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# A Modern Health Program: Methods and Objectives

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Into this program of statistics and reality, I come as a dreamer bringing my dream to share with you for a time. I hope you will take it with you and let it grow, so that some not too distant day we may return here and hear the statistics of a program based upon its translation into reality.

We have not much time, but I want to spend a bit of it sharing my thoughts with you at this instant. Because right now, I am thinking of a day five years ago when I began my practice in Mobile, Alabama. One of my first stops had to be Providence Hospital — and that I dreaded. You see, up to and including that moment, I had never been in the room with a Sister, had never seen one up close, and had certainly never had to talk with one. And the Administrator was a Sister of Charity. Things have changed, haven't they?

Seriously, the years did bring their changes, and I came to work very closely with Sisters, especially those who are Daughters of Charity, but with many, many others also. And it is out of the wealth of information I have gathered in these fruitful years that I speak with you today.

And I am more at ease today by far than I was that day five years ago. At ease — and yet in awe. For before me today are people of tremendous accomplishment, and yet surely of even more tremendous responsibility. In your collective hands rests much of the work of the Church in this country. And it is to you I submit my thoughts about community health. I ask your indulgence in some of the things that I as a lay person will say — these are things of which you are far more aware than I, things that you live with and work with constantly. Remember, however, that these things are said out of the depth of sincerity.

The first is that the population explosion and the vocation shortage have forced communities to understaff their programs. And yet these very two formidable trends force us to consider yet another program: that of improving community health on a community-wide basis. If existing vocations can be lengthened and strengthened insofar as able, contributing years are concerned, such a program can easily offset any cost in time and money it would entail.

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Now, there is a need for realism in the realm of personal health among the religious. In addition to ignorance of modern diagnostic and treatment programs, many religious are still strongly tied to such old ideas as "whatever will be, will be" and "I will offer up my suffering to the glory of God." The first, I would remind you, conflicts directly with the position of the Church relative to predestination. The second can surely be applied only to suffering not medically preventable.

For thousands of years medicine has been making steady progress against human suffering, human disease. Particularly have giant strides been made in the past several decades. I would submit to you that all that medicine has been able to accomplish has been by, through and with the acquiescence and the grace of God. There has been and is now no fight at all between medicine and religion. And I would here digress for a moment. Sickness though primarily a problem of pathology, is also a crisis of the total personality. It has been said that there is a spiritual dimension to illness; and at the moment when a man's life is in question, the developments of the character, the commitments of the heart, and the modes of answering the ultimate question of what it means to be alive become of supreme importance. When the scientific questions are answered, we recognize the process of recovery to depend also upon the pressures of the soul and the composition of the mind. While diet and physical exercise are important, so are the q ies of being human, which hav n defined as the capacity to prai he power to revere, the practice self-discipline, and the taste of s ranscendence. Religion has bee aid to be medicine in the form a prayer, while medicine is rel n in the form of a deed. From prospective of the love of G medicine and religion are one.

Now we speak of m rn medicine, of the great prom of American medicine. It is true at for the first time in history, the erage life expectancy of American sceeds the biblical three score ye and ten. Ideal it would be, of co e, if these seventy plus years coul be happy, healthy years, but oft they are not. It has been said at we are entering a stage of h ory which may see us as long-lived morons, an affluent society of spi al idiots. This is why we speak of mprehensive health care, rather an merely of curing diseases. A wi man once said that there are n diseases — there are only sick peop . We will turn to this in a mome Suffice it to say for now that the g at tragedy of medicine today is that we as Americans, and I specifically include you as religious, are not claiming the full promise of American medicine.

If we are to improve the health of communities, for example, we must recognize that this problem is a two-fold responsibility —

1. There is a very definite obligation on the part of each community to educate its personnel, institute and promote to the fullest the very best program possible for the realization of maximum good health for each member.

2. There is the same definite obligation on the part of each member of the community to maintain maximum good health. Not only can she hope to prolong her own usefulness, but also she may avoid a lengthy illness that will require the time of other personnel to care for her.

In an attempt to be realistic about good health, there should be no overstressing or preoccupation with matters of health. However, and this I deeply believe, only through adequate education can misunderstanding and fear be removed.

Now let us define a comprehensive health plan, and indeed, health itself.

*Comprehensive Health Plan:* a continuation of preventive health services to meet the total health needs.

*Health:* a state of complete physical, mental, and social well being, not merely absence of disease and disability.

Do you need this approach in your community? Or has that status quo been satisfactory? No matter what your first reaction, let us project a few figures and see if you are interested:

If 200 sisters have an average vocation of 40 years, but could gain 5 useful years:

$2{,}000 \times 5 = 10{,}000$ years

10,000 40 250 new, proven vocations.

Now let us project a comprehensive health program, beginning as simply as possible.

Preliminary Evaluation

Adequate history — complete physical

Psychiatric Eval. where needed

Beginning with the earliest days in the community, a postulant should have a good evaluation. Two things can be accomplished here. The first would be to screen out certain young women with psychoses, deep neurosis, certain types of family history. The second would be that here, in these very first days, abnormal trends toward or disease itself could be identified and followed with adequate treatment and precautions.

Let us say here that the first of these points brings up interesting debate. Should each community perform or have performed by physicians well known to the community these preliminary evaluations? Surely you are aware of just how precursory some pre-college, pre-camp, and probably pre-community examinations are. Let us look on one such family physician who knows full well the girl is maladjusted, neurotic, etc. He would like to get rid of her (i.e. get her into a community). Furthermore, should he not do this (i.e., tell the full truth about her and her family history) the family would boycott him and probably never forgive him. Seriously no evaluation is more important to you than this initial evaluation of your postulant.