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The Interaction Between Religion and Medicine

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Many who are concerned about the future of medicine as a profession are aware of the need to bring medical practice into sharper focus upon the patient as an individual. An expression of this concern is found within the medical profession as well as in the public forum. "Comprehensive medicine," "social medicine," "holistic medicine," "personal medicine," "patient-centered medical care," "treating the patient instead of his disease" have become slogans.

Departments of preventive medicine, psychiatry, and rehabilitation medicine have usually provided the fertile soil in medical schools for the development of experiments and demonstrations designed to make the physician aware of his responsibility to assume the direction of coordinating the diagnosis and treatment of the biological as well as the psychological and social components which underlie the patient's disability. Lester Evans¹ has pointed out that from 1850 until 1930 the concern and emphasis in medical education was with basic medical and biological science, research, specialization, and the causation, mechanism, and prevention of disease. Since 1930 an awareness of medicine as a social institution has been added, and medical

education is becoming increasingly concerned with society, people, health, and the continuance of the life process. Community health, interprofessional cooperation, chronic disability, mental health, and environment are now the concern of not only the medical profession itself but medical schools, universities, government, and society in general. Medical practice has changed from episodic visits between patients and physicians to a complex of services provided by hospitals, insurance companies, government, and an array of supporting health professionals and technical assistants.

The recognition that religion can be significant in a patient's reaction to illness is as old as history. The shaman, witch doctors, and the temple priests have always been duly recognized as primitive precedents of the medical profession. The involvement of the Church in the care of the sick and needy from the earliest times is one of its glories. It is, however, a glory more of the past than of our times. Beginning with the era of scientific medicine in the 19th Century, the Church's role in medicine became circumscribed and was limited mainly to the operation of hospitals and to furnishing medical service either as charity or as a function of the mission apostolate. The Catholic hospital is now a physician's workshop rather than a refuge

for the helpless. Except for its chapel and the presence of the sisters, it is almost impossible to distinguish a Catholic hospital from a non-Catholic hospital. Accreditation standards, hospitalization insurance, social security, community sponsorship, and governmental regulations are factors which have forced conformity. Catholic hospitals have become agencies of the public as a result of the "socialization" of medical and hospital care through government and semi-public financial sponsorship and regulation.

It is unfortunate that religion has not remained in the mainstream of medical progress. This is not to deny that the Church has not had a great influence on morality in medicine. Through its moralists and canonists it has protected the rights of the individual, developed norms for professional conduct, approved of anatomical dissection and animal experimentation, and in other ways has supported medicine. Through the instrumentality of the Jesuit medical schools it has directly participated in medical science and medical education. The Church has been an outspoken and vigorous proponent of norms relating to reproduction, sterilization, abortion, and, to a less extent, mental illness. This concern with what has been glibly called "pelvic morality" is considered by some Catholics and many non-Catholics to have been excessive and to have stifled the development of a broader consideration of the significance of religion in medical care. Today the role of the priest in medical care is essentially sacramental. Psychology, sociology, an-

thropology, economics, and political science have joined with medical science and clinical medicine to form a social institution which provides medical and health services to our people. A multi-disciplinary organization has been mobilized to serve a man and his family in illness, but the priest is only on the sidelines. He should be brought into the institution of medicine along with other non-medical disciplines.

Bringing religion into the institution of medicine will not be easy. There is a reluctance in priests and physicians to engage in serious professional dialogue in other than the analysis of the usual medical-moral problems. Although an opportunity has existed for more than fifty years in Catholic universities with faculties of both theology and medicine to engage in discussions and study matters of mutual interest, this has seldom occurred. Attempts to establish programs in pastoral medicine for the clergy, programs of research in medical-moral problems, and institutes of religion and psychiatry have never moved beyond the talking stage. Catholics sponsor a curriculum in hospital administration for prospective hospital administrators. Why don't we have a curriculum in pastoral medicine for prospective hospital chaplains?

The University of Chicago has offered educational programs in pastoral medicine for some time. The Texas Medical Center in Houston includes in its organization an Institute of Pastoral Medicine which is under the direction of a pioneer in the field, Reverend Granger Westberg. A number of other universities

¹ *The Crisis in Medical Education*, University of Michigan Press, Ann Arbor, 1964.

and medical centers have programs. To my knowledge, there are no pastoral medicine programs leading to a degree or certificate conducted under Catholic auspices.

How then can we bring about a convergence of religion into the mainstream of modern medicine? Catholic educators are searching for new dimensions to give a more unique purpose to our universities. In a society in which social and cultural boundaries are disappearing, and in which Catholic universities are becoming less pastoral, more secular, and less distinguishable from other universities there is need to retille the soil on which they were founded, a need to plant fresh seeds of theology, philosophy, and humanism. The seeds of physical and biological science are producing a vigorous growth which dominates the ecology. The social and behavioral sciences have established strong roots and are already exerting a strong influence in the field of medicine. We must now prepare for a symbiotic growth of spiritual concepts to add completeness and balance to the garden.

This challenge to our universities must be met by all of the disciplines and medicine must be prepared to play its part. The medical faculty must join in a collaboration with theologians and others who also study man. The graduate school is the instrument to bring this about, and the new specialty of pastoral medicine must be designated to lead the development. In practical terms this means the establishment of a master's degree program in pastoral medicine designed to prepare the

clergy for a professional role in ministering to the sick. Such a program will need students and teachers who understand the challenge and have competence to generate scholarship. The students will come from the seminaries and from departments of theology, and the teachers will be mobilized from the appropriate disciplines in the medical, social, and behavioral sciences as well as in theology. Bridges must be built to bring teachers together. Unless this is done with enthusiasm, the synthesis will not take place because it is so easy to stay close to the familiar and rewarding experiences in one's chosen specialty. Progress is made through specialization and until we have priest-specialists who qualify in pastoral medicine it is unlikely that a graduate program will flourish enough to produce more experts.

The development of a curriculum in pastoral medicine will require much planning. It is, however, possible to speculate about what its content should be. Enough time must be spent with the essentials of medical science and clinical medicine to give perspective. Familiarity with terminology and the diagnostic and therapeutic concepts of medicine is necessary. The methodology and technique of counseling a person who is ill should be emphasized. The traditions, customs, and professional manners of the health professions should be learned through active participation in the functions of medical care in a university hospital. The student chaplain should be brought appropriately into the professional team. The problems encountered will generate discussion

and research, and now and then a student may feel the urge to probe deeply into the meaning of his activity. A graduate program in pastoral medicine is bound to have an influence on medical education in a university. Medical students and medical faculty may be exposed to religious concepts, and religion may enter into their personal lives with more meaning and challenge. The influence can, however, be more significant in a larger way by stimulating the development of an understanding of the place of value systems in medical practice.

All men live according to value systems which are their own, and their voice of conscience tells them when they are stepping outside of their system. A person's value system is created out of his family background, his schooling, his social environment, his church, and his employment. It may be rigorous or lax, religious or secularist. It becomes a part of his personality and as such enters into his behavior and his judgment.

The value system of a society is a composite of the value systems of its individual members. Its boundaries are set by the "law of the land." If the boundaries are wide, the value systems of different individuals may be quite heterogeneous and even contradictory. In general, if a society is primitive, isolated, or inbred, the value system of the group will be more sharply defined and homogeneous; whereas in a complex, diverse, and democratic society like our own, variety as well as inconsistency prevail.

A value system may be thought of

as having certain components which give it purpose and direction. There are five identifiable components; namely: biological, psychological, ethnic, social, and spiritual. A physician's personality, attitude, and behavior are determined by the mix of these components and the dominance of any one of them. The same is true of his patient. In other words, body, mind, cultural background, social outlook, and religion make the man, be he patient or physician.

A successful physician-patient relationship flourishes when the physician knows and understands his patient's value system, and when his own value system is more or less in resonance with that of his patient. One of the faults of modern medicine is the patient's difficulty to relate to a "team" or to a series of consultants who participate in his care. If the physician-patient relationship is to be improved, we must learn more about it. It must itself become the subject of research and study.

The influence of the religious or spiritual component in personality is of great importance to medical practice. Birth and death, depression and euphoria, pain and pleasure all may have religious connotations for a patient. Religion can loom suddenly either as a support or a worry in time of illness. Scrupulosity and guilt can have psychosomatic as well as religious dimensions.

Religious doctrine has undoubtedly caused tensions between the clergy and physicians, and may be an impediment to a free exchange between them. The Catholic precepts regarding contraception, steril-

ization, and abortion have bothered many non-Catholic as well as some Catholic physicians. A priest's approach to guilt and sin may run counter to the psychiatrist's psychotherapy. A Jehovah's Witness' refusal of blood transfusion, a Christian Scientist's rejection of medical therapy, and a faith healer's undermining of continuing medical care seem nonsensical to most physicians. The efforts of certain parents to withhold life saving surgical procedures from their children because of religious convictions exasperate the medical profession. A graduate program in pastoral medicine should deal with these matters from both a medical and religious point of view. Physicians and clergymen, regardless of their religion, should be familiar with the significance of doctrinal restrictions of the various religions. A free inter-denominational discussion should be encouraged.

There is also a need to develop postgraduate programs for practicing physicians which are designed to understand and facilitate the interaction of religion with medical prac-

tice. A personal or family physician may easily become involved in the moral and religious problems of his patient, sometimes even more so than the clergy, particularly when his patients will not talk to a priest. Most physicians handle these problems intuitively or with just plain common sense." In the meantime, the behavioral sciences and theology are adding greatly to our knowledge and are providing principles and techniques which could be used to improve the management of these patients who are sick in body and spirit. Here is a unique opportunity for the Federation of Catholic Physicians' Guilds to sponsor a postgraduate program which is concerned with religion in the practice of medicine. Realize well that it will be difficult to assemble a faculty for such a course, we should not hesitate to invite non-Catholic brethren who have taken the leadership in this area to help with the program.

Dr. Hirschboeck has served in many areas of Marquette University School of Medicine since 1938. He has been Dean of the School from 1947 until 1964 and is now Vice-President.