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An Assistant to the Great Physician

Gary J. Bouchard

*The great Physician now is near,
The sympathizing Jesus;
He speaks the drooping heart to cheer,
Oh! hear the voice of Jesus.*

- William Hunter

Christology introduces us to many iconic images of Jesus. Even a cursory reading of Scripture leads to encounters with the infant in the manger, the Good Shepherd, the Teacher, the Suffering Servant, and Christ the King reigning at the right hand of the Father. One such enduring and inspiring image is that of Jesus Christ as healer. We see Christ involved not just in his followers' spiritual health but in the restoration of physical health as well. Indeed, His mission was often explained by making an analogy between the two types of healing: "It is not those who are healthy who need a physician, but those who are sick; I did not come to call the righteous, but sinners." (Mk 2:17) Men and women of faith are often inspired to enter the health professions by this iconic image of Christ as healer.

I have been a Physician Assistant since 1987, and I have also been a faculty member of a number of physician assistant programs since 1990. For many years, I have been honored to educate and graduate new practitioners who are, for the most part, enthusiastic, optimistic and eager to begin their professional life. Thankfully, my program, and hundreds of similar programs across the nation, have sent forth graduates into a favorable employment market for several years now. We have often seen our bulletin boards filled to overflowing with job opportunities. Despite this boon, I advocate leaving one small corner of the "Positions Available" bulletin board available for one more advertisement: The Great Physician is in need of an Assistant. Not just "physician assistants" by title, not just those licensed and board certified professionals carrying the specific credential of "PA-C." These "assistants" to whom I refer can be other allied health providers, nurses, aides, orderlies, clerical workers, volunteers . . . and great physicians, as well.

That is not to say that anything is insufficient or lacking in the healing mission of Jesus Christ; it is merely still in progress, and human hands are the tools of His trade and His medical practice. This Great Physician would love to see that practice expanding. Imagine such a practice, if you will; the largest, most comprehensive health maintenance organization ever created. It would have satellite offices in every city, town and village, in every nation, across every continent. It would be free to all the physically and spiritually ill and injured, and would require no insurance co-payment or deductible. Every employee under its roof would be devoted to the physical and spiritual well-being of its patients.

Such a medical practice does not exist in this realm, and, if it did, I imagine it would soon be spoiled by earthly bureaucrats and politicians. It is a noble ideal resembling the concept of the Church Militant on earth which is separated from, yet united to, the Church Triumphant in heaven. Health care providers should aspire to this ideal of a sort of "Clinic Triumphant." The health care worker, if animated by a truly Christian spirit, becomes aware of the missionary dimension of the work. The work demands love, availability, attention, understanding, sharing, benevolence, patience and dialogue (Charter for Health Care Workers, 1995).

For the Christian, it is a team approach to health care such as I have described that most completely allows humankind to fulfill its calling to become the healing hands of Christ on earth. Those from other faith traditions, even those who are not particularly religious or spiritual, also have an abundance of the love, attention, and understanding that is needed and they also feel moved, inspired, or even “called” to enter the healing professions. “There are many gifts, but the same Spirit” (1 Cor 12:4 – 12); likewise there are many job titles, disciplines and career paths, but one calling to help and to heal.

Assisting The Great Physician

For two decades as a physician assistant, I have felt great reward in responding to a vocation to “assist.” My chosen work is a manifestation of true *diakonia*. I have heard that vital word translated as “ministry” or “service.” It is the source of the word “deacon.” One spiritual advisor who knew my career path chose to define *diakonia* for me as “assistant,” one who does work that benefits someone else. That slightly non-traditional definition of a single Greek word has been a source of strength for me throughout my career.

The reward is felt not merely in my role as an assistant to any one specific medical doctor but, in a broader sense, in assisting wherever I can to increase and maintain the health of others. On one occasion, I recall reading my business card silently to myself. I smiled at seeing the two phrases “Physician Assistant” and “Assistant Professor” in such close proximity to each other. At that time, in my two chosen professions of medicine and academia, I seemed to be twice removed from the seat of ultimate authority. I was comfortable in the knowledge that, in the end, there is only one such seat to be had, and it will never be mine, nor any other person’s. One day, I may hear a voice say “Friend, move up to a better place,” as the humble dinner guest was eventually exalted in Luke’s gospel (Lk 14:10-11). That will be the closest that any of us gets to the seat of ultimate authority, despite what some of my more self-aggrandizing supervising physicians have believed.

There is a combination of humility and a deep sense of purpose in pursuing a career with the modifier “assistant” placed so prominently in your title. Physician assistants by definition possess a sense of humility in that we strive to do our very best work each day largely for the greater glory of another – our employer, our supervising physician, and for many, our God. Recently, physicians have been known to say that the prestige and financial rewards of practicing medicine are not what they once were. Physician assistants can expect even fewer of these perks than doctors expect. Even some physicians admit that, if they had to do it all over again, they would seriously consider a career as a physician assistant: all of the healing, with significantly fewer tension headaches. Yet PAs that I have known and have educated show great career satisfaction, with an unmatched sense of purpose in studying and practicing medicine simply to know, to help, and to heal. That is *diakonia*.

Two Aspects of the Gospel Ethic

Father John A. Hardon describes two sides to Christian ethics. The first and earliest aspect of Christian ethics involves removing obstacles, overcoming temptations and obeying commandments. This is manifest as “law” and has been revealed to believers in the Decalogue, or Ten Commandments. The second and more evolved aspect involves turning one’s self over to God. This is the expression of true Christian love and responsibility, and has one of its most clear descriptions in the Beatitudes. Hardon calls the eight Beatitudes “the Magna Carta of Christian perfection,” so central are these Gospel values to a Christian life.

All students of the health sciences should heed the message in the papal encyclical *Faith and Reason*: “The Church remains profoundly convinced that faith and reason ‘mutually support each other’; each influences the other, as they offer to each other a purifying critique and a stimulus to pursue the search for deeper understanding” (*Fides et Ratio* 1998, 100).

Physician assistant training programs, and other health education programs, have excelled at the “reason” half of the equation. It is hoped that more men and women who are capable of presenting the “faith” half of the equation will follow their calling to enter academic medicine. When faced with controversy, students need the sage advice and role modeling of mentors who will help them feel comfortable giving voice to Catholic concerns. In the classroom, in the clinic, and in all public discourse, this voice should not be silent. Hardin’s formulation of both Christian law and Christian love will contribute immeasurably to the formation of a complete health care practitioner, for whom faith and reason are truly mutually supportive.

The Decalogue: Christian Law and Health Care

The Decalogue provides clear imperative statements of how humans ought to conduct themselves. Which of these pertain to the practice of medicine? Using very broad strokes, each commandment can be defined in such a way as to carry implications for health care. These basic Judeo-Christian tenets have been incorporated in most codes of medical ethics, from traditional versions of the Hippocratic Oath to its modern revisions. After sufficient reflection, the commandment “You shall not commit adultery” becomes the normative proscription warning practitioners to keep patient relationships professional. Likewise, “You shall not bear false witness against your neighbor” can be construed as an obligation to truth telling, and so on.

The conflict between faith and scientific inquiry frequently draws its front line in the interpretation of one single imperative of the Decalogue: “You shall not kill.” Definitions of ‘life’ are rewritten as science pushes the margins of viability outward at each end of the lifespan. The very beginning of life is at issue in debates concerning abortion, contraception and embryonic stem cell research. The natural end of human life is obscured by euthanasia, capital punishment, and issues arising from warfare. Between birth and death lie issues which are just as challenging: the ethics of research involving human subjects, and the just allocation of scarce medical resources. Many pressing moral issues of the day require the expertise of medical professionals, in addition to theologians, philosophers, and politicians.

This is a compelling reason for men and women of faith to follow their vocation into medicine and the health professions. If the health sciences are staffed with no one but atheists, agnostics and secular humanists, then religious adherents have ceded their ground without even so much as a healthy debate. Many individuals, especially those in scientific fields, often feel uncomfortable airing religious views in the public square. It can be a result of external pressures such as an accusation of imposing one’s religious views on another. Legal scholars such as Robert Bork have discredited this idea. “The fear of religion in the public arena is all too typical of Americans, and particularly the intellectual class, today. Religious conservatives cannot ‘impose’ their ideas on society except by the usual democratic methods of trying to build majorities and passing legislation. In that they are no different from any other group of people with ideas of what morality requires. All legislation ‘imposes’ a morality of one sort or another.” (Bork, 1996).

If Bork is correct, the full vetting of any issue must include input from religious adherents. Christian health care practitioners can build coalitions and enlighten legislators within the democratic process,

just as any other interest group can. They need not be absent from or remain silent in policy debates concerning vital issues such as embryonic stem cell research, abortion, and euthanasia.

If the task is “building majorities and passing legislation,” it is incumbent upon religiously inclined scientists and health care providers to find their strength in numbers. Organizations such as the Catholic Medical Association (CMA) and the Fellowship of Christian Physician Assistants (FCPA) count among their membership health care providers who seek to put their faith into action. The FCPA, specifically, seeks to “share our faith, [Christ’s] strength, and our common concerns; to provide a network of support for Christian PAs; and to encourage members to let their lives demonstrate Christ’s love in the home, in clinical practice, and within the profession” (FCPA, 2008). It is certainly reassuring to sail one’s ship into this safe harbor on occasion, and enjoy the dialogue and fellowship with like-minded practitioners. The respite should be brief; then, each member is needed as we all take part in a vigorous dialogue in the public square.

The Beatitudes: Love and Health Care

Hardon places a great value on the Beatitudes of the Gospel of Matthew as a classic description of Christian love in action. The fifth Beatitude is the one most often placed in the context of health care: “Blessed are the merciful, for they shall obtain mercy.” This obliges the Christian to the corporal works of mercy: namely; feed the hungry, give drink to the thirsty, clothe the naked, house the homeless, visit the sick, ransom the captive, and bury the dead. Indeed, those in the healing professions undertake such corporal works of mercy to the extreme. They not only visit the sick, they spend their entire working day trying to ease their burden. For following their vocation of mercy, “they shall obtain mercy.”

At some point in their lives, all Christian men and women are asked to take up their personal cross and follow Jesus. Personal crosses to bear include pain, suffering, loss, and death. Although theologians maintain that suffering is necessary and salvific, we as caring human beings are still moved to compassion. Health care workers are uniquely positioned to become Simon of Cyrene for the suffering; helping the sick by making their necessary burden as light as possible.

Humankind suffers in many varied ways, not all of which can be diagnosed and treated by the specialties of medicine. In recent times, much end-of-life suffering is done in impersonal, public, institutional settings. Individuals often suffer in dispersed and disconnected ways. In contrast, a hospital ward full of sick, injured, and dying people concentrates suffering in a way that is seldom seen in other settings. This can present unparalleled opportunities for communion and solidarity (*Salvifici Doloris* 1984, 8). In addition to corporal works of mercy, two of the spiritual works of mercy will surely come into play in such a setting: Comfort the afflicted. Pray for the living and the dead.

Intercessory prayer itself has been the focus of recent research and heated debate in the medical community. One of the most recent, and largest, studies to date involved intercessory prayer for cardiac bypass patients. A random controlled study was attempted in the following way:

Randomization assignments (serially numbered, opaque, sealed envelopes) were stratified by center using permuted blocks of size 9, 12, and 15 presented in random order. The envelope message for patients in groups 1 (uncertain, with intercessory prayer) and 2 (uncertain, no intercessory prayer) stated that they ‘may or may not be prayed for.’ The message for patients in group 3 (certain, with intercessory prayer) stated that they ‘will be prayed for.’ (Benson et al. 2006).

Benson and his colleagues are to be commended for undertaking this study in a way that is not hostile to the notion of prayer. However, there are major limitations to the research design. One critic pointed out that the aim of intercessory prayer is not always a medically desirable outcome. “Even the assumption that standard clinical outcome measures are appropriate end points for studies of prayer must be carefully examined; for instance, many prayers for the sick contain the implicit objective of easing the passage of the spirit out of the body, an outcome which, by Society of Thoracic Surgeons definition, would be coded as death.” (Krukoff 2006).

A second critique of the study design is that prayer is not simply a ‘wish list’ presented to God for the granting. This view begins to resemble “a glorified version of the 5-year old deciding Santa Claus doesn't exist because she didn't get the pony that she wanted for Christmas. It reflects a juvenile (literally) attitude toward prayer that is common among preschoolers but replaced with a more nuanced understanding as faith development and abstract thinking mature during the preteen years. Such a proposed test of God's existence is . . . petty and insulting.” (Powell 2007). The prayer of a Christian with a mature faith looks more like Christ in Gethsemane: “Father, if you are willing, take this cup from me; yet not my will, but yours be done.” The effect of such a prayer becomes infinitely more difficult to measure in a scientific study.

I would add a third concern to these published critiques. The methodology was flawed in that *there was intercessory prayer for the patients in the control group*, even though Benson’s prayer group did not pray for them by name. I make this claim because the sick and the suffering are always the subject of intercessory prayers, whether it occurs within daily Mass, within the Liturgy of the Hours, or in another less formal prayer group. The sick and the suffering are often not named specifically in such settings; however, a benevolent God is not listening for the number of times a name is mentioned in the answering of prayers. (I have been thankful for this realization when, as a Lector, I mispronounced terribly the name of the person being remembered in a given Mass. A kind priest comforted me, saying, “Don’t worry, it still worked.”)

A God who “knew us before he formed us” will hear all heartfelt yet generic, non-specific prayers for health and healing such as in Eucharistic Prayer I, in which presiding priests “pray to you, our living and true God, for our well-being and redemption.” “Our well being” includes all of us – no names required.

Some critics of prayer studies are downright hostile and absurdly confrontational. Gil Gaudia proposed a hypothetical experiment, “the results of which would leave little or no doubt about the effectiveness of intercessory prayer.”

All that would be required is an adequate sample of amputees as subjects and a sizeable number of believers who will earnestly pray over them. These should not be hard to locate. The investigators could use as many universities and people as possible -- all the willing believers in the country if necessary to pray every day for a year that at least one amputee would have a limb re-grown, and then, at the end of that year, examine all the thousands of amputees for signs of regenerating limbs . . . When a single limb has thus been observed to have been regenerated, then we will have seen unequivocal evidence for the power of prayer. This would be a real test to put before the immovable object, the irresistible force, the ultimate omniscience, the omnipotent, omnipresent supremacy of all that the believers in a supernatural being endow that Master Architect with. The creator of the entire universe should have no problem re-creating a limb. (Gaudia 2007)

This is the hostile and almost mocking tone of a few members of the medical community when confronted with religious beliefs. I was immediately inclined to remind Gaudia that “you shall not put the Lord, your God, to the test.” Then I realized two things: 1) such scripture quotations would probably not move him to a greater understanding of my position, and 2) he has a point. “Putting God to the test” is exactly what studies of the effectiveness of prayer are trying to do. So, Gaudia can be forgiven for his uncharitable rhetoric in light of that one insightful observation. We might be better off refraining from subjecting the existence of God to the (statistical) test.

Some have recommended that research concerning prayer be limited or ended altogether, due to the inherent difficulties in establishing a firm theoretical base in this area (Masters, Speilmans and Goodson, 2006). By extension, are such inquiries trying to prove or disprove the existence of God? I would prefer to see the therapeutic effects of prayer investigated rather than diminished or ignored. Who should undertake such research? My preference would be individuals who are receptive to the idea that something greater may be at play, individuals who are comfortable not knowing the unknowable. These people would be faith-filled individuals who understand that we exist in this realm, that there is a realm beyond us, and there is little if any scaffolding between. We may never prove precisely what goes on where theory and theology meet, but it will require investigators who “do not abandon reason, (but) merely recognize its limitations.” (Buckley 1998)

Other Faith Traditions

The Decalogue and the Beatitudes are meaningful touchstones for a great number of spirit-filled health care providers. However, my discussion of faith and reason working in concert is meant to be extended to others beyond the Judeo-Christian tradition. Rachel Spector, in her book “Cultural Diversity in Health and Illness,” occasionally spells the word “health” using all capital letters. When HEALTH is written this way, Spector wishes to convey a broader meaning, “the balance of the person, both within one’s being – physical, mental, spiritual – and in the outside world – natural, familial and communal, metaphysical.” Her textbook is in common use in health professions education and has served as an excellent summary of multicultural health care for my students.

In a chapter of the same book, entitled “Healing-Magicoreligious Traditions,” Spector admits that that “there are far too many religious beliefs and practices related to health to include them all.” She dutifully documents the response of selected religions to important medical dilemmas such as abortion, autopsy, euthanasia, and controversial healing practices. She recounts the beliefs of Roman Catholics which always seem familiar from repeated telling in the media. However, Spector also lists the commonly held beliefs of many other faith traditions: Baha’i and Buddhism, Hinduism and Islam, Mormonism and Unitarian/Universalism. Despite Spector’s detailed research, even the most well-intentioned effort in the most all-inclusive book will be lacking in some significant way.

The crux of this essay is not necessarily to advocate for a greater Roman Catholic presence in health care, but to make all caregivers mindful of the spiritual dimension of the entire enterprise of health care. Spirituality and religion matter to the majority of our patients, and it should matter to us even if only for that reason. I have long believed that I have more in common with, for example, a devout and actively practicing Buddhist than I do with a lapsed Catholic challenging many articles of the faith. The medical community should be more tolerant of adherents to all faiths. It is hoped that spiritual people of all faiths will follow their call to heal; both their co-religionists and the population at large will benefit. After all, William Hunter’s 1859 spiritual continues to speak directly of vocation, in a later verse of “The

Great Physician,”

*The children too, both great and small,
Who love the Name of Jesus,
May now accept the gracious call
To work and live for Jesus.*

That passage helps to conclude my reflection as it began, in a fashion more spiritual than scholarly, more anecdotal than annotated, and more personal than professorial. My vocation to become first a PA and then a PA educator was not a single, past event that set an immutable course. Steering in a straight line requires innumerable minor adjustments to the wheel; the vocation I feel is a call to continual renewal and recommitment, and the journey is far from over.

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