

Virtual Mentor

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Medical education

The body and blood of medical school: one student's perspective on Jesuit education

by Jennifer K. Walter

I was not specifically looking for a Catholic institution when I applied to medical school. But after interviewing at Georgetown and meeting the ambassador of admissions, I realized that many of the characteristics I valued in a medical education were championed by the Jesuits. They advocate care of the whole person, recognizing that people are far more than just organ systems and that their religious beliefs are central to their decision making, particularly during illness. The Jesuits acknowledge that the professional role of physicians entails special responsibilities not demanded by other jobs. Not only does this role affect the individual relationship between physician and patient, it also imposes on physicians a responsibility to care for society's vulnerable and forgotten. As I come to the end of my medical training at Georgetown, I reflect on how these and other Catholic themes have been put into practice, both in the explicit curricula of the four years of training and in the informal, but probably more influential, interactions with physicians and residents in the classroom and at the bedside.

One of the most explicit ways Georgetown addresses the centrality of religion to patients' lives is in a second-year course entitled Religious Traditions in Health Care. The class provides students with basic information about the major religions we are likely to encounter and is taught mostly by physician-members of those faiths. The coursework emphasizes how these religious traditions intersect with health care, e.g., the religions' positions on organ donation, pain relief, end-of-life care and blood transfusions. In addition to this specific information, there is an overriding acknowledgement of the importance of religion in people's lives and a caution about the huge oversight we commit when we do not recognize the religious lives of patients and engage this aspect of their care. At Georgetown, time is dedicated specifically to learning how to take a spiritual history. We learned that, surprising as it may be to most medical students, many patients would not feel that their spiritual needs were sufficiently met simply by checking a box on the admissions documents that correctly identified their religious sects.

The extent to which this course affected classmates became apparent a few months later when we were introduced to the clinical world and began practicing how to take a social history from patients in the hospital. Divided into groups of 10 and led by a psychiatrist, we took turns interviewing patients who had agreed to see us. After we completed an interview with one older woman, we filed out of the room to discuss

the student's techniques. The patient had asked the last student in the room if we would stop to say a prayer with her. Because most of us had already left, the final student followed us down the hall and raised the idea to the group. There was a mixture of consternation and concern. Then a fellow student reminded all of us of the religious traditions class and the probable importance to this patient of our participation in her healing through respect for her religious beliefs. Several agnostic and atheist students were hesitant but, upon contemplating the benefit to the patient, agreed that not only was it acceptable to go back and pray with the woman, it was the right thing to do. The concept of caring for a patient as a whole person is not uniquely Catholic, but I believe that Georgetown's being a Catholic institution influenced the extent to which medical students understood the integral role faith plays in our patients' lives.

Respect for patients' and practitioners' religious beliefs was also modeled by several of the physicians with whom I worked. Dr. Edmund Pellegrino taught and practiced the tenet that a patient's spiritual beliefs trump all other values and should be acknowledged by the caregiver of every competent patient. One of the surgeons with whom I worked related the story of a patient who was a Jehovah's Witness and needed life-saving surgery that would most likely require blood transfusions. The surgeon proudly declared his Catholic faith and the fact that he had agreed to perform the risky surgery without using the blood transfusion and had preserved the patient's life while honoring her religious belief.

Respect for the moral boundaries of physicians was also modeled by some of the residents. A senior resident described the comfort he experienced from hearing Dr. Pellegrino's lecture that physicians were not required to perform procedures to which they were morally opposed. The Catholic Church's position regarding contraception and abortion was well known at Georgetown, yet students were exasperated at the unwavering way in which some physicians opposed contraception use, even when its purpose was to curb the HIV epidemic. Some students also argued that the obstetrics residents would not be adequately trained if they did not learn how to perform abortions. Many people in obstetrics distanced themselves from the Catholic position because they found that it constrained their practice, but they still accepted and respected those who chose to remain faithful to the Catholic doctrines. One of the residents, for example, was grateful that he was in a Catholic institution where he could educate his patients about all forms of contraception without being pressured to prescribe the drugs or place intrauterine devices himself.

The Catholic aspect of my medical education that resonated with me most was the commitment to social justice and responsibility to the poor and those with limited access to health care. While Georgetown's hospital is situated in an affluent part of Washington, D.C., and cares for many of the elite in the city, several programs offered by the medical school encourage work in underserved communities throughout the area. The medical school attempts to counteract the limitations of providing care largely for the privileged by training students at partnering hospitals which serve the city's poorest and clinics that accept the city's version of Medicaid.

A sense of responsibility to learn about what it means to be vulnerable and have limited access to care was emphasized throughout my time at Georgetown, from public health projects in my first year to study abroad opportunities in my final year. Several of the physicians I had an opportunity to work with in the public clinics had exceptional commitment to those without ready access to care, and, in addition to raising students' awareness about these issues, they demonstrated what it meant to assume professional responsibility for the entire community—not just the wealthy. The formal curriculum explicitly reinforced concern for the health care of the most vulnerable, e.g., the homeless, and the need to treat these patients no differently than we treat VIPs.

While no one would dispute the claim that there is room for improvement both structurally and individually in our efforts to live up to the promises of the Jesuit tradition, it is clear that many in the medical school believe in these values and attempt to instantiate them.

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