Catholics are a Little Slow in Getting Started ...

Thomas O'Leary
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.

Our tour was 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 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 cer-

Catholics are a little slow in getting started . . .

THOMAS O'LEYARD, M.D.

EDITOR'S NOTE: Doctor Thomas O'Leary recently completed a two year tour of service at a Catholic mission hospital in Nigeria. Doctor O'Leary was introduced to the hospital through the Placement Service of the Catholic Medical Mission Board, located in New York City. While serving in Nigeria, Doctor and Mrs. O'Leary were blessed with their fifth child.

Upon his return, CMMB requested Doctor O'Leary to present a candid report of his work in Nigeria. His report follows.

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 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 cer-

FEBRUARY, 1966
old friends, naevus cirrhosis from native with excess. Hepatoma and amebic liver abscess were frequently seen. Many natives had what clinically appeared to be peptic ulcer disease. Diabetes and various types of renal disease were quite common. The most frequently seen medical problems, however, were malaria and worms of all varieties. Filaria was common and a few cases of leprosy were seen. One of the most serious problems in the pediatric age group is measles. Due to the poor nutritional state of the children all of the more serious side effects are seen and give rise to a considerably high mortality rate.

Obstetrics takes a good deal of the missionaries’ time. Although the Sisters in our hospital trained native midwives who took care of all normal deliveries, there was much to be done in this area. Most native women delivered at home with a native midwife and the majority of our hospital patients had complications of some kind. Abdominal presentations of all kinds were seen and a considerable number of cesareans were done each month. It was not uncommon to have a patient at home with a ruptured uterus, secondary to dystocia and excessively prolonged labor. There is considerable gyn-surgery for a person trained in this area. The most common surgical procedure was for inguinal hernia, although the physician who did the general surgery in our hospital performed many other abdominal and orthopedic operations.

The most discouraging problem is the lack of laboratory facilities and the inability to carry out the necessary diagnostic procedures. The technicians are a great help in the mission hospitals only for their ability to direct and assist the physicians but also to help labs and train the natives in the field. Hospitals in our part of Africa are now obtaining X-ray equipment so that X-ray technicians are no longer needed at some hospitals.

In our hospital the closest dentist was 90 miles away. Although the Sisters were short of M.D.’s, a dentist would have been received with even greater appreciation. At least two of our mission hospitals in Eastern Nigeria were ready or in the process of getting ready with the necessary equipment to request a professional dentist.

Most of our mission hospitals would find it very difficult to function without the assistance of graduate nurses. A nurse in our mission area would, to all intents and purposes, be an intern in an American hospital. In our hospital of 180 beds, we had three registered nurses: one from the U.S.A., one from Canada and a third from Ireland. These girls take turns being on call and are the first ones to evaluate the condition of incoming patients. Since the doctors are so busy, the nurses are frequently asked to institute the initial treatment in such cases as pneumonia, renal infections, malaria, and worm infestations. In the maternity section they assist the midwives in normal deliveries. They perform minor operations such as doing a curettage to start difficult IV’s and at times suturing lacerations.

We would have found it impossible to function in our particular hospital without these trained nurses from Europe and America.

We were frequently very busy at night and it was impossible for the doctors to see every patient immediately on arrival in the hospital. The nurses became expert at recognizing the symptoms of such common diseases as human tetanus and would take care of the patient until he could be seen by the doctor. Each nurse in our hospital was in charge of a large ward of patients and would make rounds daily. When the doctor arrived, she would show him only the patients that it was necessary for him to see, other minor problems having already been taken care of on her own rounds. They would also assist at times in the Out Patient Department seeing and giving treatment to some of the patients and referring the others to the doctor. We had a nursing school of some 60-80 native students and the graduate nurses assisted the Sisters with classes and instruction on the wards.

Our three registered nurses really had their hands full. Among the three of them, we had supervisors for the male and female medical and surgical wards, an X-ray technician and an anesthetist. In looking back over our two years, I feel things would have been much more difficult without our American and European trained nurses.

We were very happy with CMMB’s policy of putting us in direct contact with the mission hospital prior to our departure and found that this helped prepare us for a great deal for our assignment. When possible, CMMB should continue its plan of allowing the prospective volunteer to contact other lay people either in the area or who have served a tour and have returned home. With the proper information from the mission and possibly other people who have returned from mission assignments, I do not feel any particular type of orientation is needed. With the proper local information the person interested would be able to decide whether or not he would be willing to take on the assignment. I don’t believe a long orientation is necessary or even practical for professional people who have already spent many years preparing for their vocation.

Most families will find two years at a mission a strenuous project in itself and I feel would object to a long pre-mission orientation. The proper information from the mission itself will aid the volunteer in his own personal orientation from a professional and domestic standpoint. My wife and I did try to have a spiritual orientation prior to leaving. During a five or six month period prior to leaving, we met with a priest once every week or so and had very informal discussions on various religious topics. We discussed the sacraments, the Commandments, etc., not with the purpose of teaching these subjects while on the mission, but more for our own personal development. We feel this did help orientate our thinking to the mission and helped us realize the real purpose behind our decision to accept a mission assignment in the first place. We feel it would be difficult for a
“family” on the mission without this understanding spiritual motivating force. A professional man may well go with strictly humanitarian motives but the wife and children need more than this to keep going. They need to have a solid spiritual foundation so that they can more easily endure the many domestic inconveniences encountered on the mission. This spiritual preparation may be more for some than for others, depending on personal background but it can be done on a personal basis with local assistance and need not entail any special classes, etc. To be really effective on the mission a family needs this spiritual outlook. The thrill and novelty soon wear off and then you are left with the day by day grind of living and working with many inconveniences and difficulties. A good healthy spiritual outlook will help surmount many otherwise difficult situations and problems.

Contrary to common opinion, families do well on the missions.

One of the biggest problems with work overseas in the missions area is the lack of entertainment. Large families need real time to be home-sick or long-wave and have a much easier time of it than the single person in our particular area where polygamy was so common, a large Catholic family in action was an education for the local natives.

The world is changing, as we know, and even in Africa we felt perfectly safe and with the help of the Sisters were able to live quite comfortably. You eliminate families from the mission, you will eliminate a good many professional people. Due to the great number of years needed to complete their studies, many physicians and dentists are married and have children before they can ever consider the missions as possible lay volunteers. Please feel free to have prospective volunteers write to us for more details and, of course, encouragement in their decision to give their time to the missions.

ANNUAL MEMORIAL MASS – 8:00 a.m. – JUNE 29

Celebrate: Most Reverend John P. Cody, D.D., Ph.D., J.C.D.

(Old) ST. MARY’S CHURCH

Wabash and 9th Avenue

Chicago

1,071 had a hemoglobin of

75 grams% or less...

Philip Mulholland, M.D.

The medical missions provide a peculiar and very satisfying way to answer the basic motivation that has led a physician to choose the healing art.

A physician who has gained the awesome knowledge of restoring health to a certain number of his patients, realizes early in his career that he has an obligation to contribute a certain part of his life to those who cannot afford to pay. This obligation must be distributed equally throughout the profession. I really do not know of any physicians who have denied this and I know of no one who is not making some form of contribution to the less fortunate.

The Lord chooses how and when He wishes a person to do his share. The ways of the Lord are not to be questioned once they are made known. So often what appears to be a hardship will in fact be a real pleasure in that we are fulfilling His Will.

We do have an obligation to have an open ear and to explore and consider whether various modalities conform to our particular situation in life. That is after we have given due consideration to our family and financial obligations. You may care to think of the fulfillment of your own obligation in the light of what can be done.

For this reason, it may be of some interest to recount my own personal experience in the missions. After internship, completion of military service and one year of a General Practice residency, my wife and I realized we were in a peculiar situation to spend two years in the missions.

We knew there were poor in our own city and that there were other desperate sections in our own United States, but yet we felt that we could best do our part in the context of the Pope’s appeal for Latin America.

On consulting the Catholic Medical Mission Board in New York, we were happy that the Church had given us this opportunity to seek out the fulfillment of this calling in the context of Her work which was begun by the clergy. This gave us the thrill of dedicating our work in the name of the Church. The Placement Service of the Catholic Medical Mission Board, with more than 100 requests on file for physicians, suggested that we serve in El Progreso, Honduras, at a clinic under the direction of the Jesuits of the Missouri Province.

We found ourselves in a city with a population of 14,000, with an additional 17,000 people in numerous peripheral grass hut villages. The United Fruit Company provided a fairly good standard of living and medical care for about 5,000 of these 31,000 people. This left us with a potential 26,000 people for whom to care.

The Honduran government had established some clinics for these