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Seminar on Medical Care of Religious

Catholic Physicians' Guilds

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be allowed to fulfill the capital sentence in this way.

This type of proposal has received rather wide publicity in recent years, particularly under the impetus of J. Kevorkian, M.D. He does not take a stand for or against capital punishment but writes: "as long as capital punishment is in effect, and whenever it is in effect, there is a far more humane, profitable and sensible way to implement it."4

The moral issues involved here might be summed up as follows: The state does have the right, under certain conditions, to impose capital punishment and to implement it by those methods which are designed to achieve its punitive and exemplary-deterrent objectives without exceeding the bounds imposed by a proper sense of human decency. One such accepted method: the gas chamber, does approximate the concept of execution by terminal anesthesia. In this context it would seem that the state could, at the request of the condemned, officially decree execution under deep anesthesia, culminating in decapitation, if not in the expedient itself.

This view, however, is presented as theoretical rather than practical. There is a general human integrity in the medical profession participating in the public execution of criminals, even in the extent of being appointed as executioners, notwithstanding the fact that this would be in the interest of clinical research. Moreover, the concept of prolonging the terminal anesthesia for days or weeks as the experiment progresses, and the even subconscious overtones of the ideal human guinea pig situation realized in the person of a condemned criminal, would scarcely be without the danger of a deleterious, materialistic and dehumanizing influence on the research team, and the community itself. Thus, although what is done and why it is done might be morally defensible, the circumstances necessarily concomitant to the doing of it lead us to regard the act as morally unacceptable.


Seminar on Medical Care of Religious

Note: A Seminar on Medical Care of Religious in the Archdiocese of Chicago was held at Holy Family Hospital, Des Plaines, Illinois on November 16, 1965. Charles W. Pfister, M.D., President of the Chicago Catholic Physicians' Guild at that time, opened and Dr. Philip Sheridan moderated a most interesting panel discussion. The meeting is reported as recorded.

Dr. Charles W. Pfister: We are happy to welcome you all to our round table discussion on Medical Care of the Religious.

Dr. Philip Sheridan: We are happy to welcome you all to our round table discussion on Medical Care of the Religious in the Chicago Archdiocese sponsored by the Catholic Physicians' Guild of Chicago. Our audience of priests, nuns and doctors is not gathered by accident. We are here because of common interest.

I may at this time, I wish to introduce the results of a survey of the medical status of the women religious in the United States. This may help us to get to the root of the problem that exists today in medical care of the religious, not only in the Chicago area, but certainly throughout the United States. Dr. James T. Schmitz, President of Holy Family Hospital, Des Plaines, Illinois, completed a survey of the medical inventory of the women religious, and came up with some rather startling conclusions, which I will read to you. They are five in number.

First: Health education and health counseling, periodic health examinations and health records are either non-existent or inadequate.

Second: Psychological screening as a part of the pre-admission examination is the exception rather than the rule.

Third: Overwork is the rule rather than the exception, and commonly retreats and conventions are considered as being synonymous with vacations.

Fourth: Half of community infirmarys have no nursing training. I think this is probably too high, and probably more in the order of 1/8 to 1/5 have no training.

Fifth: In two-thirds of religious communities there is no hospital insurance.

With these few ideas in mind, and I hope you will keep them well in mind, I will begin by calling on various members of the panel, after which we will throw the meeting open for discussion. I hope you will all enter into the discussion.

We certainly don't propose to give you hard and fast rules as to how to run your community. Our purpose is to give you some fairly definite ideas as to how medical care within the Archdiocese of Chicago can be definitely upgraded.

To begin, Dr. Robert L. Schmitz, who is attending surgeon at Cook County Hospital, and at Mercy Hospital, will speak on his experiences in overseeing the total health care of a community of sisters in the Chicago area, in addition to reporting on a study of the health insurance needs of this community.
Sixth, their daily lives are usually devoid of exercise and physical exertion and they are, therefore, prone to degenerative diseases, especially of the cardiovascular and musculoskeletal systems.

Seventh, they are perhaps more prone, under certain circumstances, to emotional illness and less able to overcome it because of limitation of outlets, and

Eighth, in spite of much professional courtesy extended to them, their medical care can reach only astronomical proportions, and can be a serious problem to the treasury of their Orders.

Because of one or more of these factors, it is not uncommon to first see a nun or priest with an advanced illness, not possibly amenable to any curative therapy which could easily have been curative if he or she had come in earlier.

What can be done to improve matters? There would seem to be four major needs:

1. Instruction in the essentials of hygiene.
2. A program of regular exercise.
3. Periodic health check-ups, and
4. Some type of insurance to cut the costs of hospitalization and medical care.

Religious Orders should provide instruction in the essentials of health care during the schooling of nuns, priests, and brothers. The time would be well invested. In "postgraduate life," religious could be addressed from time to time by physicians or panels of physicians in matters of dental, medical and emotional well-being. An important part of such programs should be a question and answer period.

The Catholic Physicians' Guild has played a very significant role. If the religious could be accepted in large enough numbers, the logistics should not be unmanageable.

The daily life of a religious is, in most instances, a well-ordered routine with a recreation period included. Why not during 15 minutes of the recreation period have organized calisthenics such as the Canadian Air Force Exercises? If this were adopted in the early ages, it could be continued for all, until some contraindication arose. Priests and brothers living more or less alone should work such a program into their daily schedules. The benefits would be considerable. The Canadian Air Force Exercises include movement and stretching of major muscles and joints, as well as stationary running to condition the cardiovascular-pulmonary mechanism. One fault of isometric exercises is lack of such conditioning. Emphasis should be on range of motion and exertion rather than on muscle building.

The program of regular proper health care is a more difficult one. A few individual religious manage this through their own good sense and efforts. A few Orders (the Franciscans, the Dominicans, and perhaps others) arrange for their members to have annual check-ups with physicians of their own choosing. In at least one diocese, St. Louis, such opportunities are open to all religious at a clinical facility set up for this purpose in one of the hospitals, but the vast majority are without any good way to arrange for such care, and just stumble along as best they can.

I am well aware of the arguments for and against periodic health examinations, but as a physician with a modest experience in cancer detection examinations, I am convinced that in this one disease alone the benefits justify the expenditure of time and money. If we could apply early enough in the course of this disease even such prevention and treatment as we already have available, we could improve the five-year survival rates in the six major types of cancer:

- From 40% in breast cancer to 80%.
- From 5% in lung cancer to 75%.
- From 40% in colon cancer to 75%.
- From 40% in cervical cancer to 95%.
- From 35% in oral cancer to 80%, and
- From 65% in skin cancer to 95%.

In this problem, again, the Catholic Physicians' Guild could do much to help. The solution is not clear, but several possibilities have been suggested:

1. A clinical set-up with volunteer help to which the religious could come for complete physical check-up and advice.
2. A listing of doctors who would volunteer some time in their offices per day or week or month for such examinations.
3. A modest salary might be paid to such physicians by Orders to
also; for a year the author has been a member of such a committee. The Catholic Physicians' Guild of Chicago has had a committee of doctors studying this problem, and so far our efforts have yielded very little of value.

This amounts to about $1,200 per nun. It is easy to see that such expenditures can bankrupt an Order.

Drugs and Equipment

Laboratory and X-rays (outside of hospitals)

Doctor's Fees (incl. Dent.)

Hospitalization

= 45; 60 to 69

= 44; 50 to 59

Total

= 39; 70 to 79

= 44; 60 to 49

= 38; 80 to 79

= 45; 70 to 89

= 37; 90 and over

= 27; 20 to 29

= 28; 30 to 39

= 27; 40 to 49

= 27; 50 to 59

= 27; 60 to 69

= 27; 70 to 79

= 27; 80 to 89

= 27; 90 to 99

= 27; 100 and over

Taking this up the coverage it quoted a rate five times as high, probably to show no preference. Again, in an archdiocesan wide coverage in the Pittsburgh area the cost has exceeded the premiums each year for three years by a large sum, and, therefore, the premiums have gone up significantly annually.

One insurance expert wrote our committee as follows: "I have explored the Lloyd's of London and all of the quality domestic companies in this field and have been unable to interest any of them in underwriting this particular group. I assure you that we have left no stone unturned in this effort."

If we get any offer at all it was apt to be exorbitantly high, apparently with the object of discouraging us.

A business executive wrote when discussing the report of his agent: "The second copy of letter written by the manager of our Insurance Department is self-explanatory. I believe that he has covered the situation adequately, and from his standpoint, would be willing to help in any way possible. Am just a little staggered at the total bill that would be involved in securing the coverage for the entire community."

The best offers we received ran from $35,000 to $40,000 per year for the community whose expenses ran $40,000, and all offers involved various deductions such as the first $100 of expense or payment of only a percentage of total cost.

We might examine one offer in detail. The medical plan, commonly referred to as a comprehensive major medical plan, will cover all types of medical charges including the full cost of semi-private room; other miscellaneous hospital charges; doctors' and surgeons' fees, including home, office or hospital calls; and prescribed drugs, dressings, or equipment purchased or rented from the local pharmacy or medical supply house used in the treatment of a given disability. The cost of a private nurse would be included unless the private nursing service is rendered by a nun. The proposed plan contemplates a $100 deductible for all medical expenses accumulated over a period of six consecutive months or less. The balance of all medical charges after the first $100 has been expended would be reimbursed at 80% for the balance of the calendar year. The maximum lifetime benefit under this plan would be $10,000 of reimbursed medical charges. The estimated cost of the comprehensive major medical plan would be approximately $7.50 per month per nun. Naturally the rate indicated is an estimate based on the current rate structure used by (blank blank) and assuming an average age of approximately 45.

"In addition to the medical plan, (blank blank) is requiring that $2,500 of group term life insurance be purchased for each sister. You may find that a greater amount may be needed when the training and replacement cost of a deceased nun is contemplated. The actual cost of the $2,500 insurance can only be estimated, as the final cost would be based on the age of the persons insured under Illinois insurance law. A reasonable estimate for the full amount would be approximately $1.80 per month per sister."

LINACRE QUARTERLY

Mar., 1966
A little arithmetic will show that the premium for the medical plan runs about $30,000 per year, and for the term life insurance a little over $7,000 per year, and this with the deductibles mentioned in the quotation. Remember also that these figures and would be raised promptly if the company felt the need. So we see that the problem is far from solved.

In further deliberations, one must consider the size of the community to be insured. The larger the community the better. Therefore, it would seem desirable to lump together all provinces of an Order on a national basis or to use local geographic boundaries and lump together all religious in a diocese or archdiocese. If these groups are too cumbersome to administer and lump together all religious on a diocese or archdiocese, it would seem desirable to lump together all provinces of an Order on a national basis or to use local geographic boundaries and lump together all religious in a diocese or archdiocese. If these groups are too cumbersome to administer and lump together all religious in a diocese or archdiocese.

Orders could help their own causes by building infirmaries and training enough nurses and practical nurses to care for their sick and aged. Such hospital stays could be shortened and perhaps those over 65 could be excluded from insurance coverage. Workmen's compensation insurance can be obtained and has been applied to working religious such as teachers, but, of course, it applies only to accidents or illness which result at or from work.

Social Security and Medicare will apply to many religious over 65 years of age effective January 1, 1967. However, members of communities subject to the law of poverty are excluded from participation under the provisions of the Social Security Act. They may, however, participate in Part B of Medicare under the Voluntary Supplementary Medical Insurance by paying a monthly premium of $3 which the government will match with $3. Such insurance may be of great value in caring for older religious and make the under 65 group much more desirable risk.

Since ordinary hospitalization and medical care insurance is not available at an acceptable cost, other types of coverage should be considered.

Self insurance is one possibility, but it might be difficult for an Order to accumulate enough principal to make this feasible.

Group life insurance could be used to defray funeral and burial expenses and leave a residue that might grow into a significant principal.

Major medical insurance could be obtained to cover when expenses exceed $300, $750, or $1,000, and perhaps premiums on such coverage would be manageable.

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It would seem there has been enough discussion and investigation into the general problems of health care of the religious. What we need now is a concerted effort on a large scale by people with experience in the matter to outline a plan of attack and see that it is fulfilled.

DR. SHERIDAN: Thank you, Dr. Schmitz. You certainly touched on a number of pertinent points. Two
community is far less tolerant of deviant behavior, plus the high aspirations of the religious and the danger of scandal to others.

Sixty-three per cent of the religious patients came from the lower socio-economic group as compared to 39% of lay patients. This may be due to the fact that the religious have more problems adjusting to the professional status which comes to them through the mere fact of religious profession. There was also a lower scholastic level of the religious than the lay patients.

Among the nuns, sisters with late vocations had a greater frequency of psychiatric disorders. This may be due to the fact that being older they are less flexible and probably in the past were unable to make adjustments in their lay life.

The religious often had an attitude that they were forced to come to the hospital as a form of punishment and many were actually not referred by physicians. The lay patients were better motivated for therapy. It was also found that the religious had longer hospital stays. This possibly is accounted for by the fact that the medical staff would have higher standards for the religious group out of respect for their position, plus the financial burden to the lay patients was a factor which did not affect the religious in the same way.

Their conclusions were that psychiatric evaluation and treatment of religious candidates could do much to relieve the unhappiness that results from a commitment that creates conflicts. Healthier attitudes toward psychiatry on the part of the religious superiors could do much to relieve the guilt and scorn incited by those who had such care.

The following is a summary of my experiences in treating Catholic religious on in-patient basis. It is not an attempt to provide a detailed study of the various factors that relate to the presenting disorders. It is merely an accounting of what went on.

I reviewed the records of 40 sisters who had been referred to the office. It was found that the majority were in the age group of 40 to 60. The age group of 40 to 60 comprised 15 nuns, 60 and over comprised 8 nuns; age 30 to 40 comprised 7 nuns, age 20 to 30 comprised 7 nuns. Many of the sisters had been in the order for at least 20 years or more. There was no one particular Order represented, since there was a sprinkling of at least eight different religious communities. The most common presenting complaint was a disturbance on the somatic area. The diagnoses ranged as follows: Anxiety reaction, 13 patients; depressive reaction, 4; conversion reaction, 2; involutional depression, 3; paranoid schizophrenia, 8; alcoholism, 1; drug addiction, 4; chronic brain syndrome, 5. The interesting thing was that no phobics or obsessive compulsives were encountered, a diagnostic category which is common among the lay patients, especially the phobic group. The majority of the sisters were referred by the Order itself, only 8 of the group were referred by physicians and only 2 self-referred. The majority of the sisters felt that they were forced to make the visit and were not motivated for any sort of psychiatric care. As a result, the majority of the group made one or two visits. It was a common finding that a request was made for a written report or else a companion came with the sister who wished to discuss her particular problem. I suspect that the problem with confidence had some bearing on the motivation and subsequent course.

In the sisters who remained in therapy, a common statement and finding of theirs was that they felt rejected, received no understanding, plus implications were made that they were gold-bricking. There was also reported by some of the patients concern of the superiors who did not want everything to be revealed about the functioning of their house. It was especially difficult for the chronically ill psychotic. The sisters who were 60 years or over had the usual problems of old people of finding a place in their particular home and community.

The next group treated were the priests who comprised a smaller outpatient group. The priests were usually self-referrals or referred by doctors. As a result, their motivation for therapy was considerably better than was found among the sisters. The priest would usually come with his visits until treatment was terminated. The problem about confidentiality with the priests was easily settled, probably because of the priests' customary use of this method. The diagnostic categories were a sprinkling of the usual groups that are seen among male lay patients.

The four sisters with drug addiction had a long history of somatic complaints with multiple surgical procedures with eventual habituation to drugs and finally, after all somatic possibilities were exhausted, they were referred on for psychiatric care. I would suspect that somatizations among the religious would be a much more acceptable route than the other neurotic forms which are seen among the lay group. It is difficult to visualize how a phobic or obsessive compulsive could exist in any religious community.

A large problem with motivation presented above perhaps might be eliminated if the referrals were more carefully done and explanations made by a medical source. Perhaps the lack of financial responsibility for treatment may have some bearing on the lack of involvement in the therapeutic process. Tolerance and dissemination of information on psychiatric disorders might be helpful in alleviating the difficulties with acceptance that the ill sisters find in living in their particular community. I suspect also that it must be done for some of the religious patients to differentiate between problems which are spiritual and psychological, and whether their particular kind of help should come from a priest or a doctor. It is true that it would take a person who is familiar with the principles of religious life in order to make any attempt to deal with this group. Any good doctor could take care of the religious group as such, but I do not
believe he could do so without accepting these principles.

DR. SHERIDAN: Thank you, Dr. Maslanka. Your remarks were directed primarily to out-patient care of the religious and do not take into consideration the hospitalization of individuals with mental aberrations which require inpatient care. Would you care to say something about your impression of the incidence of mental illness? Is it true that the incidence of psychosomatic illness among the religious is about the same as in the average population?

DR. MASLANKA: No. I would say from my own personal observations it seems to be considerably lower. That is, the religious hold out better than the average lay person does.

DR. SHERIDAN: We will now hear from Dr. Robert Lappe of Holy Family Hospital, who is in a unique position of overseeing the medical care of a group of religious, that is, priests. He will relate his experiences in taking care of this group.

In the past Dr. Pfister and I have accepted medical responsibility for a small community of teaching priests. Our objective has been to offer to a member of the community the opportunity for a complete medical evaluation once a year, or more often if indicated.

The medical evaluation of these 44 or 48 priests is accomplished on the initial visit. There is a complete history, physical examination, urinalysis, blood count and EKG. This requires the best part of one hour. These gentlemen are then reevaluated at the next office visit, and, if necessary, more information secured in order to come to some conclusions as to the presence or absence of disease.

Some of the recent problems seen in the members of this small community include the following: malignancies, including leukemia; arteriosclerosis; generalized peripheral vascular disease—both arterial and venous; chronic bronchitis and emphysema; other pulmonary diseases; arthritis and rheumatoid states, including degenerative arthritis and "slipped disk"; arteriosclerotic heart disease, compensated and uncompensated, with or without high blood pressure; a variety of disease states of the kidney; and under active thyroids, including one case of myxedematous heart disease, which is rare, complicated with severe thrombocytopenic purpura, possibly related to amphetamine habituation; there was one emergency colostomy for acute perforation of the colon in a 29 year old man; a number had nutritional skin disease. Indeed, the whole spectrum of disease states, usual and unusual, is harbored by this small religious community, and would remain undiscovered until too late if an active approach to ferret out these problems was made by a physician.

We have been left with a number of impressions and even prejudices. For the latter I alone assume responsibility. There is no doubt in my mind that the clergy, particularly those sequestered, direly needs periodic health examinations, quite similar to those done for business executives and captains of industry. The analogy is obvious. Surprisingly, some of these men accept our medical consultation in an undisciplined fashion. There are many who drink too much, smoke too much, think too much—and still do; on occasion of the next visit the priest or the nun wants to see the "other doctor," who may not be "so hard on him." In the past fortnight we recommended to one man that he retire from active teaching because of a progressive cerebrovascular state with impaired cerebral function. His superior was grateful to us for this advice because the superior had already recognized the man's flagging teaching efforts. The superior could not bring himself to relieve the man of his duties. The priest, however, cannot or will not accept this, and he plans on returning to his classroom following further convalescence, much to the consternation of his superior and to the detriment of his teaching schedule. Some of the parents will resent this if they think their children are receiving a truncated educational experience from an incapacitated old man.

In summary, we find that clerics are just like people: they become sick in body and soul. They need medical attention. Better still, they need prophylactic medical care so that incipient disease may be dealt with long before the clergy person is prematurely incapacitated. The clergy is in short supply. Let's keep them around for a while.

DR. SHERIDAN: Thank you, Dr. Lappe. Your remarks about the clergy being in short supply and the value of preventive medicine seems to mind a short notation in the journal put out by Dr. Nix relative to medical care recommended in a few areas of preventive medicine, which he feels might add on the average of up to five years in general to the life of every member. If we have a community of 2,000 sisters and could add five years to the life of each member, we would gain 10,000 years. On the basis of 40 useful years of life for every vocation, that community would gain 200 new vocations. This is one of the significant factors which comes to light.

Sister Mary Felicia, sister of the Order of the Holy Family of Nazareth, is Health Director of the Sacred Heart Province in Illinois, Wisconsin and Indiana. There are roughly 600 members. She has been director of the program for four years in Wisconsin and Indiana.
years, and it has been in existence in the Province since 1958. Sister Felicia will discuss the problems encountered in overseeing the health care of the religious, that is the medical care and the broad activities in the Province of the Holy Family of Nazareth.

SISTER MARY FELICIA: When I was asked to discuss the sisters’ health program before such a distinguished audience, I shuddered at first, but gladly consented to do so. For days and weeks I thought of just how I would do this in a limited time. Since my topic is to deal with the development and function of the health program for our congregation, I find it appropriate to give my theme some type of introduction.

Aside from the general introduction, the following highlights will be presented: A cumulative health record, infirmarians, convent physicians, the first preventive and active programs, yearly physical examinations and follow-up, educational and mental health programs, and, finally, general problems encountered and what has been done to solve them.

At this time, the question may arise, “When did the Health Care Program for Religious originate?” The Church, confronted with a critical shortage of Sisters, suggested a unified action in regard to a health program for religious in the United States effected through the Catholic hospitals and centrally directed nationwide participation. Since the Catholic Hospital Association was asked to implement such a program, the assistance of the National Federation of Catholic Physicians’ Guilds was sought. In 1959, Father Flanagan, Executive Director of the Catholic Hospital Association, and Dr. William Walsh, President of the National Federation of Physicians’ Guilds, appointed a central committee on the medical care of the religious and care for the purpose of setting up a modern health program. This committee placed on reduction in mortality and an increase in productivity and longevity of religious personnel. The first action of the central committee was to appraise the health of individual members of the religious community through the first of the physical examination. The committee then set up a standard program of health care programs under the auspices of religious superiors.

It would be difficult to find a period in history in which the need for leadership in health is more urgent than in our time. The sister of today, as you may know, is under mental pressure because of insufficient time to fulfill the heavy requirements of the apostolate and the numerous obligations of the religious state. Naturally, the adverse health consequences of a lack of time result in tensions, frustrations, aggressions, curtness and a sense of failure in completing the spiritual as well as the mental and physical demands. Those who are aware of the existing problems for health purposes, encourage improvement and change. Pope Pius XII, Pope John XXIII, and Pope Paul VI have stressed the need for adaptation to the needs of the present day, for modernization of religious communities, and for development of the sisters’ high potential.

Indeed, amazing progress has been made in personnel management in Catholic hospitals due to a combination of the influence of the National Catholic Hospital Association, the growing number of hospital administrators. Secular employees are trained to 40 hours a week. They are given fringe benefits, including vacations, sick leave, legal holidays, annual physical examinations, immunizations, continuing education, retirement, hospitalization, and in-service education. The unfounded basis of better adjusted employees, higher morale, a sense of security, better health — mental and physical — and, eventually, better patient care. Sensibly comparable progress has not been made in the religious sector.

Sister M. Gerald, CSC., at one time administrator of the Holy Cross Hospital in Salt Lake City, Utah, has this to say. I quote:

“Sisters are human beings, too. What is good for the mental and physical health of a secular employee is good for the sister. A well-adjusted, healthy, professiona l and competent sister will be a religious whose influence for good can change much in this world of ours. The influence can be incalculable. On the one hand, a sister who lives and works under a spirit of prayer, a sister who is at peace with God, with her neighbor or with herself, can pierce down the work of the Church and inspire the efforts of the other religious. I should like to see the health care of the sisters as real an obligation on the part of the superiors as is the responsibility of providing clothing and food. Teaching sisters should not become charity patients when they enter a hospital. Superiors should not expect the local citizens, through the hospital, to underwrite the health program of the religious congregation. Instead, superior should encourage bishops and pastors to provide health insurance for teaching sisters. If they are unsuccessful, however, superiors should undertake this responsibility themselves.”

I am assuming that this background material which I have presented will help explain earlier and later developments in the field of medical and surgical care in our congregation. The emphasis by the Catholic Hospital Association is the demand for a well-formulated health program by every community in cooperation with the hierarchy of the Church, and perhaps, the natural motherly concern for the conservation of the religious’ health, led Mother M. Aloysius, former Provincial Superior, in the summer of 1958, to investigate the health needs of her community and to find out how much illness existed among the sisters. To this effect, a survey was conducted upon a firm decision to establish, organize, and implement a future health program to include the Sisters of the Holy Family of Nazareth in the Chicago area and vicinity. This included Wisconsin, Indiana, and at that time, areas of Texas and New Mexico.

This survey was begun by taking a complete history, including present complaints and past medical and surgical histories. After a system review was made, it was followed by a complete physical examination. Each sister had her weight, pulse, and blood pressure taken and re-
corded. For the initial work, Mother Aloysius engaged a competent female physician and two registered nurses. Totally, 650 sisters were examined. Though a simple record was used, this record served well when one of the 650 sisters called to report a problem or to seek advice. Afterwards, a composite of major health problems was made, indicating the number of sisters having each condition, with management and comments.

A year and a half later, all of the previous findings were investigated and tested, the second survey was in order for August, 1960, which Mother M. Getulia, the next Provincial, so gladly recommended. In addition to routine eye and routine lab tests, it was decided that an EKG should be done for all sisters over 45, a Pap smear on all sisters over 40, and more thorough examinations of the legs and feet, with proper referrals for surgery, supports, or shoes when indicated.

In 1962, Mother Getulia furthered the advancement of this health program by doing her utmost to comply with the requests and demands of the central health committee. To this end, a medical director known as the community physician, was employed for the entire Province.

In 1963, a central office under the name of the Sisters Health Service had been established at St. Mary of Nazareth Hospital to provide a better communication system and where all official health records, various reports, etc. are kept in strict confidence.

Next under consideration was the selection of 30 sister-infirmarians—one for each convent, with formal training in the nursing which included basic instruction in bedside care, tray service, temperature and blood pressure readings. For proper care and health instruction, each infirmanarin is in possession of a Health Manual. The infirmanarin acts as an intermediary between the physician and health director. She is the chief writing sisters and helps those who continue their recovery at home after surgery or acute illness rather than prolonging their hospital stay unnecessarily.

Fortunately, there is a full-time registered nurse in the Provincial house who not only exercises professional care toward the individual patient, but also teaches home nursing and first aid to the junior professed sisters, novices and postulants.

Part of the function of the health program was the choice of a regular physician for each convent, whereby a sick sister could turn to diagnosis, treatment, care, advice and help. Preference was given to the physicians on the hospital staff and to those whose office was closest to the convent, provided these doctors actually cared to give the sisters medical care. Preference for a certain doctor, if desirable and necessary, was honored when requested. Remuneration for services rendered remained with the doctor's decision.

Since sickness is, to a large degree, preventable, as a part of the preventive health program, the following measures were undertaken:

1. For sisters under 35, a regular physical examination is desirable every two years. For those age 35 and over, a routine annual check-up is required, including cancer detection examinations. A sister is encouraged rather than forced to undergo physical. Any sister who is admitted to the hospital is automatically included from a routine physical examination.

2. Routine laboratory tests including urinalysis and a complete blood count are done. Other diagnostic tests are made, depending on what the doctor finds on physical examination and the history given.

3. An electrocardiogram is made when the doctor considers it desirable.

4. A chest x-ray is done yearly on all sisters at the time of the retreat at the Mother House.

5. For sisters age 65 and over, for known cardiacls, diabetes, and other serious conditions, a positive Mantoux test (for tuberculosis), a chest x-ray is taken and repeated in six months.

6. Periodic dental, ear, and eye check-ups are also in order.

7. Also keeping tab on the appetite IQ, that is, cutting down on calories in order to reach or maintain normal weight is stressed. The consumption of proteins, vegetables, and fruit and the avoidance of refined foods are suggested, and ways to balance exercise, rest, and relaxation are recommended. Overweight has proved to be a potential threat to health and longevity and is closely connected with specific health hazards such as heart and circulatory disorders, diabetes, and a host of daily discomforts. Prevention is the best answer. Life is much easier in many ways for people who are not too fat. They feel and look better, they are less likely to suffer from backaches, foot troubles and constant fatigue. Normal weight is worth the effort it takes to reach and keep.

Another important phase of the health program is to see that the sisters receive necessary immunizations against preventable and communicable diseases. During the past two years, the screening program for tuberculosis and the immunization program against smallpox, diphtheria, tetanus, and polio were carried out with the full cooperation and authorization of Dr. Edward Piszczek, Field Director of the Public Health Service in Cook County. Seasonal booster shots against flu are administered to the sisters annually at the hospital.

The hospitals carry out this portion of the health program. All follow-up care rests with the convent physician with referrals if necessary. The sisters are usually advised to see the doctor, by appointment, either at the hospital's outpatient department, medical center, health clinic, or doctor's office. Through the courtesy and cooperation of the convent physician, all arrangements for hospitalization are made. For hospitalized or seriously ill sisters, whenever possible, replacements are being made. Because of an acute shortage of teaching sisters, such replacements are made with difficulty. A sister who is in need of a simple follow-up...
is encouraged to phone the Health Directress or the physician in order to give progress reports or to discuss new problems and medication refills. The sisters are strongly urged to follow doctors’ orders and to use medicines as prescribed.

To keep abreast of current research in areas relating to medicine and public health, to have a working knowledge of the functions of the body, and to conquer ignorance which blocks the intelligent use of medical knowledge and know-how, extensive health education programs are occasionally conducted.

In the summer of 1964, at retreat time, the sisters had access to a book display, received literature on Mental Health, heart trouble, cancer of the female organs and immunizations, and about tuberculosis. They also viewed films about the human body, hypertension, cancer of the female organs, prevention of tuberculosis and preventive health. This time also proved advantageous for lab work on the sisters and for preparation for the physicals, after which each sister received lab reports and a physical exam form to take to the convent physician. The educational program for the past summer comprised the following: Films and lectures on good dental care, on eye conditions prevalent today, and means of prevention of eye diseases, a film on ulcer, and a lecture on the ulcer personality, and a lecture on poise and personality. Physical fitness included a program of calisthenics and games. At this time, routine chest x-rays and lab work were done also on the sisters.

Medical theory recognizes the human cannot be separated into parts for care and treatment of his illness. They are areas psychosomatic illnesses. Emotional tensions can and do play a prominent role in many physical ailments. Since man is a whole being, his health is affected by physical, mental, emotional, and social factors. It is in ill health he requires total care and treatment. Every person has an innate desire to become a whole human being, hence the long process of education and maturing which gradually prepares him for a wholesome life in this world so that he may become truly complete in union with God in the next. Wholeness is achieved by the development of all three dimensions of the human personality; the psychological, the physiological, the intellectual and emotional, and spiritual. Since mental health is far more than merely the absence of mental illness, it has to do with everybody’s everyday life. Mental health means the way people get along—in their families, at school, on the job, at play, with their associates in their communities, and the sisters in their convents. It has to do with the way each person harmonizes his desires, ambition, abilities, ideals, feelings and emotions, and his conscience in order to meet the demands of life as he has to face them. To learn more about this business of keeping mentally healthy, a two-day Mental Health Institute in instructional workshop, was held in November, 1964 at St. Mary of Nazareth School of Nursing, Lectures on Mental Health in Our Afluent Gargantuan Society, Teachers’ Attitudes and Their Effects on Child Development, Well-Balanced Ratio of Mental and Spiritual Well-being, Mental Health and the Modern Religious Women, and Deinstitutionalization of Man were presented. There was also a display of appropriate books. In February, 1965, this program was followed by Father Anthony Becker, a psychologist.

One of the functions of the health program is recommending a practical and effective method of treatment for mental and nervous disorders and treatment by a capable person or persons. During the past year, there was a marked increase in referrals to the convent physician for sisters with a psychiatrist or psychologist. At least three sisters were admitted to the hospital with a working diagnosis of anxiety-neurosis. A special private unit was established for psychiatric needs of our sisters. There is a full-time registered psychiatric nurse, assistant nurse, and a regular consultant psychiatrist.

The program, such as has been outlined, is in itself extensive and costly. If we did not have our own hospitals, we would find it difficult to finance such a program. I could hardly appreciate the many financial problems encountered by those families who haven’t hospitals. I express my gratitude to the many good and dedicated doctors and hospital personnel who willingly contribute their time and services to our sisters.

As I observed the health program of our community in its initial stage, I marveled at my predecessor’s endurance and persevering call to the endless work of appointments for physicals, follow-up care, looking for doctors for acutely-ill sisters, and for those who needed surgery. On the other hand, too many sisters wanted the services of the same doctor who already had a big patient load. Waiting periods for sisters were long. Doctors, at times, would forget and leave the hospitals. The sisters were often seen waiting at the entrance to the hospital just to catch the doctor so they could receive his care. This situation called for some organization. To this end, a full-time health directress and regular convent physicians were scheduled, as well as regular visits to the convent physician.

To make the new health program effective there was a further need to formulate its philosophy, main objective, chief functions, and policies. To convince the sisters of the need for an organized program such as this, my personal visit to each convent proved necessary. There is still general apathy towards certain aspects of the program such as immunizations, physicals, convent physicians, and organized activities. To conquer the attitude of indifference, ignorance, and prejudice, educational health programs are being held. In spite of the attitude of indifference among the religious, the educational health programs should continue.

DR. SHERIDAN: Thank you very much, Sister Felicia. I was especially interested in your comments by Sister Gerald, which were touched upon by Dr. Nix, and are quite pertinent because we hear time and
time again from doctors who have the responsibility for the health care of the religious, that the first phase is the overwork which, so frankly, is almost a disease of the religious because of their zeal to do the work to which they have dedicated themselves, and this frequently results in friction which invites psychoneurosis, as pointed out by Dr. Nix in his book.

Also, as has very well been said, why should nuns have been singled out as objects of charity when it comes to medical care? I think this is an absurdity, and yet the economics of our life in the Church in America dictates this. Yet, hopefully, there will be some recognition of the facts by the administration of the Chicago Archdiocese.

We would welcome remarks or questions or criticisms and observations directed to any panel member.

DR. ROBERT SCHMITZ: I might say I am overwhelmed by what the sisters at Holy Family of Nazareth have accomplished. I was totally unaware of their program. I think we have all been working in our own little areas, and there has been no national effort, or, if so, reports of efforts have never filtered down to the individual chapters. I also reviewed some of Dr. Nix's work, and that is why we have to have some sort of forum for bringing together these ideas. But more than that, somebody has to know about these good sisters. They have really done a job.

DR. SHERIDAN: Out of all that has been said, I think we could begin to draw some conclusions.

If there are any questions while we go over these, you are more than welcome to ask them. Generally, I would gather that the remarks made here tonight at the following would certainly be in order for the religious, whether female or male.

First of all, there has to be psychological or psychiatric screening of all postulant. Second, physical screening is equally important. Third, a physical exam with Pap smear for every member female over age 35 to 40. That was a factor just touched on, but I think this is of real significance. Fourth, a unified record should be useful for research, that is a unified record where the initial physical examination, history and evaluation would be kept. These would be two or three copies for each nun, and it has been well pointed out that each nun should have her own copy of this record in spite of the overprotective attitude of the superior who wants to keep undesirable information from her.

Number five on our list is recommendations, and some of these things are so obvious that we hesitate to mention them. However, we do, and one is the avoidance of overwork. Psychoneurosis is the commonest illness of nuns in the United States, and is almost always directly related to overload of mental and physical effort. Sixth, the corollary of this is that each individual should have a real, true legitimate vacation, certainly every other year if not every year. This does not mean to attend conventions or retreat.

DR. MASLANKA: Apropos overwork, I have been more or less our feeling that hard work never makes you ill. All of this is the manner in which the work is pursued, affected by the intensity with which the individual labors and the standards he applies for himself. The commonest thing is the degree of perfectionism, and the ultimate goal that he expects as a result of it. The usual thing is that it is good for people to get to work and keep busy, and I think this is a great step toward the preservation of mental stability and making a good adjustment.

DR. SCHMITZ: You are saying in effect that hard work never killed anybody, but we would like to hear more about the vacations.

DR. SHERIDAN: I am sure we would agree that hard work is not synonymous with overwork.

Relative to vacations, this is something I am sure will be in the future, but if you don't reach for the stars, you will never get there. Vacations for the nuns are desirable. There is no shortage of doctors taking vacations, and it is just as desirable for the nuns. As Dr. Lappe said, they are people too.

Are there any remarks from the audience?

QUESTION: I would like to suggest that in this Archdiocese they put into effect the insurance program they began in St. Louis, where the parish did assume responsibility for the insurance for those working there. I think it ran to $8.65 or $8.95 for the pastors of the parish. I don't know the exact amount, but it in-
volves both Blue Shield and Blue Cross.

DR. SHERIDAN: Your point is very well taken, Sister. I can assure you that at least the head of the Catholic Board of Education is urging this. He wants this. How far it has gone beyond there I do not know. We had a meetling wirth Cardinal Meyer on this very subject, but discussions were concluded by his untimely demise. Now we will have to begin again in this same direction. It may be as a central Archdiocesan project because there are parishes that just can’t carry the burden. There will have to be some compensation for them.

Perhaps, Father Marren, you would like to close with a prayer.

FATHER JOSEPH W. MARREN: Almighty God, we wish to glorify You by the efforts we put forth each day. We ask You to bless on all we do. We ask You to accompany the healing works our hands with the consoling and strengthening graces of Your goodness and mercy. We beg that You guide us, all our families, and all who work with in the end to eternal happiness with You. Amen.

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Oral Progestins and the Catholic Physician

EUGENE F. DIAMOND, M.D.

Clive Wendell Holmes has wisely said, “A medicine should always be perused to be hurtful. It is always already hurtful; it may sometimes be indirectly beneficial.” It is laid down originally by Galen, that a drug given to a healthy person cannot augment but only diminish it. What kind of drugs are the oral progestins? Their package inserts suggest that they many contraindications/indicate definite risks in their use. They are given to healthy persons and can only diminish it. What kind of drugs are the oral progestins? Their package inserts suggest that they many contraindications indicate definite risks in their use. They are given to healthy persons and can only diminish it. What kind of drugs are the oral progestins? Their package inserts suggest that they many contraindications indicate definite risks in their use. They are given to healthy persons and can only diminish it.

As physicians, how are we to evaluate their use against time-honored therapeutic principles?

It is against a background of positive bias, then, that the pill must be evaluated.

SIDE EFFECTS AND CONTRAINDICATIONS

In pregnancy, there is a hypercoagulable state related to augmented levels of intrinsic thromboplastin, Stuart factor, plasma thromboplastin component, and fibrinogen. When this hypercoagulable state is further complicated in pregnancy by stasis or slowing of blood flow, an ominous setting for thrombosis occurs. Indeed, thrombophlebitis and thromboembolism are well recognized complications of pregnancy.

It has been shown that the hypercoagulable state of pregnancy is reproducible, at least in part, by the administration of oral progestins. As a matter of fact, hematologists at two centers have reported the use of oral progestins in the therapy of hemorrhagic disorders — notably those due to Factor VII and Factor X deficiency. In addition, it has been shown that the oral progestins produce pelvic vasodilatation which might be associated with the association between oral progestins and thrombotic complications highly plausible, if not proven. As a matter of fact, recent publications fairly uniformly admit the association between oral progestins and thrombophlebitis...