Mortality and Morbidity Studies of Religious (A Contribution to National Public Health)

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in Asia. There is a particular lack of Catholic physicians, medical books, and other literature. He stressed the need of help from Catholic physicians who live in more fortunate areas.

**Dr. Decker of Southern Rhodesia**

**THE WORK OF MISSIONARY DOCTORS IN SOUTHERN RHODESIA**

Dr. Decker discussed the work that she and several missionary doctors from Germany are doing. It was interesting to note that although there are several American non-Catholic medical missions in the area, there are no American Catholic medical men or women there.

**Dr. Alice Baker Holoubek, Shreveport, La.**

**HEALTH CARE OF THE CLERGY AND RELIGIOUS**

Dr. Alice described the health care program being sponsored by The Catholic Hospital Association of the United States and Canada and the National Federation of Catholic Physicians' Guilds. The Health Record form was distributed. The paper was well received by the audience.

**Dr. Joe Holoubek, Shreveport, La.**

**ACTIVITIES OF THE NATIONAL FEDERATION OF CATHOLIC PHYSICIANS' GUILD**

This report was published in The Linacre Quarterly, August, 1960. The activities of our Guilds will be a stimulus to those in other countries. Dr. Alturung discussed this paper and stated that he was first introduced to the work of the National Federation during his three years in Boston where he was inspired by the retreats of that Guild. He has since formed a Guild in the Philippines and was chairman of the First Asian Congress of Catholic Physicians.

**Mortality and Morbidity Studies of Religious**

**(A Contribution to National Public Health)**

By Con. J. Fechter, Ph.D.

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The results of the recent study covering a half-century of the health and longevity of nuns should have valuable implications in a nationwide effort to formulate a future health program for religious men and women, in the United States. This study supplemented with further research in the field of morbidity (disability) of both groups will produce statistics on disease, injury and impairment which now have a direct bearing on the well-being of every community measuring its usefulness to God and Country. Studies of this kind can contribute a wealth of knowledge to public health administrators, giving them an accurate appraisal of the extent and character of certain diseases, their distribution, severity trends and influence on eventual death. The value of this information to be gained for the nation as a whole is difficult to estimate. The potentials will be in direct proportion to what can be accomplished in future studies of mortality and morbidity of religious. The administration of any extensive public health service maintained by small or large communities to prevent the spread of disease and to raise the general health level is based upon a detailed body of mortality and morbidity data. With information of this kind on hand a community is in position to evaluate its health needs and to plan specific future health programs accordingly.

**Mortality**

The basic data from which much of our knowledge concerning the health of the population in the past arose from the entries of causes of death or mortality statistics. But mortality data alone fails to provide a complete health picture of a community or of the nation since there are many disabilities that do not terminate in death but do present important health problems. A comprehensive system of morbidity reporting comparable to that of mortality will answer many questions that are now unanswered with respect to certain causes of death.

Little or no definite information in respect to death rates of religious had been available before 1900. Vital statistical studies reflecting mortality of religious orders, nuns and monks, had been made in Europe in the 18th and 19th centuries, by the Frenchman,
Deparcieux in 1746 and George Cornet in Germany in 1883. Deparcieux made a study of the death rate of monks and nuns in 1746 in and about Paris while Cornet limited his group to the Catholic nuns serving hospitals in Germany in the late 19th century. Deparcieux found that the average length of life of these nuns was longer than those of the general population when based on the mortality records of London, Breslau and certain towns in Holland, while that of the monks was similar to the general population. Dr. George Cornet of Berlin about 1883 made an investigation of the mortality of members of Catholic religious houses in Prussia who cared for the sick (Krankenpflegeorden). According to his study entitled, "Ueber Tuberculosis," the major group under investigation were members of Catholic religious nursing orders who ministered to hospitals, the patients of which were mainly sick with tuberculosis. Due to the fact that little was known concerning the bacillus of the disease and much less of its possible contagious characteristics, these nuns became ready victims of this dread disease. The study showed that the tuberculosis death rate of these nursing sisters was exceptionally high as compared to the general population of Germany. He came to the conclusion that a healthy girl entering a sisterhood at seventeen died 21.5 years earlier than her sister belonging to the general population; and that such an inmate in her twenty-fifth year stands in regard to expectation of life in the same class as a female outside at the age of sixty-two.

These adverse health findings of nursing and hospital sisters were applied to the health conditions of all religious communities in England, on the Continent and later to the communities in the United States. Statisticians and writers in the late 19th and early 20th century would invariably point to these century-old figures of Deparcieux and the findings of Cornet to support the contention that the span of life of monks and nuns was much shorter than that of the general population, and mainly due to the peculiar mode of living, namely that of celibacy. It comes as no surprise to find that similar opinions concerning the health of nuns were applied to the many communities of sisters in the United States early in the 20th century.

Let us too might place too much emphasis on the figures of Deparcieux and Cornet to prove a point let us ask ourselves what have been the findings of the recent health study of nuns in the United States? How many years have been added to their life span the past half-century? Can the nun of today expect to live a longer life than her counterpart in the world? Before answering these questions let us analyze the meaning of a mortality table.

The mortality table is a human document, a kind of story of man's efforts to prolong life to its maximum. We well know that biological and sometimes environmental factors set a limit to existence. How does the incidence of certain causes of death contribute to the life or mortality table? On the basis of the table it is possible to ascertain the probability of dying (ratio of number of dying to the number of living) from certain specific causes of death like tuberculosis, or cancer in the past. Comparing these with the probability of dying from the same specific disease as of current date one is able to calculate the average number of years of life that had been gained or lost by the group.

Since the total death rate is the resultant of many contributing causes the question quite naturally arises how many years of potential life are sacrificed to any particular cause of death; conversely, what addition to the average length of life would result if any one particular cause or the sum total of all causes of death could be reduced. A case in point demonstrating this fact can be clearly shown in a recent study made of the group of 90,000 nuns in the United States covering the period from 1900 to 1930 thus showing a decline of over 60% in the tuberculosis death rate. At age 40 a smaller but still important reduction had taken place.

Further investigation of the reduction of all causes of death during the same period showed that the reduction of tuberculosis accounted for more than one-half of the total. How did this reduction in all death rates from 1900 to 1930 increase the average length of life of the sister of age 20? Since the method of measuring the life span applies the actual effects of all death rates upon the total span of life yet to be lived, the reduction in mortality reflects the additional years gained by the young sister of age 20. The study showed that a sister, 20 years old had an even chance of living another 45 years in the 1900 period. Due to the reduction in all causes of death a sister of age 20 living 30 years later could look forward to an average of better than 51 years, an advantage of six additional years. The study further showed that the reduction in the tuberculosis death rate accounted for nearly 60% of this increase.

Thus having learned of the influence of the reduction of certain causes of death upon lengthening the life span in the 30 years, many...
communities of sisters became conscious of introducing definite health programs. The results of their efforts produced further reduction of all causes of death the last twenty-five years. This has added an additional eight years to the life span of the sister of age 20 today. However, a similar reduction in death rates had taken place among the population in general during the same period.

For comparative purposes the white females (married and single) of the United States have been chosen covering the same ages and the three decades, 1930, 1940 and 1950. Figure 1 indicates the number of dying per 100,000 for the two groups at age 20, 30, etc. The upper dotted line represents the death rate of the white females and the lower solid line that of the sisters. The two lines are joined with a distinct shaded area for each decade, demonstrating the difference in death rates of the two groups. It is to be noted that the sisters had decidedly lower death rates at all ages and in all three decades, having the greatest advantage at the younger age groups in the 1940 and 1950 decades. The difference in death rates between these two groups is very striking at age 20 in the 1950 decade (14 per 100,000 for sisters and 70 for white women). Why this advantage of lower death rates of the young novices and newly professed sisters? A few years earlier they, having been members of the white female group, now appear to be a select group, no doubt due to some process of screening. The advantage of lower mortality of sisters is still lived for within the first ten and twenty years of communal life much of the advantage of the lower death rates disappears. What it does account for the apparent increased death rate of the nuns in early communal life? Some of them are quite obvious; others are as yet to the point of specification. The significant thing about uncovering this increased mortality experience of the sisters in the early years of communal life is the light that it throws on the area in which further life extension is possible. This fact alone confirms the importance and value of collecting vital statistics on this group of nuns. It is true that the study uncovered a number of highly interesting and even surprising situations with respect to the increased longevity of nuns. Perhaps the greatest was the fact that the nun of today has the advantage of living three years longer than her counter-part in the lay world. These findings were substantiated by those of Rev. Francis C. Madigan, S.J., in his "Health Study of Religious" in 1957.

MORBIDITY

What is it and what is its purpose? Life tables which had been considered above were based on mortality observations, that is, causes of death and their influence on longevity of approximately 90,000 nuns. This group consisted of persons in all states of health and of three or four varied occupations. Some of them were and

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are now fortunate enough to be in excellent physical condition. The majority are in what might be described as ordinary good health. But as one would find in the general population there is a sizeable contingent of nuns, some in the younger and middle-age groups and especially among the older-age group with impairments of a more or less lasting character. These disabilities include acute and chronic diseases and other conditions which have proved to be a handicap to longevity. It has often been said that every individual is subject to a continuous scale of well-being extending from the best of health to severe sickness. A collection of statistics on disease, injury, impairment, disability or any morbid condition would be classed as morbidity data.

Many morbid (sickness and accidental) conditions present important health problems to the individual and to the community. A prime example is the common cold with its severity and its influence on later chronic ailments resulting many times in an early death. In many instances, tuberculosis, heart disease, cancer and diabetes have forerunners of many times in an early death. In many instances, tuberculosis, heart disease, cancer and diabetes have forerunners of many times in an early death. In many instances, tuberculosis, heart disease, cancer and diabetes have forerunners of many times in an early death. In many instances, tuberculosis, heart disease, cancer and diabetes have forerunners of many times in an early death.

A tremendous interest has been engendered in the health of religious in recent years. The Catholic Hospital Association and the Catholic Physicians’ Guilds have organized a Committee on Medical Care of Clergy and Religious. Doctor James T. Nix, chairman of the committee states that the aim of the committee 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.

The immediate objective is a standard health record system which should include a standard pre-admission examination form, a “Medical Identification Card.” The pre-entrance standard examination form adopted by the committee will be offered to all religious communities in time and will provide all information of past medical history, hereditary as well as individual impairments of each member at admission into the community. The disadvantage of data from health examination given only once is that it cannot provide diagnosis of the many disability conditions which require repeated and continuing observations and tests before they can be identified. It is necessary to supplement this data, therefore, with a record system of current disabilities and certain medical screenings of each member after being admitted into the community. Figure 2 below, known as a “Medical Identification Card” will provide this information for each member while in the community. Duplicate cards for every member of a community should be provided for each respective house (clergy and religious), one card to be kept in the possession of the member and the other card in the files of the Superior.

The face of the Medical Identification Card has been so devised to provide information on immunization, laboratory studies, diagnoses, operations, dietary restrictions and other medical findings. These measures may be performed either by the community infirmary or by physician at periodic intervals or when necessary. They will aid in early detection of severe acute or chronic disabilities. Immunization and drug sensitivity will be listed to avoid the possibility of severe allergic reactions.
The reverse side of the card will carry a record of current disabilities, chronologically recorded with respect to condition, its severity, duration and result.

Acute conditions will be classified according to the International Classification of Diseases, 1957 Revision. An acute condition is generally defined as a condition which has lasted less than 3 months and at least for one day. All minor acute conditions involving neither restricted activity nor medical attention are excluded from the report. A morbidity or simply a condition as qualified above is to be entered upon the card by the attending physician or nurse or by the Superior of the house. Each condition would be recorded according to a number of criteria: such as type of disease, injury, symptom, number of days confined to house or bed, number of physician’s visits, description of operation if performed, if accident part of body and how, and type of dental service.

A condition would be considered chronic if it is classified as one of the chronic diseases on the “Check List of Chronic Conditions & Impairments” and that the condition has lasted longer than 3 months. It would be recorded on the medical identification card according to a limited criteria; type of condition, whether patient is inactive or immobile to the extent of 50 or 100%, and number of visits of physician in a given period of time of from 3 to 12 months.

When physical examinations are uniformly carried out, the data supplemented with that on the Medical Identification Card will provide a wealth of medical information for the individual sister or priest, and for the Superior and those interested in the member’s well-being. Those in authority will be able to evaluate and recognize the physical and mental limitations of the member. It will be most valuable to the new physician who will be fully cognizant of previous conditions, diseases and operations. It will aid him in diagnosing the case quickly, efficiently and avoid duplicated and unnecessary diagnostic tests. For the nation it will be of great value. It has been stated by noted authorities of the U.S. Public Health Service that the national surveys made to date cannot meet all of the most pressing needs for morbidity statistics unless they are supplemented by data from physical examinations. Furthermore, they admit that it is nearly impossible to have a controlled group of the population of which morbidity data from both physical examinations and current disabilities may be obtained.

A morbidity study of religious as proposed by the Committee on Medical Care of Clergy and Religious will be the first step in accomplishing its immediate objectives. The recent mortality study of nuns has shown definite areas were further lengthening of life is possible, thereby increasing the productivity and longevity of religious personnel. A comprehensive study of morbidity conditions in these areas for the next five or more years would give the religious Superiors, the Hierarchy, the medical profession and all operating health agencies an accurate appraisal of the extent and character of diseases and disabilities in these areas. This data would show distribution of trends of morbidity which are so essential to evaluate the health needs of any community and to plan specific future health programs.