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Health Care of Clergy and Religious

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HEALTH CARE OF CLERGY AND RELIGIOUS

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THE HEALTH of religious is a matter of grave concern to the Church, and more particularly to those religious superiors directly charged with guarding the physical well-being as well as the spiritual growth of individuals in their care. Much emphasis has been placed on plant maintenance, yet little has been done to further the usefulness of our much needed and limited number of religious personnel. Although recent medical advances have resulted in an improvement in the health of religious, a modern health program would further reduce morbidity, and increase the productivity and longevity of religious personnel.

At the request of Reverend John J. Flanagan, S.J., Executive Director of The Catholic Hospital Association, Dr. William J. Egan, President of the National Federation of Catholic Physicians' Guilds, in 1959, appointed a Committee on Medical Care of Religious. Members of this committee are:

Reverend John J. Flanagan, S.J., St. Louis, Mo.
Reverend Marvin Bordelon, Shreveport, La.
Dr. Eusebius J. Murphy, Bronx, New York
Dr. Alice Holoubek, Shreveport, La.
Dr. Francis T. Harrington, Dallas, Tex.
Dr. L. J. Johnston, Dallas, Tex.
Dr. William J. Egan, Brookline, Mass.
Dr. J. T. Nix, Chairman, New Orleans, La.

The committee's scope includes both long-range and immediate objectives, and envisages a pilot study as an initial step in evaluating a standardized and effective health program for religious.

OBJECTIVES

The long-range objectives of the Committee on Health of Clergy and Religious include:

1. National survey on health of clergy and religious with emphasis on:
   a. Disease incidence
   b. Occupational diseases
   c. Community rules
   d. Specific diseases
   e. Overwork
2. Organization of community physicians to obtain pooled experience nationally and cooperation locally.
3. Development of standards for admission as part of a complete record system.
4. Financing of centrally located national office for a modern health program through public health grant. This would provide for the organization of information as well as a statistical and reference library.
5. Supervision of education of each of the following groups to bring their specialties in line with the program:
   Ancillary personnel (infirmarian, dietitian, nurse, technician)
   Community physicians

The immediate objectives of the committee are:

1. Standardization of a preadmission physical with printing and distribution nationally. The form is largely a question and answer type to be filled out by the religious.
2. Establishment of a pilot project, employing the preadmission physical form in selected communities and areas of the United States. It is hoped that the pilot project will make possible the most good for the largest number in the shortest period of time. Furthermore, the experience of community physicians and supervisors in executing the project will prove valuable to correct any defects in the standardized form prior to more widespread distribution. It is hoped that the local Catholic Physicians' Guild in each community will be able to collect necessary statistics to prove the value of the program.

*This preliminary report, presented at the Federation Executive Board Meeting, June 15, 1960, Miami Beach, Florida, was prepared by Dr. Nix, Chairman of the Committee on Medical Care of Clergy and Religious of the National Federation of Catholic Physicians' Guilds and The Catholic Hospital Association.

SUGGESTED HEALTH PROGRAM FOR CLERGY AND RELIGIOUS

In the absence of detailed scientific data and until such facts are available, the following pilot program for an initial physical examination and general directives on health are suggested. Major emphasis is placed on the role of the community physician and the necessity for standardized medical records, kept as a continuous index of the health of each member of a religious community. Consideration is also given to disease prevention and treatment.

Community Physician

The community physician must know the personnel, rules, and customs of the community and must have the confidence and collaboration of the superior. He should, if possible, be an active member of the local Catholic Physicians' Guild. He may be a non-Catholic but should be approved by the Chancellor of the diocese.

Individual members of the clergy and religious should have the right to select either a personal physician or the community physician. In any event, the physician of choice should be approved by the Chancellor. This is particularly important in the selection of psychiatric consultants. The community physician should either perform the preadmission physical examination or pass judgment based on the recommendations and findings of the personal physician. He must play a dual role — sharing the confidence of the patient, yet bound as community physician to submit a sincere opinion to the

superior. He is morally and legally obligated not to share the confidence of the individual religious with the superior without the individual's authorization. He should learn from the industrial physician the economics of illness and the significance of religious hours lost. He should profit from the collected experience of others rather than rely solely on his own judgment.

Upon request he should be allowed to question a religious without another fellow religious present. This is particularly important in psychiatric or emotional disturbances.

Admission Physical

Disease in general among the religious could be considerably reduced if standard admission requirements were used to eliminate those physically or mentally unfit for the strain of religious life. At present each community has different medical requirements, and many have practically none at all. Competent medical opinion could help evaluate the suitability of candidates. However, if requirements too severe and inflexible were adopted, many true vocations might be lost. It is always well to bear in mind that the best medical recommendations can never envisage the efficacy of the grace of God.

Admission requirements for religious life should clarify the mandates of Canon Law, should satisfy the requirements of community rules in the specific religious vocation and reflect the experience and recommendations of the community physicians. Gradation of physical requirements would be necessary, with those for diocesan priests and seminarians the most rigid; as sight, manual dexterity, and vocal inflection are essential for saying Mass and hearing confession. Admission requirements for missionary and contemplative religious life would need special consideration.

Fingerprint and dental data should be filed locally and centrally, to make physical identification of religious possible and identification of religious communities unlikely in the event of a national emergency. The various subspecialties of religious life could be coded by the color of the application sheet and eventually a punch-card system could be used for statistical analysis.

The physical examination portion of the preadmission physical should be performed without charge by either the community physician or the personal physician. However, in deference to possible parental objection, it would seem advisable that the community rather than the individual be responsible for special laboratory studies. In any event, the community superior should make the final decision as to the acceptability of the applicant for religious life. Psychiatric screening would be necessary to decrease the number of breakdowns in religious life. The physical examination should be repeated at the end of the novitiate, prior to entry into full community life.

A standard initial physical examination for clergy and religious has been prepared by the Committee on Health of Clergy and Religious of the National Federation of Catholic Physicians' Guilds and The Catholic Hospital Association and has been printed by the Association's central office in St. Louis. If used as pre-entrance, complete record should be forwarded to the proper religious superior. If used as initial physical examination for priests, brothers, and sisters, this record should be considered *privileged information* and cannot be *communicated* to any religious superior unless specific *permission* is given by the examinee.

Correctible defects requiring surgery should be attended to preferably prior to admission. The Committee on Health of Clergy and Religious considers that surgical correction of the following operable defects would render the candidate eligible for admission:

- Harelip
- Goitre
- Pilonidal cyst
- Fistula in ano
- Cholelithiasis
- Intervertebral disc rupture
- Ruptured meniscus of knee
- Hernia
- Hydrocele
- Undescended testical
- Phimosis
- Uterine prolapse

Admission Standards

Adoption and distribution of a standard physical examination form and analysis of the findings therefrom must naturally precede development of admission standards.

Health Record System

Widespread use of a health record system would furnish data, including a scientific appraisal of the occupational hazards of religious life. The preadmission physical examination would collect all the past medical history of the individual and supplement this with a complete report on current health. This record should be maintained throughout the entire stay of the member in the community and should be kept in triplicate; one copy to the personal or community physician, one copy to the infirmarian, and the third copy to the central office.

Each local station should have an infirmarian trained in medical records. Possibly, a course could be arranged through the facilities of The Catholic Hospital Association. The infirmarian would be responsible to see that tetanus, polio and smallpox immunizations are kept current. Drug sensitivity, as listed in the history, should prevent needless, allergic reactions to penicillin, antitoxin and other drugs.

The community physician, with the authorization of the individual religious, would provide the superior and the infirmarian data on positive laboratory studies, diagnoses, operations, dietary restrictions and the limitation of activity. This could be done by photostating copies of original laboratory reports and, occasionally, by giving a report to be presented as a summary at the time of transfer to a new station. This would provide the new physician with a record of previous diseases and opera-

tions, would facilitate emergency treatment and would avoid useless repetitious and expensive diagnostic tests. The new community would be informed of the capabilities of the individual religious and thus better able to control assignment to full or limited duty.

Disease Prevention

Immunization against the following diseases should be provided:

Tetanus
Typhoid
Diphtheria
Polio
Smallpox

Revaccination should be done when necessary.

Dress

May need to be altered to suit season and climate, with material nonflammable and style nonrestricting.

Diet

Dietitian for each individual station should be trained through the facilities of The Catholic Hospital Association rather than appointed by the community.

Diet should be adequate to prevent:

Avitaminosis
Obesity
Constipation
Food poisoning

Provision should be made for special diets, when indicated, as in diabetes and duodenal ulcer. Some prohibitions should be dispensed with to facilitate the treatment of ulcer cases. Feedings betwen meals and before Communion should be allowed.

Sleep

Rigid rule of seven hours nightly should be mandatory; not subject to the desires or work load of individual religious.

Individual Routine

Proper health habits should be maintained.

Contagion

Precautions should be observed regarding the possibility of contagion from within and without the domiciles of religious life.

Accidents and Accident Prevention

As novices, postulants and seminarians devote much of their recreation time and energy to sports, fractures and accidental injuries are most common. Sports involving bodily contact should be indulged in only when the participants are properly protected and in good physical condition.

Recreation

A daily allotment in fact rather than in name and an annual allotment of one week in addition to retreat should be mandatory. Vacation facilities on a farm or beach, if possible, would be recommended.

Physical Examination

Physical examination every year for personnel over forty to include chest *X-ray, electro-cardiogram, urinalysis* and *hemoglobin*. Emphasis should be placed on weight gain to prevent obesity and on adequate special studies because of the high incidence of cancer. This examination should be repeated prior to advancement to greater responsibility in the community in order that the community protect its investment in superior-executive personnel.

Limited service assignment or compulsory retirement should be applied to personnel upon approval or advice of the community physician.

Treatment

General Principles

The individual religious would have choice of either a personal physician or the community physician. The individual religious should authorize the physician to forward a health report to the superior.

No religious should be allowed to remain in his or her quarters for more than forty-eight hours without seeking medical advice. Prolonged illness should require transfer to the community infirmary or to a hospital.

In matters pertaining to their personal health, superiors should be required to report to a specifically designated member of the community whose recommendations regarding medical care should be accepted as mandatory.

Infirmary Care

Standard floor plans according to purpose of infirmary — *convalescence, rehabilitation, psychiatric* or *geriatric care* with isolation for contagious disease — should be used.

Infirmarian should be trained by local Catholic hospital in emergency routines for treatment of accidental injuries, burns and ingestion of poison.

Hospital Care

Should be provided preferably in Catholic hospital. Provision should be made for insurance coverage in non-nursing communities. Charges should be at a standard reduction rate. Room accommodations should provide privacy and bath. Private rooms would be preferable. In the case of two or more occupants, the other patients should be religious.

Education

Individual religious occasionally resent physical examination and insist on chest auscultation through life habit. Other religious expect supernatural intervention, neglecting the natural means of treatment.

"Heaven is our home" is often the accepted attitude of religious but does not keep teachers in the classroom.

Undue emphasis on religious orders or directives, that warnings and signals of the body are to be ignored or pushed aside, should be discouraged. *Cancer* does not respect the cloister and a ruptured appendix cannot be sublimated.

It is fair to assume that most communities try to maintain a well-balanced ration between physical and spiritual well-being. However, there are a few who believe physical disease should be ignored or endured.

The health of our clergy and religious is a matter deserving seri-

ous study a[nd] more intensive m[e]-
ical resear[ch]. While conclus[ive]
data is not available, it seems s[afe]
to predict that the health of [the]
clergy and religious can best
served by a combination of g[ood]
medical records, adequate care,
interested physician and an al[ert]
superior.

In December, 1959, the Co[m]-
mittee on Medical Care of Cler[gy]
and Religious inaugurated a pi[lot]
project in the dioceses of Loui[si]-
ana. The Catholic Physician
Guilds of Louisiana tailored th[eir]
methods to meet the local situatio[n].
By way of illustration, as northe[rn]
Louisiana is predominantly Prote[s]-
tant, many examinations were do[ne]
by non-Catholic physicians prev[i]-
ously instructed by the committe[e].
Without exception, the respon[se]
of physicians, clergy and religio[us]
alike has been most gratifying.

PILOT PROJECT

Education and Orientation

Our prime motive is to develo[p]
interest in the Health Progra[m]
among the clergy and religious as
well as physicians. Our educa-
tional efforts have included articles
in Catholic newspapers, talks be-
fore Catholic Physicians' Guilds
and hospital groups, and general-
ized distribution of the health rec-
ord form to religious communi-
ties, individual diocesan Chancery
offices, and Catholic physicians.
Future issues of THE LINACRE
QUARTERLY will contain articles
aimed at informing prospective
community physicians regarding
the aspects of religious life affect-
ing medical care. In addition, Dr.
Alice Holoubek of Shreveport pre-

sented the entire program bef[ore]
the International Catholic Doct[ors]
Congress held in Munich dur[ing]
July.

Standard Health Record Syste[m]

The health record of each [re]li-
gious should include a stand[ard]
preadmission physical examina[tion]
form, a physician's report s[heet]
and an immunization and mo[bil]id-
ity card. The physician's re[port]
sheet makes possible rapid [com]m-
unication of essential data t[o] the
superior of the individual relig[ious].
The immunization and morb[idity]
card was designed by the [com]m-
mittee in conjunction with Dr.
Constantine J. Fecher to be [us]ed
both by the pilot project in L[ou]isi-
ana and for his morbidity and
mortality studies on a na[tion]al
level. To date sixteen rel[igi]ous
communities with provinc[ial]ates
locally, representing twenty[-e]ight
hundred clergy and religious have
adopted the health record s[yst]em
for candidates and professed. An-
nual physical examinations since
January, 1960 exceed eigh[t] hun-
dred. In the New Orlean[s] area
alone, eighty Catholic phy[si]cians
have volunteered their serv[ic]es as
community physicians. Th[e] Pro-
gram has the approval [of] the
Bishops of the dioceses.

It is our opinion that the pre-
admission physical and annual
check-up forms should be distinct
and separate entities. As some of
the questions on the form might
be misunderstood by the candidate
or his or her family, the pread-
mission form should be given to
the examining physician rather
than to the candidate. Further-

more, a most urgent, current need
is a method of psychological eval-
uation.

Our committee hopes to have a
revised preadmission physical ex-
amination form and a standard
record system for new applicants
suitable for nationwide use by
December, 1960. In subsequent
years, our initial national effort
will be extended by the addition
of programs and procedures al-
ready tested in the Louisiana pilot
project.

Development of Methods

In New Orleans much thought
has been given to coordinating
Catholic health facilities and pro-
viding channels of communication
between the various segments of
religious and medical life. Com-
mittee consultants have been ap-
pointed in the allied fields of
medical care (nursing, pharmacy,
dentistry, psychiatry, hospital man-
agement and pharmaceutical dis-
tribution) and in paramedical fields
(legal, statistical and clerical).
The local committee embraces all
recognized medical specialties. Af-
filiation with a local Catholic hos-
pital as a research center is in
process of arrangement in order
to obtain grants for research proj-
ects and to finance the Program.
The names of community physi-
cians, prioresses and superiors are
kept current. Additional lists are
being compiled of Catholic physi-
cians training religious and non-
Catholic physicians treating reli-
gious. The provincials of the local
communities are automatically in-
vited to meetings as called.

The constitution and by-laws
of the New Orleans Catholic Phy-
sicians' Guild were not designed
to sponsor and manage efficiently
large projects such as the Health
Program for Clergy and Religious,
along with the Catholic School
Health Program. Arrangements
are being made with local business
men to finance offices with central
filing and permanent personnel
to help administer the Program;
$12,000.00 is to be provided an-
nually.

SUMMARY

To bring consideration of the
Health of Religious Program to
a close for this issue, it can be
stated that effectiveness will be
achieved through the following
regulations set forth by the com-
mittee:

1. The Chancery of the diocese
must be kept informed and its
approval must be secured prior to
the institution of any phase of the
Program. This makes for slower
but safer progress.

2. The individual religious com-
munity is approached through its
community physician.

3. All examinations and all
phases of the program are volun-
tary.

4. Each new procedure is tested
in one community prior to advoca-
tion of its acceptance throughout
a diocese.