A Modern Health Program: Methods and Objectives

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Recommended Citation

Monsignor Fitzpatrick in his address as incoming President of the Catholic Hospital Association in 1961, opened up new vistas for its members in reminding us that, "To say the purpose of Catholic hospitals is only to care for the needy is to live in the past. Ours is an active, apostolic mission to be in the world, to be the leaven, always looking for new goals. In the grand march of medicine and research we are partners. Our achievements must match this advance, not for our glory, not for our satisfaction, but for the welfare of our patients."21

Doctor Taylor in his paper, "The Scope of Excellence," presented the challenge: "Opportunities for exploring ways to fulfill excellence for all patients are innumerable, but does the Catholic hospital dare to get involved? Does it dare capture its early spirit and make itself heard in the forthcoming needs of mankind and of science? Does it dare integrate Catholic thinking with that of medicine and science? It is hoped that in full ecumenical character of the times, together with the motivation of medical staffs — in the context of ecclesiastical authority and in dialogue with experienced medical educators, the Catholic hospitals would seek out ways, both old and new, to increase the utilization of the richness of their tradition and in the emerging role of the Church in the context of ecclesiastical authority — and in dialogue with experienced medical educators, the Catholic hospitals would seek out ways, both old and new, to increase the utilization of the richness of their tradition and belief, and thereby not only pursue excellence but express it in ways finally real for all patients."22

22 "Complacency, Obstacle to Progress," Thornton, F. M. J., Hospital Progress, 38:60, July, 1957.

A Modern Health Program:
Methods and Objectives

E. JEAN COWSERT, M.D.

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 under-staff 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.
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 qualities of being human, which have been defined as the capacity to pray and the power to revere, the practice of self-discipline, and the taste of transcendence. Religion has been said to be medicine in the form of a prayer, while medicine is religion in the form of a deed. From a perspective of the love of Christ and religion are one.

Now we speak of modern medicine, of the great promise of American medicine. It is true that for the first time in history, the average life expectancy of Americans exceeds the biblical three score years and ten. Ideal it would be, of course, if these seventy plus years could be happy, healthy years, but often they are not. It has been said that we are entering a stage of history which may see us as long-lived monstrosities, an affluent society of spiritual idios. This is why we speak of comprehensive health care, rather than merely of curing diseases. A man once said that there are no diseases—there are only sick people. We will turn to this in a moment. Suffice it to say for now that the great tragedy of medicine today is that while 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 twofold 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 over-stressing 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 - 250 new, proven vocations.

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

Preliminary Evaluation

Adequate complete history 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 precarious some pre-college, prep- 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.