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HEALTH CARE OF CLERGY AND RELIGIOUS

James T. Nix, M.D., Ph.D., KSG.*

The health of religious is a matter of grave concern to the Church, and more particularly to those religious superiors directly charged with guarding the physical well-being as well as the spiritual growth of individuals in their care. Much emphasis has been placed on plant maintenance, yet little has been done to further the usefulness of our much needed and limited number of religious personnel. Although recent medical advances have resulted in an improvement in the health of religious, a modern health program would further reduce morbidity, and increase the productivity and longevity of religious personnel.

At the request of Reverend John J. Flanagan, S.J., Executive Director of The Catholic Hospital Association, Dr. William J. Egan, President of the National Federation of Catholic Physicians' Guilds, in 1959, appointed a Committee on Medical Care of Religious. Members of this committee are:

Reverend John J. Flanagan, S.J., St. Louis, Mo.
Reverend Marvin Bordelon, Shreveport, La.
Dr. Eusebius J. Murphy, Bronx, New York
Dr. Alice Holoubek, Shreveport, La.
Dr. Francis T. Harrington, Dallas, Tex.
Dr. L. J. Johnston, Dallas, Tex.
Dr. William J. Egan, Brookline, Mass.
Dr. J. T. Nix, Chairman, New Orleans, La.

The committee's scope includes both long-range and immediate objectives, and envisages a pilot study as an initial step in evaluating a standardized and effective health program for religious.

OBJECTIVES

The long-range objectives of the Committee on Health of Clergy and Religious include:

1. National survey on health of clergy and religious with emphasis on:
   a. Disease incidence
   b. Occupational disease
   c. Community rules
   d. Specific diseases
   e. Overwork

2. Organization of community physicians to obtain pooled experience nationally and cooperation locally.

3. Development of standards for admission as part of a complete record system.

4. Financing of centrally located national office for a modern health program through public health grant. This would provide for the organization of information as well as a statistical and reference library.

5. Supervision of education of each of the following groups to bring their specialties in line with the program:
   - Ancillary personnel (infirmary, dietitian, nurse, technician)
   - Community physicians

The immediate objectives of the committee are:

1. Standardization of a preadmission physical with printing and distribution nationally. The form is largely a questionnaire and answer type to be filled out by the religious.

2. Establishment of a pilot project, employing the preadmission physical form in selected communities and areas of the United States. It is hoped that the pilot project will make possible the most good for the largest number in the shortest period of time.

   Furthermore, the experience of the physician and supervisors in executing the project will prove valuable to others. It should, if possible, be an active member of the local Catholic Physicians' Guild. He may be a non-Catholic but should be approved by the Chancellor of the diocese.

   Individual members of the clergy and religious should have the right to select either a personal physician or the community physician. In any event, the physician of choice should be approved by the Chancellor. This is particularly important in the selection of psychiatric consultants. The community physician should either perform the preadmission physical examination or pass judgment based on the recommendations and findings of the personal physician. He must play a dual role—sharing the confidence of the patient, yet bound as community physician to submit a sincere opinion to the

*This preliminary report, presented at the Federation Executive Board Meeting June 13, 1960, Miami Beach, Florida, was prepared by Dr. Nix, Chairman of the Committee on Medical Care of Clergy and Religious of the National Federation of Catholic Physicians' Guild and The Catholic Hospital Association.

Linacre Quarterly

August, 1960
Adoption and distribution of a standard physical examination form and analysis of the findings therefrom must naturally precede development of admission standards.

LINACRE QUARTERLY

AUGUST, 1960
I would be informed of the capabilities of the individual religious and thus better able to control assignment to full or limited duty.

**Disease Prevention**

*Immunization* against the following diseases should be provided:
- Tetanus
- Typhoid
- Diphtheria
- Polio
- Smallpox

Revaccination should be done when necessary.

**Dress**

May need to be altered to suit season and climate, with material nonflammable and style nonrestricting.

**Diet**

Dietitian for each individual station should be trained through the facilities of The Catholic Hospital Association rather than appointed by the community. Diet should be adequate to prevent deficiencies:
- Avitaminosis
- Obesity
- Constipation
- Food poisoning

 Provision should be made for special diets, when indicated, as in diabetes and duodenal ulcer. Some prohibitions should be dispensed with to facilitate the treatment of ulcer cases. Feedings between meals and before Communion should be allowed.

**Sleep**

Rigid rule of seven hours nightly should be mandatory, not subject to the desires or work load of individual religious.

**Individual Routine**

Proper health habits should be maintained.

**Contagion**

Precautions should be observed regarding the possibility of contagion from within and without the domiciles of religious life.

**Accidents and Accident Prevention**

As novices, postulants and seminarians devote much of their recreation time and energy to sports, fractures and accidental injuries are most common. Sports involving bodily contact should be indulged in only when the participants are properly protected and in good physical condition.

**Recreation**

A daily allotment in fact rather than in name and an annual allotment of one week in addition to retreat should be mandatory. Vacation facilities on a farm or beach, if possible, should be recommended.

**Physical Examination**

Physical examination every year for personnel over forty to include chest X-ray, electrocardiogram, urinalysis and hemoglobin. Emphasis should be placed on weight gain to prevent obesity and on adequate physical examination.

**Standard Floor Plans**

Standard floor plans according to purpose of infirmary — convalescence, rehabilitation, psychiatric or geriatric care with isolation for contagious disease — should be used.

**Infirmary Care**

Infirmarian should be trained by the local Catholic hospital in emergency routines for treatment of accidental injuries, burns and ingestion of poison.

**Hospital Care**

Should be provided preferably in a Catholic hospital. Provision should be made for insurance coverage in non-nursing communities. Charges should be at a standard reduction rate. Room accommodations should provide privacy and bath. Private rooms would be preferable. In the case of two or more occupants, the other patients should be religious.

**Education**

Individual religious occasionally present physical examination and insist on chest auscultation through the habit. Other religious expect supernatural intervention, neglecting the natural means of treatment. "Heaven is our home" is often the accepted attitude of religious, but does not keep teachers in the classroom.

Undue emphasis on religious orders or directives, that warnings and signals of the body are to be ignored or pushed aside, should be discouraged. Cancer does not respect the cloister and a ruptured appendix cannot be sublimated.

It is fair to assume that most communities try to maintain a well-balanced ration between physical and spiritual well-being. However, there are a few who believe physical disease should be ignored or endured.

The health of our clergy and religious is a matter deserving seri-
ous study and more intensive medical research. While conclusive data is not available, it seems safe to predict that the health of the clergy and religious can best be served by a combination of medical records, adequate care, and an interested physician and an al-

superior.

In December, 1959, the Committee on Medical Care of Clergy and Religious inaugurated a pilot project in the dioceses of Louisiana. The Catholic Physicians' Guild of Louisiana tailored the methods to meet the local situation. By way of illustration, as northern Louisiana is predominantly Protestant, many examinations were done by non-Catholic physicians previously instructed by the committee. Without exception, the response of physicians, clergy and religious alike has been most gratifying.

PILOT PROJECT

Education and Orientation

Our prime motive is to develop interest in the Health Program among the clergy and religious as well as physicians. Our educational efforts have included articles in Catholic newspapers, talks before Catholic Physicians' Guilds and hospital groups, and general distribution of the health record form to religious communities, individual diocesan Chancery offices, and Catholic physicians.

Future issues of The Linacre Quarterly will contain articles aimed at informing prospective community physicians regarding the aspects of religious life affecting medical care. In addition, Dr. Alice Holoubek of Shreveport presented the entire program before the International Catholic Doctors Congress held in Munich during July.

Standard Health Record System

The health record of each religious should include a standard preadmission physical examination form, a physician's report sheet, and an immunization and morbidity card. The physician's report sheet makes possible rapid communication of essential data to the superior of the individual religious. The immunization and mortality card was designed by the committee in conjunction with Dr. Constantine J. Fecher to be used both by the pilot project in Louisiana and for his morbidity and mortality studies on a national level. To date sixteen religious communities with provincials locally, representing twenty-eight hundred clergy and religious have adopted the health record system for candidates and professors. Annual physical examinations since January, 1960 exceed eight hundred. In the New Orleans area alone, eighty Catholic physicians have volunteered their services as community physicians. The Program has the approval of the Bishops of the dioceses.

It is our opinion that the preadmission physical and annual check-up forms should be distinct and separate entities. As some of the questions on the form might be misunderstood by the candidate or his or her family, the preadmission form should be given to the examining physician rather than to the candidate. Further, a most urgent, current need is a method of psychological evaluation.

Our committee hopes to have a revised preadmission physical examination form and a standard record system for new applicants suitable for nationwide use by December, 1960. In subsequent years, our initial national effort will be extended by the addition of programs and procedures already tested in the Louisiana pilot project.

Development of Methods

In New Orleans much thought has been given to coordinating Catholic health facilities and providing channels of communication between the various segments of religious and medical life. Committee consultants have been appointed in the allied fields of medical care (nursing, pharmacy, dentistry, psychiatry, hospital management and pharmaceutical distribution) and in paramedical fields (legal, statistical and clerical). The local committee embraces all recognized medical specialties. Affiliation with a local Catholic hospital as a research center is in process of arrangement in order to obtain grants for research projects and to finance the Program. The names of community physicians, prioresses and superiors are kept current. Additional lists are being compiled of Catholic physicians training religious and non-Catholic physicians treating religious. The provincials of the local communities are automatically invited to meetings as called.

The constitution and by-laws of the New Orleans Catholic Physicians' Guild were not designed to sponsor and manage efficiently large projects such as the Health Program for Clergy and Religious, along with the Catholic School Health Program. Arrangements are being made with local business and permanent personnel to help administer the Program. $2,000.00 is to be provided annually.

SUMMARY

To bring consideration of the health of Religious Program to a close for this issue, it can be stated that effectiveness will be achieved through the following regulations set forth by the committee:

1. The Chancery of the diocese must be kept informed and its approval must be secured prior to the institution of any phase of the Program. This makes for slower but safer progress.
2. The individual religious community is approached through its community physician.
3. All examinations and all phases of the program are voluntary.
4. Each new procedure is tested in one community prior to adoption of its acceptance throughout a diocese.