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Medicines and Equipment ... and Healing Hands to Use Them

Edward F.X. Kennedy

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They’ve nicknamed it “The Warehouse with a Heart!” From its portals flow a constant stream of medicines, instruments and equipment to more than 5,000 Catholic hospitals and clinics in Africa, Asia and Latin America. This 30,000 sq. ft. one story building houses the Medical Supply Program of the Catholic Medical Mission Board.

Back in the days of its foundation (1928), the Catholic Medical Mission Board gathered sample medicines which it wrapped and shipped to missions overseas. Gradually, the word spread around the mission world and CMMB received more and more requests for supplies, most asking for specific medicines. Realizing that its sample program could never meet the needs, CMMB went directly to the pharmaceutical industry and within a short time, became the outlet for the industry’s donations of medicines to Catholic missions. Physicians and hospitals have become the primary source of instruments and equipment. Some 3,000 groups of women (Blue Cross Circles) throughout the country roll bandages and prepare surgical dressing for shipment overseas.

Through sound planning and the generosity of its friends, the Board was able to ship 2,592,000 pounds of medicines and equipment overseas in 1965. Thus, from a modest sample program, CMMB has developed a meaningful medical supply operation for the missions.

By entrusting its shipments to dedicated professional missionaries, CMMB guards against misdirection and abuse of this valuable material. Its policy is simple:

Any authorized missionary, of any nationality, of any Religious Order, who needs medicine for his sick, poor, will receive it without charge, provided that the material freely received will be freely administered to those too poor to pay. Each mission supplied by CMMB will receive drugs and instruments according to the professional qualifications of the mission staff.

At one time, hospitals and clinics received shipments of medicines from CMMB every two or three years. Now CMMB is able to make one shipment a year to each hospital and clinic overseas. With forms sent out to the missions each year, CMMB gets detailed requests from each one and makes an individual shipment to each of the 5,000 mission hospitals and clinics which are now receiving help from CMMB. In many cases, CMMB is able to send the exact medicines requested. When it can’t, it sends the best substitutes.

PLACEMENT OF PHYSICIANS

The Medical Supply Program has been the primary function of CMMB for the past 37 years. Of more re-

The Reverend Edward F. X. Kennedy, S.J.

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Have you written a story or a poem that you would like to share with others? Are you interested in writing about your personal experiences or your observations on current events? Do you have a question or concern that you would like to discuss? If so, please feel free to submit your ideas or questions to us, and we will do our best to incorporate them into the NACRE QUARTERLY.

Secondly, a general practitioner can no longer practice solo. The time has passed when one man can provide complete full-time family care. He must work as part of a team with one or two men in some type of group practice, in order to meet all the demands. Around the clock service is essential, but there must be time for relaxation as well as for continuing education.

Thirdly, directly within the group or indirectly by voluntary association, he must have close contact with specialists. The medical profession must do some serious soul-searching in this regard, because close identification and rapport between the general practitioner and the specialist is essential for the best care. In doing this it will of necessity raise the cost of good family care. The kind of family physician of whom I am speaking must be compensated for his services at the same general level of the specialist. This means a basic change in our thinking, and I believe, implies a voluntary standardization and fixation of the specialist’s fee, with a corresponding increase in the recompense of the key person in the whole development, the general practitioner or family physician.

If our mission in medicine is in part to fight against error by seeking light and truth, we must take whatever means are necessary to obtain them. With this in mind all of medicine must be mindful of the fact that the general practitioner’s aim is to render a service that complements, not competes with members of the various specialty boards. The medical profession along with all professions which are small societies within a greater one have the right in its own sphere and for the good of their members to make rules, to keep their observation, to punish delinquents and to expel the unworthy. However, it is my opinion that the authorities should consider each individual physician and his privileges individually according to his competence, training, interest, knowledge and experience. This should be done with integrity and justice and in no way should it contribute to intellectual stagnation of the general practitioner. Never should the entire group have privileges reduced or stymied because of the incompetence of one individual member of that group.

The majority of our general practitioners are honest, ethical, moral men who practice good medicine and have done so for many years. Most of these men are engaged in the practice of general medicine after considering many other fields and decided that the exclusion of any area was unprofitable. These men have long ago decided that it is probably just as important to know not only what they can do but what they should not do. These men have long ago learned that it would be far easier to be a good specialist than a good general practitioner. It is to that latter goal that the majority of them have disciplined themselves to a continuous, never ending educational program. It is these men who can be the foundation for the rebuilding of general practice and the key to the whole, much needed and desired development of the family physician.
The only "ministry" required is patience. The only "ministry" required is patience.

Approximately twenty nurses have served two-year tours and placements included general practitioners, surgeons, pediatricians, obstetricians and gynecologists, ophthalmologists and internists. (Articles by three of these physicians can be found in this issue of LIN-ACRE.)

CMMB screens both long and short term volunteers for services in Catholic hospitals and clinics in Africa, Asia and Latin America. These men and women serve the sick poor through their medical skills. The only "ministry" required of them is that of their profession. Membership in the Catholic Church is not necessary for placement through CMMB.

During the past four years, CMMB has placed twelve physicians for two-year tours of service, six physicians and two dentists for one-year tours, one physician for six months and over fifty physicians and dentists for one-month tours. These placements included general practitioners, surgeons, pediatricians, obstetricians and gynecologists, ophthalmologists and internists. (Articles by three of these physicians can be found in this issue of LIN-ACRE.) Approximately twenty nurses have served two-year tours and eleven have served for six months to a year. All three long term medical technicians have served.

The Placement Service is presently screening several physicians who, it is hoped, will begin their medical missionary work overseas sometime during 1966.

Since 1928, concerned people have used the Catholic Medical Mission Board to help reduce the shadow of disease in underdeveloped areas of the world. Their financial support has kept the work going and expanding. They have had the satisfaction of knowing that every penny is spent carefully for the purpose given. Think it over, here is a charitable organization, completely unsubsidized, whose operating costs (packing, travel costs, medical personnel recruitment, promotion, salaries, etc.) are only 15% of contributed resources.

Much has been done ... but the sky is the limit. What could be done with adequate support. For instance, CMMB has to purchase many things that cannot be donated, at least in sufficient quantity: medicine for leprosy, for malaria, for tuberculosis, for worms. Instruments, like microscopes, are needed by the score. Additional funds would enable CMMB to transport young medical volunteers to areas that cannot manage even that expense.

The need is great. The satisfaction of helping is still greater. To be a link in the chain of compassion for our stricken fellow man is to be blessed more than he.

We are finally getting our family settled after our tour in Nigeria. It's nice to be home with our relatives and friends and of course to have the many conveniences of living in the U.S.A., although we are already becoming lonesome for the wonderful people and way of life we experienced on our mission tour. Two years were really very brief when compared to the service of priests, nuns, brothers and, of course, the non-Catholic missionaries who spend an entire lifetime in the foreign missions. We Catholics are a little slow in getting started. However, the lay mission movement is catching on and I'm certain that some day it will be commonplace for single and married people to volunteer for short periods of work either in missions at home or abroad.

The two years spent in Africa have really opened our eyes to the spiritual and material needs of others and we hope and pray that this relatively short experience will be only the beginning for us. Although our large family may have slowed us down somewhat, as far as overseas work is concerned, I'm certain that we will find ample opportunity here at home in furthering our work with the underprivileged in various local community projects, in the St. Vincent DePaul and other similar organizations. Two years on the mission has been a great start and we feel that our outlook on life, in terms of what we expect to accomplish in a material way, has changed considerably. It's actually hard now to avoid being very, very much aware of those less fortunate than we in our own small circle of friends and acquaintances. With this awareness, we hope we will have a continued desire to assist these people in any possible way.

Professionally speaking, the mission offered a real challenge. I saw and treated many diseases that were only mentioned in passing while in school. On the other hand, the vast majority of patients had illnesses similar to those seen in the U.S.A. such as the most severe hypertension and hypertensive cardiovascular disease. We treated many patients with cirrhosis secondary to vitamin deficiency states, post hepatitis, worm infestation and believe it or not, our