

Hospital Workers: Evangelisers of Life

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Abstract

To evangelize means to bring Good News. Jesus gave a good example of spreading the good news of love and salvation through the healing ministry. But worldwide health workers who are the inheritors of his ministry today seem not to find it easy to emulate Him. We are often absent from the sick both physically and spiritually. Christ was present to restore the confidence and dignity of the sick and healed them; He was non-segregative and built faith in them as a key ingredient of healing. Today health workers seem to demonstrate less and less of Christ's image in their health care practices. Health workers need to become more compassionate and closer to patients and communities making compassion the hallmark of Catholic health care practice. We also need to evangelize people in authority and policy makers. Vices that conflict with the Catholic doctrine need to be resisted, especially as they are increasingly tied to major donations to poor countries. Various methods of evangelization by health workers may include: Strengthening servant leadership and management, strengthening hospital Chaplaincy, increasing the participation of religious congregations in health care especially in non-traditional areas of focus. Others include encouraging the health worker to treat the patient and not only the disease, being defenders of the human dignity and respect for life, fighting for equitable or non-segregative health care.

We should aim to provide quality health care that "markets" itself, pay attention to spiritual and emotional needs of health workers and get more involved in policy dialogue to influence national policies. We need to ensuring physical and spiritual presence to the communities that need us whether in times of conflicts or peace, times of economic boom or difficulties.

Introduction

The Greek noun "euangelion" means "Good News" and is literally translated as "evangel" or gospel. Thus "evangelism" originates from the word "euangelizomai" which literally means "I bring Good News." The old Greek also used it to mean "bringing good news of victory". The good news is that God loves us so much that He gave His only begotten Son, Jesus, to die for our sins and to bring salvation to us. Jesus Himself spread His Father's good news of love. One of the ways He used was the healing ministry. He combined the preaching of the Word with the practical healing of diseases and sicknesses (Matt 4:23). In other words, healing was one way of preaching the good news or showing God's love. He passed this on to his disciples "...and gave them authority over unclean spirits with power to chase them out and to cure all kinds of diseases and sickness" (Mt. 10:1). "And as you go make this proclamation 'the kingdom of heaven is at hand'. Cure the sick, raise the dead, cleanse the lepers, and drive out the demons" (Mt. 10:7-8). Health workers are people called to continue and bear witness to that work of the first Apostles commissioned by Jesus before He ascended into heaven "You will be my witnesses not only in Jerusalem but throughout Judaea and Samaria, and indeed to the ends of the earth" (Acts 1:8-9). How well health care is managed and provided implies how well the good news of love is passed on.

In many countries Catholic health care still makes a sizable proportion of the national health care system, both institutional and non-institutional. This is definitely the case in many African countries including Uganda as will be seen later. It is reported that even in the United States, away from Africa, Catholic health care forms the largest proportion of not-for-profit care (1). But how do we or can we use the big numbers to influence health care so that it reflects the healing ministry of Christ? This is a big challenge for all of us.

What were characteristic of Christ's Healing Ministry?

What were some of the key features of Christ's healing practice? What opportunities are we missing to be evangelizers as inheritors of the ministry? How can we revive or strengthen our role as evangelizers? At least seven characteristics of Christ's healing ministry may be identified which we can examine against or compare with current health care practices.

1. Jesus expressed the good news not only in words but a lot in deed. Today's health workers are often absent from the sick both physically and spiritually, thus missing the opportunities to emulate Jesus in the healing ministry. Various levels of physical absenteeism of health workers have been reported. A World Bank study in Uganda, for example, reported absenteeism of health workers in government facilities (after two visits) up to 37% (3). Another study in Bushenyi district of Uganda (after seven unannounced weekly visits) recorded average aggregate level of absenteeism of 47.9% (4). Besides physical absenteeism, health workers are often also in great unmet need of spiritual support, making it difficult for them to use the opportunity of clinical care to also spiritually support the patients and relatives. In many instances spiritual care is thus sought separately from clinical care.
2. Restoration of the confidence and dignity of the sick was a feature of Jesus healing ministry. He identified closely with and touched them and allowed them to touch Him (Lk.4 40; 5:13; Mk 1:40-42). Instead today health workers are widely perceived to be detached from patients and often separated from them by attitude and technology thus missing the opportunity to touch them physically and spiritually and to be touched by the patients. The emotional and spiritual detachment is also one of the factors leading to some health workers carrying out abortions or calling for legalization of abortion as they do not feel for the life of the unborn.
3. Jesus did not segregate against any person. The people he treated ranged from the poorest like lepers (Lk. 5:12-14), a man with a withered hand (Lk. 6:6-9), a blind man (Mark 8:22), to healing the servant of a centurion, a rich man (Lk.7:1-10). Today, most of our health care systems are inequitable and segregative. Even "social health care" systems favor the rich more. Corruption has not spared the health sector in a number of countries. The poor patients suffer the final effect of corruption as they fail to receive the services they need when they need them or in the required quality.
4. Faith of the person to be healed or the ones taking care of the sick is as important as the physical touch by a doctor or administration of medicines. This spiritual aspect is seen in many examples of Jesus' healing ministry as was the case of the healing the centurion's

servant when He said, “I tell you, not even in Israel have I found faith like this.” (Lk 7:9-10) or when He healed the paralytic (Lk. 5:17-25)

5. Jesus allowed the quality of his work to speak for itself. He told his patients not to tell others what he had done (Lk. 5:14-16, Mk. 1:44) and yet his reputation continued to grow by the day through the good work without advertisement. Health care is today increasingly commercial. In many countries the rise in the cost of health care is disproportionately faster than the expected rise in quality of care. In poor communities this often results in marketing poor products or poor quality of health care to the unsuspecting and desperate people. The poor, often uninsured, ends up struggling to pay catastrophic costs out-of-pocket thus gets poorer.
6. Jesus preached and demonstrated compassion. Healing by touch demonstrated the high level of compassion because under the Jewish law touching the sick was a sign of impurity. Unfortunately, today more and more health workers are seen to be “aggressive” with little or no love shown to the patients. The sick are often poor or made poor by the illnesses. Christ’s compassion for them is also reflected in His directive that the presence or absence of money must not be the primary determinant of access to care. At their commissioning to heal and cure the sick, Jesus told the disciples “You received without charge, give without charge. Provide yourselves with no gold or silver, not even with a few coppers for your purse, with no haversack for the journey or spare tunic or footwear or staff, for the workman deserves his keep” (Mt. 10:8-9)¹. This does not mean Jesus downplayed the fact that health care has a cost to be met including the human resource cost and that health workers deserve a fair pay, but he was stressing that money should not be the primary barrier to access to health care.
7. But “touching” and healing also meant reaching to the souls of the people he served. “Crowds were amazed when they saw the mute speaking, the deformed made whole, the lame walking and the blind able to see, and they glorified the God of Israel” (Mt. 15:31). In this sense He did not only touch the sick but also touched and healed the minds of the crowd who then believed him.

Opportunities availed for evangelization by physical presence of health facilities and health workers

First, the case of Uganda is here presented simply to exemplify such opportunity and share some of the attempts being made by Catholic health care to evangelize.

The first Catholic health facility, Rubaga hospital, was opened in 1899. Since then the number has grown to 284 health facilities distributed across the country and accredited to the Uganda Catholic Medical Bureau, which is the health department of the Uganda Episcopal Conference. Thirty of these are designated as hospitals while others are health centers or clinics of varying levels with some soon to be formally recognized as hospitals. The growth pattern appears at some stage consistent with responding to the vacuum created by years of conflict and

¹ The African Bible

instability coupled with economic collapse and a more poorly functioning government health system (Fig.1).

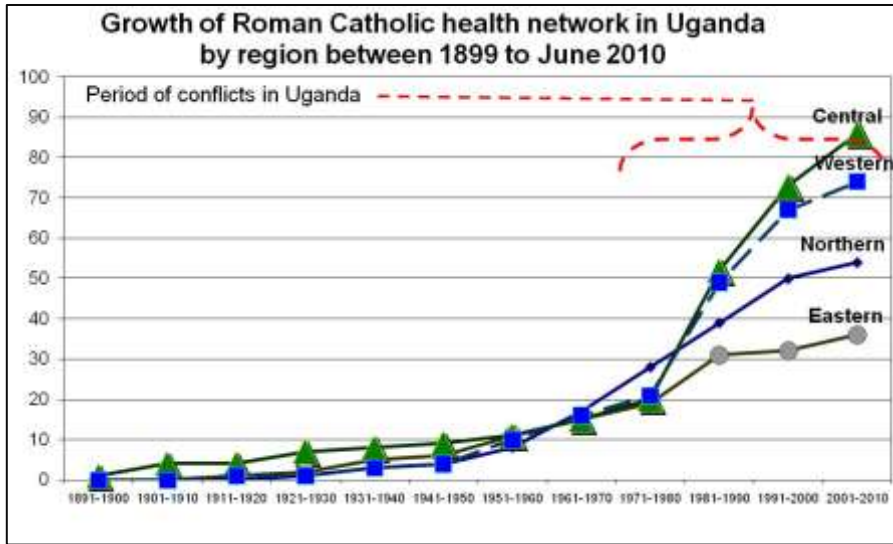


Fig 1: Trend of growth in number of Catholic health facilities by region in Uganda

Together, Catholic health facilities had 8,043 health workers by June 2012, about one quarter of the combined government-Catholic health workforce.

The Private-not-for-profit (PNFP) hospitals, almost all being religious-founded, make up 43% of total hospitals (also having 43% of available hospital bed capacity). Catholic hospitals alone make up 23% of the total in the country and 28% of the hospital bed capacity (*calculated from the MoH data of Dec. 2009*). But Catholic hospitals make up 53% of the PNFP hospitals. Out of 32 Institutions training nurses and midwives, 20 are PNFP (over 60%). Of these Catholic-founded training institutions are 13, making 40.6% of all institutions training nurses (and midwives) and 65% of all PNFP health training institutions in the country. So, the Catholic Church has a sizeable presence in Uganda. It has the largest non-state health care and training in the country.

Most of the 8,043 employees in Catholic health facilities are Catholics. But besides those working in Catholic-founded facilities, there are several Catholic health workers in non-church employment like government hospitals, various non-governmental Organizations dealing in health or health related work or in private practice.

This means that the opportunity for Catholic health workers to evangelize exists both in the large contribution the church makes to the country's health care system and beyond the Catholic Health Care.

Challenges

Jesus and His early disciples carried out evangelization amidst many challenges, including persecution. The healing ministry today also faces a number of challenges, but probably of a different nature. They are challenges that also affect the wider health system in the country and are mainly economic or economic-related and spiritual.

The widely acknowledged high level of corruption in the country has not spared the health sector. There is a policy of free health care in government facilities but in fact there is a lot of bribery to access even basic care. Health workers are frequently accused of having lost motivation to serve and often seen as not caring enough for the sick. More and more health workers, especially in government institutions are also viewed not to be manifesting their religious beliefs and ethics in their health care practices. Shortage of medicines and medical supplies is common yet the government is reluctant to increase the health care budget.

These mean that even those who have the inner joy to serve may fail to translate that message of love and compassion into practice because of the broken health system.

Despite the fact that the Catholics are the single majority religion in the country, Catholic health workers particularly in non-Catholic institutions are increasingly facing intimidation because of their faith. There is so much singing of “evidence-based interventions or approaches”, “human rights to health care including the call to legalize abortion,” etc. The easiest person to blame for the stagnation and rise in prevalence of HIV is the Catholic Church for being against these so called “evidence-based interventions like promotion and distribution of condoms”. The pressure is even increased by the donors. The US government, for example, has now severely cut off PEPFAR funds to programs promoting abstinence and faithful marriage in the control of HIV despite these having been the hall-mark of the successful HIV prevention in Uganda in the past. Catholics in positions of responsibility in government health care and other non-Catholic owned organization find themselves between the Catholic teaching and having to comply with priorities of organizations employing them. Some of them feel some level of intimidation and “identity crisis”. These Catholic health workers need to be supported to maintain their confidence and become evangelizers of the system.

What is the Catholic Health System doing?

Amidst all these challenges, Catholic-founded health institutions and other faith-based health care facilities have endeavored to bear witness to the presence of Christ among Ugandans. They have remained the beacon of hope to many in regions affected by armed conflict for over three decades. In such moments they have lived to Jesus’ teaching that “The greatest love a person can have for his friends is to give his life for them” (John 15:13) and are largely still perceived as being more compassionate than those in government facilities.

However, Catholic health institutions and workers in Uganda and elsewhere would still do better if they emulated even more of Christ’s way by integrating medical care with spiritual

care. Christ as a healer of the body was also a healer of the soul thus using the occasion of healing to evangelize. The following are some of the things being done in Uganda.

Improving governance and management

Weak leadership and management have been blamed for much of the problems faced by the health sector. The Catholic Health Department, the UCMB, has for its part made strengthening of Corporate Governance in its network one of the top priorities among its Systems Strengthening strategies, something for which it has gained respect within the Uganda's health sector. UCMB first ensures that its own governance structures function. It supports and strengthens governance and management of the health institutions accredited to it through training of individual managers, of Boards of Governors, and collective workshops. It also carries out support supervision and provides scholarships. Catholic health facilities use the national Health Management Information System. But UCMB has made this HMIS so far most functional in its network, thus strengthening its capacity for planning and advocacy.

Deliberate effort to increase accessibility to the less privileged of society

The problem of inequity is not unique to Uganda or developing countries alone. Michael Sheedy gives an interesting description of a graphic manifestation of such inequity even in the United States. In Uganda (and other similar countries) the rising cost of health care against reducing external donation to church-founded institutions (which are often rurally placed among the poor) poses pressure to raise user fees that threaten to reduce access to care by the poor. The Catholic health facilities under the UCMB have struggled amidst all these to keep fees as reasonably low as possible while advocating for more subsidy from government and donors. UCMB monitors the trends of cost and user fees and the general economic trend in the country and offers advice to the network to ensure that economic accessibility to the poor remains the basis of all management decisions in responding to the external challenges while remaining true to the reality of the economic environment. In this way, we try to show concern and love for the poor.

Building a spirit of compassion and service

The report of absenteeism of health workers in Uganda's public facilities being between 37%-49% is disturbing. We do not have figures for faith-based facilities, including those of the Catholic Church. However, health workers in faith-based facilities are still perceived as being the most physically present despite their lower pays and tend to shoulder both formal and self-referrals from the public facilities where high absenteeism is experienced. This physical presence, even amidst economic difficulty is quite consoling to the community. People qualified from Catholic health training schools are generally considered more kind and compassionate and hard working. In this way they show the love of Jesus to the patients. But the combination of heavy workload and low salaries make faith-based facilities have high annual staff turnover, reaching 50% for some cadres, although these are quickly replaced.

Seeking and responding to patients feedback

UCMB, together with the respective hospitals, carries out annual patients' satisfaction surveys. This information is shared within the network so that Catholic health facilities try to remain relevant to the communities that use them by trying to address patients' concerns where possible.

Training in Clinical Pastoral Care

The Catholic Medical Bureau (UCMB) is at the moment the only institution in Uganda that trains Clinical Pastoral Care givers, many of whom are already health professionals, to strengthen hospital chaplaincy. Training a health professional in pastoral care offers a perfect opportunity to respond to the medical as well as spiritual need of the patient and care-takers in an integrated manner. The demand for them has grown so fast that the over 70 people trained so far are not enough for the 30 hospitals as they are often pulled into the health centers as well as out-of-hospital care of the sick. UCMB's strategy is to have a Chaplaincy team composed of both Ordained and lay ministers.

Increasing awareness of health workers on the Catholic Social Teaching

In an effort to address the increasing pressure from the pluralistic society, UCMB endeavours to ensure that Catholic Social Teaching is emphasized among Catholic health so that they understand the basis of certain positions taken by the church. This is done during the Annual General Assemblies, technical workshops as well as during induction of new staff in some cases. For this purpose, UCMB spearheaded the formulation of a guideline for induction of new staff both at the national headquarters (Uganda Catholic Secretariat) and for hospitals and diocesan health offices.

Recommendations to Catholic Health Hospitals, Clinics and Health Workers

The above are all examples of Christ sharing the good news with the sick and the crowds that brought them. Today these mean patients and the communities among whom they leave. Having been created in the image of God (Gen. 1:26-27), we as health workers must let patients and communities see that image of Christ in us. Hospitals and clinics need to be seen to be not only as places of high medical professional practices but also as living testimonies of the healing Ministry of Jesus. Health workers can do this by emulating, among others, the above characteristics of Christ's healing practice. The following 13 recommendations are made:

1. The work of evangelization starts with us, the people entrusted with leadership and management of the Catholic health facilities. We need to evangelize ourselves, other leaders and the people we serve by demonstrating good leadership and stewardship in our institutions. Jesus already had authority but decided to earn respect instead of demanding, he demonstrated servant leadership and in fact emphasized the "The greatest among you must be your servant" (Mt 23:11). We are called upon to strive to serve as

leaders but also leave what is entrusted to us better than we found it (1 Pt. 4:10). This means we must put good systems in place so that the institutions shall live beyond us.

2. To do the above we need to get leadership and management positions occupied by people appropriately prepared in knowledge, skills and attitude for the job. This applies to both hospitals and other health related institutions like the medical schools and other training institutions of the Church.

We need to strengthen health leadership and management training in Catholic Universities by making them special, able to impart the kind of attitude required of servant leaders.

3. We need to make a hospital not only a place for consultation and administration of medicine but also a place of prayer and strengthening of faith. Chaplaincy should be strengthened by training both priests and professional health workers as clinical pastoral care givers (thus forming the chaplaincy team), enabling pastoral care to be an integral part of the general care of the patients. In Uganda the Catholic Medical Bureau is at the moment the only organization training people for hospital chaplaincy. It is expensive and difficult to sustain single-banded, but needs to be continued.
4. Catholic Medical Schools or training institutions need to strengthen and integrate ethical teaching and spiritual mentoring into the routine training irrespective of the specialty of training.
5. Leaders and managers need to put a special focus on improving both physical and functional presence of health workers among the patients and their immediate communities whether in times of conflicts or peace, times of economic boom or difficulties. Again this has a lot to do with attitude and work ethics while appreciating that in serving there is the opportunity to give for Jesus himself said "It is more blessed to give than to receive" (Mt.20:35).
6. In addition to the above we can further increase the participation of religious congregations in health care. Religious congregations need to be stimulated to once again become innovative and provide more health care especially outside the traditional systems (hospitals). They should also move into home care and other community-based services that make them take the "face of Jesus" directly to the community.
7. A more human face can be given to patient's care. Technology is fast reducing the doctor-patient interaction. More and more the doctor knows the patient's illness better while knowing the patient less and less. Jesus touched and knew the people He healed. Patient-centered health care that also reflects the social teaching of the Catholic Church needs to be emphasized in training and in practice.
8. As health leaders, managers and health workers, we must be or become defenders of the human dignity and respect for life and without shame, fight against all the crusades that dehumanize the sick and the unborn, for example the pro-abortion campaigns.
9. Catholic health workers should champion the fight for equitable or non-segregative health care that can be accessed by even the poorest of our societies, within the context of the realities of reducing resources and increasing costs to the health facilities. The principle of "distributive justice" especially for basic care should be central in our planning and

provision of care, as well as advocacy actions. But with the economic challenges raging on, this calls for some health care financing innovation even within the church. Partnership with those who have same objectives to serve the population, including governments is one way to go. But we need to be firm on the rules of the partnership game. We also need to explore other probably more sustainable resource mobilization mechanisms within the different country contexts.

10. We should aim to provide quality health care that “markets” itself as exemplified by Jesus’ own healing ministry.
11. Kindness and compassion should become the hallmark of our health care practices. We need to show more love to the people who come to us for care. This requires attitude and practice that should be built both during training and in-service.
12. More attention should be paid to the spiritual and emotional needs of health workers themselves than currently is the case. A sick doctor or nurse cannot administer well to another sick person. We need support in training clinical pastoral care givers in “provider-oriented” pastoral care in order to support the health care providers besides the patients and communities. However, the long-term solution lies in strengthening the foundation of one’s faith. A new evangelization targeting families, creating stronger Catholic families where future health workers will grow might be the solution. Focus should not only be on health workers in the Catholic-founded hospitals, clinics and community-based programs but also outside. For example Catholic health workers, wherever they may be within the country, should be reminded of the duty to evangelize from where they are and assisted to be proud of their identity so as to take care of their own spiritual lives.
13. Health workers, especially those in leadership and management positions, need to move closer to and be present where policy is formulated in the respective countries or at least find ways of influencing policy. Traditionally doctors and other health workers have kept their place in the hospital, fearing to be seen as becoming political. This needs to change. Catholics even outside the health system need to play a stronger role in influencing national health and economic policies. There are policy decisions that sometimes make the health system destructive to the human dignity. Examples include the legalization and procurement of abortion, promotion and distribution of artificial family planning pills, under-funding to the health sector resulting into poor health systems, among others.

Conclusion

The Catholic Church has the mandate to provide health care as a fulfillment of the scripture, thus a continuation of Christ’s spreading the good news through the healing ministry. Health workers are people called to individually and collectively continue this evangelization. In many countries Catholic health care still forms a significant part of the national health care. More needs to be done to evangelize both within the Catholic health care and by Catholics working in government and other non-Catholic health care. Challenges to Catholic health care seem to be world-wide, though to varying extents. More innovation will be needed to help mitigate effects of the challenges faced by Catholic health care in emulating Christ and showing His presence among the sick and

their communities. Health workers themselves need to be evangelized and spiritually supported so that they may evangelize better.

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