/medicine-licensed person, coupled with the attendant response from that person, can make for circumstances bound to drain and exhaust the heartiest of souls, bodies, spirits, psyches and any and all other pieces of this unusual human dynamo.

Health care executives such as I have no credentials in scripture, medicine, psychology, anthropology, sociology or any related specialties. They are the generalist of generalists whose main source of ideas comes from years of watching, caring, loving and functioning in the field of hospital administration. An additional disclaimer is that they know little about religion-based physicians in countries other than the U.S. and the manner in which these adapt and survive in foreign missions. Learnings about living and lifestyle from foreign experience probably cannot be transferred to the U.S. situation.

Religious physicians (technically this does not include priests but this article intends to include them) in the U.S. are continuing to increase in numbers. There is no particular pre-planning related to this. The very special demands placed upon the religious physician call for special attention in terms of having a support system. Yet there is no support system in place. There needs to be one to encourage more religious to pursue medicine. Why we need to encourage more religious to pursue medicine is elaborated later.

System of Support

What might or ought a system of support look like? One aspect is most assuredly the fledgling Association of Sister, Brother and Priest Physicians. That group's annual gathering serves them well. But what about the rest of the year? What about the days, the nights, the weekends, the holidays, the up times, the down times, the needy times, the celebrating times? Does the environment of sisters, brothers and priests include a close-by person who is tuned in to the totality of their complex life and the spin-offs they are on as human beings? If it doesn't, it certainly must at some point. If their "species" is to be preserved, attention needs to be paid to their very specific needs for support. They must not be left out there alone, just because they are so self-sufficient. Their work is likely so engrossing that there may be little need for anything but a bed on which to "collapse." But in the long run, they need a support available only from another person who can comprehend them and their lifestyle. Even if that other person is equally "exhausted and collapsed," they need to know there is someone who has solid comprehension of their unique life. "Nearby" may mean the same building or simply the same city or town or maybe even an adjacent city or town. But it means close enough and available enough for regular periodic person-to-person contact.

The nature of the way the religious physicians' uniqueness has evolved and the unusualness surrounding their minority status hardly allows for a lot of pre-planning on the front here described—the personal support

system front. But planning for this sort of support needs to begin now, not when the burdens of life close in on them. They are probably more expert than others at thinking up ways that personal support might, should or does happen. On the other hand, they may be so immersed in the multiplicity of demands placed upon them and in the complexity of locating professionally, that planning an ongoing support system may seem virtually impossible. Nevertheless the impossible must occur if this precious apostolate is to be preserved for the Church. It is possible to proceed quite independently for periods of time ranging from shorter to longer, depending upon the individual. But in each individual's life, there will most certainly be a point at which a relevant, tangible, responsive person, persons, or system will need to be referenced to a greater or lesser degree for support, sustenance, refurbishing, re-directing, re-grouping or the like. Better that such support be there in an anticipatory fashion rather than needing to be ferreted out under adverse or semi-urgent circumstances. For the female religious physician, there is the added stress of functioning in a profession traditionally male-dominated, changing somewhat in recent years, though remaining male-dominated in practice.

One obvious approach to a support system is the search for a ministry area where two physicians are needed simultaneously. This seems too simplistic a proposal, but there are a number of such around and about and a number of such in communities adjacent to main-line components of the Catholic health care apostolate. This moves us to the next point of comment, which is the religious physician as a unique, unexpected but blessed addition to the struggling Catholicity of the existing Catholic health care and hospital system. What does this mean?

Hospital Power Centers

There are two power centers operative in a hospital: one is comprised of society's most fully licensed and veritably autonomous citizens called physicians; the other is the governance and administrative arena which makes decisions about resource allocation in the hospital corporation. So much for Introductory Hospital Administration 101.

The composite resources, talents and activities of the first category, i.e., the physician group, are, in the end, more powerfully controlling in the hospital than the administrative and governance function. In other words, though not universally true, more often than not physicians are more determinative than administrators of the final nature of the end product for a given hospital.

Catholic hospitals have evolved through the years up to today's systems approaches and tomorrow's conglomerates. Along the way over the past few decades, religious working in health care have been increasingly disinterested in being administrators. For the most part, religious do not choose religious life to minister at a point remote from needy people, i.e., at the administrative level. The endless shuffling of paper, finances, resources, etc., and the daily diet of regulators, contractors, bankers, etc.,

frequently do not transmit a sense of fulfilling a religious vocation. Most, though not all, religious prefer exercising their God-given talents closer to the needy in society and farther away from the seemingly endless increase in regulation in the hospital as a whole.

One by one by one religious have, through the years, left the administrative and managerial levels in the hospital and sought other apostolic endeavors more closely matching their perception of the call of their vocation. The result: a Catholic health care system with religious involvement more and more narrowing to the governance level predominantly, with smaller and smaller numbers of sisters, brothers and priests at other levels within the sponsored hospital. Operating a sponsored apostolate with few or no members of the sponsoring group visible to the rank and file of the hospital and medical staff tends to make for a remoteness of the sponsor.

Thus, even now the health system is evolving to a point in history in which there is no religious leavening mixed inside it—it is all at the top. Up there it is not as effective at actualizing and bringing to life for a hospital that quality/service dimension of caring uniquely emanating from a consecrated life totally given over to Jesus. Except for the Pastoral Care Department, the fabric of the Catholic hospitals' daily endeavors rarely includes sisters, brothers and priests anymore.

Perhaps there is a need for a totally new type of religious presence—one conspicuously evident in the midst of the hospital arena. How can one be more in the midst of the health care delivery scene of a hospital than as part and parcel of that hospital's medical staff? There, delivering medical care side-by-side with other practitioners—how much more intimately could one possibly touch the core of the hospital? There probably is not a more substantive way.

If a medical staff counted religious physicians among its members and peers, one could envision an impacting extending hospitalwide, beyond what any other health professional or administrator category could do. The physician, after all, touches a whole array of health care delivery persons right at their site of delivering care. In addition, the physician touches these people with the power of office granted by the State in bestowing a license to practice medicine. The religious physician constitutes a power presence never before inserted in the midst of the hospital operation—and all of this power used by the religious physician leavens the hospital as never before in history. There are endless possibilities presented by this scenario.

Hospitals Better Staffed

Because of the large number of new physicians entering practice annually, the race is on in hospitals in terms of medical staff. As a whole, hospitals are better staffed with physicians now than they ever have been. At the same time the reimbursement patterns are rewarding providers for keeping patients out of the hospital. The pressures certainly are growing to

test the mettle of physicians in terms of quality care in an era when one is not always rewarded for delivering true quality care. Enter the religious physician—a new conscience presence in the midst of the race; one whose life circumstance does not require him or her to be pre-occupied with the economic side of medical practice. For the Catholic hospital always concerned about keeping Catholic caring values alive and well, there is a whole new element to assist; for the religious physician a whole new dimension of his/her apostolate which as a by-product would provide a frame of reference for the religious half of the religious-physician phenomenon.

Today's practicing religious physicians and others currently in residencies should be encouraged to align their practices with Catholic hospitals and to become vibrant active staff members of Catholic hospital medical staffs. With more and more religious in medicine the idea becomes more and more feasible.

Many physicians tend to be rugged individualists, and thank God there is still some of this element around. Setting up a medical practice isn't all that easy and teaming up in practice around a Catholic hospital isn't without pre-planning. But certainly it is feasible as a goal to work toward.

Consider religious physicians using the power God has put in them (the same power of which Sirach speaks) in a way which will greatly expand their power base for His sake: for the greater honor and glory of God and in the long run for the greater service of His people. In context of the overall apostolate, the daily nuisances of working in or close to the medical economic model will be less of a potential distraction—just a minor factor to be tolerated in light of a broader role totally unique—a role totally needed—a role which is a great opportunity for real apostolic endeavor.

Hopefully the religious physician of the future will be the new leaven in Catholic hospitals. The way Catholic hospitals are going now, without the religious physician, the leaven, of necessity, will more and more be written policies, philosophy statements, mission statements, value statements and so forth. Sponsors will have to depend more and more upon these written documents to "be" Catholicity in Catholic hospitals. This is a poor substitute for a living, pulsating, vibrant piece of humanity personally dedicated/consecrated to Jesus Christ.

A Real Concern

It should be of real concern that the religious sponsoring groups are having to settle for a presence in the hospital in the form of policies and statements as opposed to lived religious experience. The religious physician in the Catholic hospital can be the new lived reality of a life dedicated/consecrated to Jesus Christ.

There is no one function in the hospital that can impact like that of the physician. He or she can touch a cross section of the hospital like no one else. Recently a sister-physician listened to a scenario as developed here and accepted the challenge to actualize it. The result: living evidence that these theories and ideas are on target. In one year she impacted the hospital

in which she is on staff far more than the best hospital administrator could ever hope to impact in a year—and far more than any other health professional could ever hope to touch. The physician has entree and can claim legitimacy for interacting in almost any department of the hospital and in almost any office in the hospital. As Sirach says: "Knowledge makes the doctor distinguished and gives him access to those in authority."

An administrator cannot freely move in and out of departments because of the necessary pattern of delegated authority which has to be operative in the organization. The physician does not have these constraints. In addition, the physician has regular interaction with peers on the medical staff. The religious physician thus brings right into the heart of the hospital and of medical practice the lived standards and ethical convictions which are bound to preserve a balance during a medical care era more and more impacted by economic consideration.

Consider the impact if religious physicians as a group were to pursue a joint posture which would bring endorsement to the concept of the role of the religious physician as that of leaven and enspiritor in the Catholic hospital system. This could be facilitated by religious sponsoring groups in the form of communication with sponsoring member and hospitals about the concept; assistance in identifying practice availabilities; educational processes in the understanding of hospital and medical staff organization; opening new territory in terms of tying in philosophy, mission and values with physician orientation and CME in Catholic hospitals; and many other approaches.

Are religious physicians willing to accept the role of catalyst in a way that only they can, toward the goal of keeping our Catholic hospitals really Catholic during these rapidly changing times for Catholic hospitals? Without them, Catholic hospitals seem destined to become remote operationally from the urgency of the message of Jesus about suffering and human dignity, as brought by the dedicated/consecrated religious.

This is not to imply that there are not marvelously dedicated people delivering care in our hospitals—there are. What this refers to is the witness dimension particular to the life of a person dedicated/consecrated in religion. This dimension clearly leavens extraordinarily. Any administrator can testify to that.

The thoughts expressed in this paper may have been operationalized by some religious physicians long ago. Also there is a broad range of needs for religious physician services outside the Catholic hospital system. These comments are not to disfavor any of the many existing and very important apostolates in which religious physicians are involved, but rather to provide a clear awareness of a growing issue of significant impact for the Catholic Church in terms of apostolic endeavor. It could well be that the religious physicians' assistance would take the form of communicating the problem to religious currently in medical school or in residency programs, as opposed to being applicable to those already established in a specific practice. But certainly it would have applicability to anyone considering transitions.

This paper struts and frets as a poor player, not in the Shakespearean sense of poor, but in an apostolic sense of poor: as speaking for Catholic hospitals which are poorer for having fewer and fewer religious in their midst. Is this voice to be heard no more? Given the nature of the religious physician, probably not. They possess very great love and generosity. Certainly they will reflect long and hard on their relationship to the Catholic hospital system as it faces a future in which they could play such a vital role. And certainly other Catholic physicians will encourage them.
