Placing Mercy at Our Portals: Ethical Response in Tough Times

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"All over the world today people's lives are being darkened by the lengthening shadows of retrenchment, unemployment, and depression."[1] In an article published by the Catholic Hospital Association in *Hospital Progress* more than 77 years ago, the author describes a reality jarringly similar to what we are experiencing today.[2] As health care sponsors, trustees, leaders and managers grapple with diminishing financial resources and an ever-growing need for charity care, what can we learn from Catholic health care's response during the early years of the Great Depression? What principles guided its organizational ethics discernment?

First, a caveat. Obviously today's situation is vastly different from that of the Great Depression, particularly in health care. While direct comparisons may be inadequate, analogies may prove helpful. For example, medical reimbursement was completely different during the 1920s and 1930s. Then, although some persons had what really amounted to "disability" insurance, most health care encounters were fee-for-service.[3] Hospital costs were relatively low in an era that preceded the pharmaceutical and technological advances we now enjoy. Physicians were often paid what their patients could afford, sometimes accepting food or in-kind services for medical treatment. But as medical education became increasingly professional and demanding, the charges for physician's services gradually increased.[4]

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Past issues of *Hospital Progress* from 1930 to 1933 illustrate that hospitals faced daunting economic challenges – challenges their leaders addressed with energy, commitment, common sense and the rich resources of their Catholic faith and tradition. These characteristics still flourish in Catholic health care leaders and are fostered in formation programs within Catholic health care today. Furthermore, most institutions and systems have ethical decision-making tools in place to enable leaders to weigh, deliberate and address the many challenges they face.

The principles cited in several articles from 1930 to 1933 speak of the same norms presented by the United States Conference of Catholic Bishops in Part One of the *Ethical and Religious Directives for Catholic Health Care Services.* These include stewardship, dignity of each person, care of the poor and common good. Furthermore, the directives urge transparency in business practices and a warning that, even in the midst of constraint, quality must not suffer.[5]

Although the term stewardship was not commonly used at that time, the articles (many first presented as speeches at the annual CHA assembly) speak in terms of "increasing economic efficiency" or "making sacrifices." Stewardship, as it is used today in the directives, focuses not only on finances, but also on equipment, supplies and personnel. Leaders of Catholic hospitals in the 1930s similarly called for careful use of these treasures, but cautioned against inferior care of the sick. Aware of the dignity of each patient, one administrator advised, "The best care possible is not too good for the sufferer."[6] Indeed, according to several articles, economic challenges were often regarded as opportunities to achieve economies of scale and efficiency and to increase professionalism.

Catholic hospitals, many founded to care for immigrant populations who lived in crowded and unhealthy conditions, exercised creativity to continue their commitment to the poor and needy. Most hospitals throughout the country had three

types of patient rooms: wards that served what were called "free" patients; semi-private rooms with two to four patients assigned to what were called "partial-pay" patients; and private rooms reserved for persons with sufficient means to pay the cost of a hospital stay. One presenter at the annual assembly in 1931 estimated that "free" and "partial-pay" patients represented about one-third to one-half of all patients, while the priest who headed Catholic Charities in the Diocese of Denver estimated that the 12 Catholic hospitals in his diocese gave the largest share of charitable services in his area.[7,8]

The question was not whether the hospitals would treat the poor, but how they would do so. Hospitals exercised sensitivity and creativity in their care of all patients, but especially those who were "free" or "partial-pay." In 1931, one administrator from Keokuk, Iowa, related a moving story of a woman in need of surgery. The woman and her husband had one child and lived on the husband's salary of $23 per week. Because the surgery and hospital stay were beyond the family's means, the woman initially declined treatment. When asked if they could pay the hospital $3 per week, however, she agreed. The administrator noted the family met every payment and, in the process, kept their self-respect.[9] During that era, many Catholic hospitals first employed social workers to delicately query patients prior to admission to determine if and how they could pay. The administrator of Mercy Hospital in Baltimore cautioned that such social workers must employ "the most careful treatment" to preserve an individual's dignity.[10]

In an effort to care for the poor, hospitals deliberately reached out to anyone who could help their ministries. They exercised ingenuity to ensure that "financial difficulties must not permit the arm of the Lord to be shortened."[11] Although they did not deliberately use the term "common good," their ethic was one of community, recognizing that all are sisters and brothers to one another. Sister administrators often unashamedly sought bequests from the community on behalf of patients without funds. Sr. Mary Helen speaks of a successful appeal to a local philanthropist who contributed $1 million to defray the cost of expenses for partial-pay patients.[12] In another case, Sr. M. Dominica Spreewenberg, OSF, RN, reached out to a philanthropic organization 200 miles away in order to assist patients who could not pay for their care and to guarantee the hospital's ability to reimburse physicians for their delivery of uncompensated care.[13]

Recognizing that the goods that they shared with the sick were gifts not only from their loving God but also from the broader community, Catholic hospitals committed themselves to transparency in their financial accounts.[14] This was recognized as part of the stewardship they owed as recipients of the beneficence of so many.

While health care, public policy and reimbursement systems are vastly different today than they were during the Great Depression, Catholic principles remain the same. Catholic health care remains committed to the dignity of every person, to care of the poor, to the common good, and to providing excellent care to all who come to our doors for service.

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Sr. Rose Alice, RN, at the June 1931 assembly, confessed that she found the business side of hospital administration unattractive. But she eloquently combined what she called "the duties of a business executive with the all-embracing charity of a St. Vincent de Paul." She noted that the very reason for our existence is the charity of Christ for the suffering sick and she exhorted her

audience to "place mercy at our portals that none in need may hesitate to come to us."[15] ■

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NOTES

1. Mary Robert, "Hospital Economics: Depression and Its Effect on the Hospital," *Hospital Progress* 12, no. 8 (1931): 319. Unfortunately, the early issues of *Hospital Progress* often do not cite the congregation of the religious presenter, nor his or her hospital affiliation.
2. Catholic Hospital Association is the former name of the Catholic Health Association. The name changed in 1979. The name of CHA's annual convention became the Catholic Health Assembly in 1972. *Hospital Progress* was the predecessor to *Health Progress*. The name changed in September 1984.
3. John T. Preskitt, "Health Care Reimbursement: Clemens to Clinton," *Baylor University Medical Center Proceedings* 21, no. 1 (2008): 40-44.
4. Preskitt credits the work of Abraham Flexner through the Carnegie Foundation for the Advancement of Teaching as the primary impetus for the advancement of medical professionalism during this period of our history.
5. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 4th Edition (Washington, D.C.: USCCB, July 2001), Part One, www.usccb.org.
6. Robert, 321.
7. G.E. Quick, "The Effect of Capital Expenditures in the Hospital on the Cost of the Patient," *Hospital Progress* 12, no. 8 (1931): 322.
8. John R. Mulroy, "What the Public Does Not Know About Our Hospitals," *Hospital Progress* 12, no. 8 (1931): 324.
9. M. Dominica Spreewenberg, "An Experiment in Hospital Costs for the Patient of Moderate Means," *Hospital Progress* 12, no. 2 (1931): 62.
10. Mary Helen, "Medical Social Service and Hospital Rates," *Hospital Progress* 11, no. 2 (1930): 70. See note No. 1 regarding lack of information on author.
11. Mulroy, 325.
12. Helen, 71.
13. Spreewenberg.
14. Mulroy, 328.
15. Rose Alice, "The Effect of Occupancy on Hospital Costs to the Hospital," *Hospital Progress* 12, no. 8 (1931): 331-333.