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Scope of Excellence: For All Patients

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lawful to give sedation to relieve a patient of pain if the use of the sedation would at the same time shorten the patient's life. He replied in the affirmative, in an address on February 24, 1957, saying:

If there exists no direct causal link, either through the will of interested parties or by the nature of things, between the induced unconsciousness and the shortening of life ... and if, on the other hand, the actual administration of drugs brings about two distinct effects, the one the relief of pain, the other the shortening of life, the action is lawful. 12

CONCLUSION

In conclusion, I would urge that we all promote the idea of bene mori, a dignified, pleasant death, in the dying patient. There is no need to prolong the dying process, nor is there any moral or medical justification for doing so. Euthanasia, that is the employment of direct measures to shorten life, is never justified. Bene mori, that is allowing the patient to die peacefully and in dignity, is always justified.

Shakespeare must have had something of this in mind when in King Henry VI he has Salisbury say concerning Cardinal Beaufort, "Disturb him not, let him pass peaceably." 13

REFERENCES

3. Ibid., p. 260.
16. Ibid., p. 66.
19. Ibid., p. 62.

SCOPE OF EXCELLENCE*

For All Patients

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The Conference's theme, Pursuit of Excellence, implies not only awareness of need to maintain the kind of standards that safeguard the living but perhaps eagerness to strive well to increase standards of patient care. But whatever the kind of excellence being pursued in hospital practices, and however its scope for all patients, ill or well, shall use it to mean the proud fulfillment of performances with standards as high as the degree of knowledge and morality allows. Thus excellence is an intellectual and moral fulfillment, a proof of the principle that what one does for God and in service of man, one may do with quality and sense of distinction.

SAFEGUARD OF PATIENTS

Safeguard of all patients is a hospital's moral and intellectual responsibility. This is a fundamental ethical fact and neither presupposes, nor over simplifies, nor overasses the kind of concern for all human-beings (regardless of color and age) as a means of doing something excellently. Thus in the scope of excellence, our attitudes and practices concerning patients become right or wrong only in relation to the good for individual patients—not just medical good but also moral and social good.

Hospital attitudes and practices respecting human-beings are fulfilled in a variety of individual ways: from the gentleness of admission clerks and the courtesy of maids and porters to the validity of concern of nurses and supervisors. Excellence also is the sense of compassion of physicians, and of understanding by laboratory and technical personnel. And it has to do with the humaneness of hospital cashiers.

But excellence for patients may be determined not by the complexity and number of diagnostic procedures but also by the simplicity and effort of diagnostic thought, not by undue and unwarranted periods of hospitalization but by the brevity, indeed the certainty of need, of hospitalization, and not by the use of needless and extraordinarily expensive therapeutic drugs but by the use of specific products (which often are the least costly)—and all with a humble respect for the special healing value of human understanding and kindness.

However idealistic, the foregoing notion of excellence aims...
simply to fulfill what is best and right for human-beings who happen to be sick and thus be our patients. But mere talking excellence will not create it, nor will mere pursuit; it must be captured, and then expressed in ways which are practical and real. This, of course, may be one of the reasons why there is an eternity. Nevertheless, in order to try to express excellence in ways practical and realistic for patients it often is necessary for us first to know ourselves better, and reappraise and study our own personal attitudes and practices, both old and new, that relate to patients and their care. For the value of excellence, however few who actually achieve it, is finally measured not by words but by the humble Socratic attitude: "I know that I do not know." This attitude is significant, not because of its negative implication but because of its positive effect. Nor is the importane of excellence gauged primarily by intellectualism; in the long run it is determined by the kind of discipline and tenacity which permits opportunity for reform and innovation. To use an analogy, the Church, however infrequent in its long history, has held historic ecumenical councils, bringing about major adjustments, reforms and innovations. At the Second Vatican Council, the first in almost 100 years, Bishops from every part of the world, in the context of a complex modern era, gather and "consider in particular," in words of His Holiness Pope John XXIII, "the growth of the Catholic faith, the restoration of sound morals among the Christian flock, and appropriate adaptation of church discipline to the needs and conditions of our times."

The Church's spirit of ecumenism is of universal character. Thus it is above national and provincial interests. Nevertheless its work in Ecumenical Council is the clarification of the Church's place in modern life. But the spirit of ecumenism also is born and reared in our neighborhoods and lecture-rooms. Hardly a day goes by that there is not opportunity to see our practices and attitudes through the eyes of others. And even more importantly, so that these opportunities may be worthwhile, hardly a day passes that there is not a chance to use the technique of dialogue as a means of understanding and of bringing about understanding. Dialogue, regardless of circumstances, simply is a profoundly useful way whereby persons come together and learn to know as others know, as others live, and as others think. When carried out in an atmosphere—these are stern requirements—of intelligence, tolerance, mutual respect and confidence, the law of dialogue permits truthful communication and knowledge—not only between religious leaders and between Catholics and non-Catholics, or between administrators and nurses, physicians and patients, and teachers and students, but also between all human beings.

In ecumenical dialogue on Christian beliefs, for example, it would be well for me to try to know what Protestantism is, but even more importantly what it is not. And if I know not whereof I speak, I should not jump into the very depths of theology and of doctrinal differences and shake thereby the ecclesiastical timbers of the Ordinary's office. And similarly, if dialogue concerns with excellence it would be well for me to know what excellence is and what it is not; that of which we may easily speak is not always practiced. The law of dialogue is personal contact, and personal give and take. And it is equality, not superiority. It simply is to listen and be heard when speaking. It is not advice, exhortation and theory, nor is its purpose to win argument, nor in religious discussion to gain converts. Indeed, dialogue is a kind of bond and communication in our professions which allows physician and nurse alike to construct a bridge of trust and understanding between themselves and their patients. It is the kind of two-way relationship that permits a child's faith in his physician and nurse to depend not falsely on distrust and threat of punishment but simply on belief in our honesty and in our ability to talk and communicate at his level of understanding. It also is the kind of attitude that allows us to respect and admire a Jewn's youth as he explains well his Jewish belief and holidays. It is the kind of atmosphere that permits me with medical students to discuss that the life of a human-being begins not at 40 nor at birth, but at conception, and thus, even though a two-month fetus looks scarcely human, I cannot suggest taking its life.

Communication between human-beings is difficult. Electronic devices of various kinds may communicate the beep-beep of messages originating thousands and thousands of miles away, yet human-beings can hardly talk to one another without misunderstanding and misinterpretation. Some of us hardly communicate at all, or we practice the fallacy of the extreme judgment, or the easy answer and the pat answer. To a two-year-old child in the hospital who cries repeatedly that he wants his mommie, and we repeatedly reply, "Your mother will return in 30 minutes," our answer is easy and pat but unrealistic. A two-year-old wants his mommie now, yet he has no concept of the meaning of time, thus no comprehension of our reply. The problem here is not that the child is willful and spoiled, or that he does not trust us, but that we do not understand him. Or to tell repeatedly a young woman with cycles of deep-entrenched fear and apprehension that she only needs...
cal excellence involves all successful ecumenism. Moral-medical patients, and the Catholic hospital establishes the pattern for mediocrity but to ecumenism that leads to ways to capture and excellence. Ecumenism in the Church, its principles are well-sorted and medical care. This puts an suited not to provincialism and expression excellence in hospital self-criticism is the key to successful ecumenism. It also is one of the means cause it leads to the prodigious· turity. And it is scientific because it leads to the prodigious seeking of facts.

**SELF-CRITICISM**

Although the foregoing are qualities for effective dialogue, self-criticism is the key to successful dialogue. But self-criticism is difficult. Yet it is one of the keys to successful ecumenism. It also is one of the means that leads to ways to capture and express excellence in hospital and medical care. This puts an obvious obligation on the Catholic hospital because, like the Church, its principles are well-sorted not to provincialism and mediocrity but to ecumenism and excellence. Ecumenism involves all people, and the Church establishes the pattern for successful ecumenism. Moral-medical excellence involves all patients, and the Catholic hospital should establish the pattern for moral-medical excellence.

But there are old and new criticisms of Catholic hospitals. But there are old and new criticisms of Catholic hospitals. Despite the role Catholic hospitals have generally played in holding strongly to the ideal principles of moral excellence, there is the criticism that they have assiduously and paradoxically copied the worst features of secular hospitals: unnecessary hospitalization, impersonal attitudes which dehumanize human-beings, unjustified diagnostic tests, nonindicated medical treatments, and unwanted surgical procedures, or indeed, the very failure even to meet minimal hospital standards of a professional sort. And to, there are Catholic hospitals that refuse to hospitalize and care for human-beings who happen to be non-white. But it would be well to note some of these practices exist, although approved secondarily but responsibly by the governing boards of the hospitals, they often are primarily the practices and attitudes of the medical staff. It would also be well to note that even though Catholic hospitals are noted for their well-en-trenched ideas about sterilization, abortion and euthanasia, I should reply that these are neither the ideas, nor the moral doctrines of Catholic hospitals, nor even of the Catholic Church, primarily, they are simply the moral doctrines of God. Thus, excellence for all patients — the fulfillment of what is intellectually best and morally right for each patient — depends not on how few hysterectomies are scored on the hospital's annual report, nor on the absence of directly sterilization and euthanasic practices, but on the quality of standards of medical and surgical practices and of social and moral attitudes which concern all human-beings.

In his book, *Morals and Medicine*, Reverend Joseph Fletcher, Professor of Pastoral Theology and Christian Ethics at the Episcopal Theological School in Cambridge, Massachusetts, writes: "There is practically nothing in the teaching of Jesus about the ethics of sex. He said nothing about birth control, fornication and premarital sexuality, sterilization, artificial insemination, abortion and the like." Mr. Fletcher also states he does not hold that "the foremost concern of the Christian ethics is with souls, that the soul is a "supernatural something" made for heaven and eternity." Indeed, his view is just the opposite; he puts "the priority on personality, and frankly views with skepticism the claim for a soul." The very word "soul," according to Mr. Fletcher, "is in the same dubious, murky condition that we have found in the term 'natural law'. It is too vague, too confused to receive any further use in either common-sense or Christian ethics." One of the confused concepts of our society is that identifying morality with religious practice. Yet neither Calvin nor Luther nor even Fletcher guide and teach on the morality of issues in medical and hospital care, thus one of the reasons why a system of medical morality is needed. It also is the reason why, in an age often offering no hope of a moral future, the Catholic hospitals, perhaps like the monasteries of old, must keep alive the moral laws of God and show those around them the purpose and sense of a spiritual way of life.

As Chesterton — paraphrase him — put it aptly (he often put things aptly), "I need not the help and guidance of a system that is right when I am right; I need it when I am wrong."

**ALOOF AND EXCLUSIVE**

Imagined or true, there exists an image that Catholic hospitals are aloof and exclusive, or worse still, dominated and controlled by the clergy and Bishops as part of a great authoritative monolith called "Romanism." Thus Catholic hospitals are hierarchical and a dangerous threat to everyone around them. Now nothing tends to arouse more antagonism than the notion that someone is aloof and exclusive. But if we are, and wholly some interested in those around us, or if confused notions about our hospitals still exist, we should talk to one another. Father Gustave Weigel obviously reminds us, "we must come together for conversation. Good conversation requires sincerity on the part of the speaker. Evasiveness and dehumanization Image that Catholic hospitals can be described as monolithic "Romanism." However, Catholic hospitals are not monolithic, and they can be described as both aloof and exclusive. Nevertheless, it is well for us to know if we are really aloof or not, or convincingly ego-
Persons outside Catholic hospitals may not accept Catholic hospitals, but they expect more of them — that they should not only show the scientific gains in medicine but also be the summit of all gains in human and spiritual understanding. Persons outside Catholic hospitals may distrust them, and even think the Sisters are something second-rate, normal or human. For there also exists the curious notion that non-Catholic patients in Catholic hospitals are regarded as neces­ saries of Christ and must consequently be captured and probes­ into conversion. Such notions express provincial understanding — a limited provincialism at that — and are a caricature of the attitudes of a distant ancestor. At times, however, such notions are the paradoxical expression of what really is felt — trust and confidence, and indeed, because of the religious in hospital, the kind of responsibility, selflessness, lofty purpose and saintly attitudes that are the very means of helping innumerable persons recover their life’s purpose — not by imposing a belief on them but by understand­ ing them through dialogue and example.

**THE NEED**

Catholic hospitals are not strangers in our midst, but in our midst are strangers to the once glorious tradition of Catholic hospitals. The oldest in Christendom, they are medica­ ine’s forefather. Indeed, in early times both hospitals and medical schools were under Catholic religious auspices. But custom and practice change. Now Catholic hospitals and medical schools, however excellent their leadership in the ancient moral issues of contraception, sterilization and direct abortion, no longer are great leaders in medical care and learning. Indeed, today the need for initiative in the Catho­ lic medical world is crucial. That task is needed. But what really is the sense of medical and educational mission which survival itself may demand. There is need for Catholic hospitals to strike out in full ecumenical spirit and define new goals, innovate new practices and establish new concepts in an era of intense scientific activity in medicine and hospital care. Should Catholic hospitals not repurse and capture their past roles in medical and educational achievement, and in a partnership of moral and intellectual excellence assume the responsibility of guiding and controlling the enormous power of medical technol­ ogy and science. Or do Catholic hospitals dare to become in­ volved in a new age in medical history and by the eternal stan­ dards of right and wrong, make themselves heard in the needs of mankind? Excellence is an ide­ alistic goal. But few really pursue it, let alone achieve it. Nor is it thrust upon us, it must be worked on and fostered. More importantly it must be insisted upon.

But Catholic hospitals are rich in educational opportunity; and the extent and vitality of their richness should not be underes­ timated. Catholic hospitals, as a source of wondrous good in medical education and in training, would be capable of raising standards in medical care. In­ deed, there are opportunities in general hospitals that provide the kind of wisdom born of experience and ethic which often is beyond that gained in element­ ary ways in medical schools and in university or medical center hospitals.

Medical science now is in an era looking to the social and behav­ ioral sciences, and also to moral science, for knowledge and guidance to help explain man’s health. Medicine again is point­ ing up the need to stop the present fragmentation and specialization of human-beings either by part or by disease. Not only is there great universal need to put fragmented religions back together again, there also is great ecumenical need to put man back together again, and in our hospitals bring about a reunion between patient concern and medical education. Medical re­ search is necessary and important to medicine, but patient care is the keystone to medical learning. Indeed the need is great to accord the teaching and study of patient care the same priority hitherto accorded re­ search in fundamental mechan­ isms of disease processes.

The Catholic hospital is uniquely suited to programs of this kind. But a stout barrier — part real and part unreal — is said to exist between Catholic hospitals and medical education, and between Catholic institutions and secular institutions. This barrier may in part exist because of a supposed dichotomy between Catholicism, humanism and science. But real science is neither anti-humanistic nor anti-Catholic. Nor is humanism and Catholicism anti-scientific. Humanism and Catholicism and sci­
ence are complimentary; there need be no alternative. There need not be the plight of decisive choice that faced the worldly young monkey who escaped from the zoo and was found later by his keeper in the city library reading both the Bible and Darwin's Origin of the Species. His question of the zoo keeper was this: "Am I thy brother's keeper, or, am I thy keeper's brother?"

Inside hospitals, the most intimate activities embrace all people and have to do with medical welfare and also with spiritual, social and cultural welfare. And humanistic physicians and scientists are fully capable of perceiving and appreciating and of effecting the kind of social and religious values which are important to human-beings; indeed they are being called upon more and more to "help make policy decisions of great social and moral consequences." Thus, in its purest way, however applied to the intellectual, social and scientific advances of society, the extent of excellence achieved by a culture ultimately depends upon society's scholars. And the extent of excellence achieved by a hospital for all its patients ultimately depends upon the hospital's medical and scientific scholars.

Therefore, each Catholic hospital should play a role, however individual its separate role, in bringing about harmony in medicine, education and science, and in integrating doctrines of morality with doctrines of medicine and science. But Catholic hospitals face a problem. The problem is not of morality taking over where science and biology end, nor of staking out doctrinal claims only in areas where medical science is ignorant or nonexistent. Nor is the problem simply one of Catholic hospitals tolerating, or living in fear of the material advances taking place in medicine and medical science. The problem is whether the Catholic hospital is going to participate actively in medical education programs and in scientific activities, and in addition contribute adequately to them.

REFORM AND INNOVATION

Today's challenge is exceedingly great — what is the Catholic hospital's effort in educating and training a scientific breed of physician caught in the inexorable bind of his material and biological self, even his psychological self. What is the Catholic hospital's effort in medical education in interpreting — no subjectively to our individual selves, because in our exclusiveness we know this well — in imaginative and in inspiring ways the modern age of nuclear and genetic medicine. Is there not need for an ecumenical attitude — in the full spirit of ecumenical reform and innovation — to self-criticize well, and above all, not to abandon what we know and teach well but also to be enthusiastic for what is new and unknown.

How might the foregoing be achieved in a time of changing concepts of medical thought and practice? Not by today's programs that train intern and resident physicians unless these programs undergo total renovation. Nor simply by labeling hospitals major teaching, minor teaching, or non-affiliated. Modern hospital administrators know well the beneficial role of learning and teaching programs and of research activities in hospitals, but they must depend on their medical staffs for the strength, as well as the weaknesses, of these programs. Therefore the nature and extent of training plans often finally depend on the motivation and experience of the medical staff. But one just doesn't decide to establish a training program; indeed the creative process may be long and evolutionary, growing sometimes by plan, and sometimes by accident.

Nevertheless educational exchange is the kind of dialogue in medicine that is the lifeblood of a hospital. The result often is the kind of contagious standard that spreads throughout an organization, stirring the air, invigorating attitudes and practices, and strengthening patient care programs. But educational exchange can be bought neither by salary nor by fringe benefits. Neither can it be purchased by the program of a paper organization, nor by a program of rote service to staff physicians; it can be bought only by opportunity for quality training.

In medical education there is a diversity of learning programs. There also is a diversity of hospitals and physicians to provide the learning and training opportunities. Each, however, should develop its own individuality, and in its individualism strive for excellence in a context of usefulness for all. This is one answer to the obvious need to avoid and also decrease the needless duplication of separate programs and facilities. In addition, it puts to advantage all the obvious but natural differences which exist between hospitals and between physicians. Thus one of the simplest means of achieving unity of excellence in a framework of diversity.

In recent years more and more young physicians have caught their training in university and medical center hospital programs; there is full awareness of the advantages and disadvantages to this trend. The competition for house officers, between all hospitals, indeed between medical centers, is real, and however unfortunate, more and more general hospitals, both secular and religious, have abandoned their unfilled training programs and relinquished this responsibility to those hospitals and institutions oriented to a spirit of training and learning.

TRAINING AND LEARNING

In medicine there is an enormous need to put man back together again; this is part of medicine's challenging future. Both patients and our religious have said for years and years: reclaim medicine's challenging future. Both patients and our religious have said for years and years: reclaim in medicine man's social, moral and spiritual being. The Catholic hospital is eminently suited to this task. Therefore it is uniquely suited to establish in medicine the kind of training programs in family medicine and practice that actually claim a right to the wholeness of man. There are medical students and interns who want to practice this kind of medicine and provide their patients continuous and personal care, and would serve in hospitals providing a training ground thought out well, and organized and geared to quality.
And really effective training and learning of this kind should be complemented in the general hospitals. But few places today are well-suited or well-established to this purpose. Most university and medical center hospitals are not primarily suited to this task. This does not mean a lack of interest in patient care; it means a lack of experience in patient and family care and an emphasis primarily on elementary foundations of medicine and the advanced specialty training programs.

The general hospital, on the other hand, is oriented well to individual and to family and community health problems, and is uniquely situated to integrating and applying not only elementary medical knowledge but also advanced specialized knowledge relative to mankind’s changing health problems. This is a marvelous way for a general hospital, Catholic or not, to bring home to physicians (student and intern and practicing physician) one of today’s gravest problems — the problem of fragmented medicine and hospital care, and give them realistic training in holding it together. I speak not ex cathedra, but a school of medicine with a department of family medicine chartered and staffed by physicians competent in this phase of medicine would bring about an educational affiliation between the university and hospital and also draw upon the sources of wisdom and experience of each group regardless of geographic, religious, and secular boundaries. It would allow the fulfillment of a well-recognized need for individuality and of differentiation of interest, capability and function among hospitals, as well as among physicians. The responsibility of all hospitals for physicians, after all, is the same; merely the emphasis is different. Therefore it would seem both timely and realistic for Catholic hospitals not merely to stress a philosophy of health care that integrates social, spiritual and psychological care with medical care but indeed to consider in their health services those roles challenging to their ecumenical spirit and their imaginative spirit.

**NEW ROLES**

Today’s health problems at first glance are paradoxical, but they merely may reflect the changes of medical civilization. There are less and less acute illnesses but more and more chronic illnesses, and less and less mortality but more and more disability. In addition, and however unimportant, is the problem of becoming of age. The question to be decided more and more by the patient and his insurance and has been by the physican and the patient’s illness? But chronic disability and illness are limited neither to the old nor to the young, over half these persons are under 45 years of age. Yet, as medical and hospital care has assisted the prolongation of lives, neither physician nor hospital should want to fail in responsibility to habilitate those lives. Disability and illness, both physical and mental, creates a need for new ways of living, and opens up whole new roles in the medical, social and vocational aspects of health care. But extraordinarily few hospitals have the kind of habilitation services that help disabled capable persons in new ways of life, or train professional persons in ways providing increased medical care outside hospitals. Yet these very roles are uniquely suited to the heritage of the thinking of Catholic hospitals: the idea of innovation and helping those in most need. The Catholic hospital is a hospital, but it also is a religious hospital; its attitudes should be those of full esteem and consideration for all patients.

More and more hospitals, however, are modeled after hotels with diagnostic laboratories running hot and cold. But however long-standing the need to fulfill total responsibilities in medical care there also is a desperate need to reserve hospitals for patient care, in particular for the care and treatment of persons requiring hospital facilities. There is need for hospitals and physicians to come together and reclaim their rights, and in order to fulfill better their total responsibilities in medical care, to emphasize that most sick persons, and obviously those well patients obtaining diagnostic studies, often are better cared for not in hospitals but in the home. However handicapping illness and disability, there are ways of caring for the sick — the aged and the young alike — in the home and the hospital. To the patient and family fare better. Innumerable hospitals will continue training programs for interns and residents. The monthly staff meeting may be the fullest extent in educational achievement. Hospitals, however, are fully capable of educational achievement in other areas. Visiting physicians, individuals and teams, may be invited to hold conferences, rounds and “think sessions” and carry out — in the context of dialogue — a useful role in continuing medical learning. Another hospital might establish a selective field in medicine or basic clinical and fundamental investigation and allow it to achieve such excellence that it and the hospital would not only attract research fellows but provide the foundation for advanced fellowship training in other fields of medicine. A department or institute of genetic medicine, for instance, because genetic knowledge is enormously important and complex, would be an area, perhaps thought unusual at first, in which the Catholic scientist, hospital and physician could become an established authority and a source of immense usefulness to physicians and the community. After all, a Catholic monk started the whole business of the Mendelian law in genetics.
Conclusions

Opportunities for exploring ways to fulfill excellence for all patients are innumerable, but does the Catholic hospital dare to get involved? Does it dare re-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? I should hope 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 belief, and thereby not only pursue excellence but express it in ways finally real for all patients.

References
7. ibid. p. 191
9. ibid. p. 163
10. ibid. p. 218

CMRB Reports

During 1962 the Professional Placement Service of the Catholic Medical Mission Board, 10 West 17th Street, New York 11, New York, processed 117 volunteers for overseas medical service. At year’s end, 84 of these were at varying stages of CMRB’s placement procedure. The remaining thirty-three physicians, dentists, nurses, medical technicians and one pharmacist — were placed and have served or are now serving in medical installations throughout the mission world.

Seventy-four of the volunteers were doctors — 19 general practitioners, 13 dentists, and 42 specialists (including 17 surgeons). The next largest group were the registered nurses. There were 27. Fifteen medical and paramedical technicians and assistants constituted the remaining number. More than half (50) of the total 117 volunteers — whether doctor, nurse or medical technician — were people whose ages ranged from 30 to 39.

Most (92) of the 117 volunteers are from the United States. And of those 92, 21 are from the State of California. (This latter fact is explained largely by the activities of the Sacramento County Medical Society which has group-sponsored the hospital run by the Sacred Heart Fathers at Quiche Mission, Chichicastenango in Guatemala. The Society has been supplying the small hospital with a physician on a monthly rotation basis since last April, and is presently raising a fund of $25,000 to improve the physical facilities of the medical installation in which its members are serving.)

Beside California twenty-three other states furnished volunteers. All but 17 were U. S. citizens. Seven came from Canada, four from the Philippines, two from Britain, two from Germany, one from Ireland, and one from Switzerland.

Who referred them to CMRB?

Most of the volunteers came directly to CMRB, but a few were referred by other organizations. The largest percentage (18.5%) of referrals came from the American Medical Association’s Department of International Health.

And Since January 1963

... Until the last meeting of the Catholic Medical Mission Board’s Medical Advisory Council on March 23, 21 members of the medical profession offered to serve in overseas missions. There were 6 volunteers in January; 9 in February; another 6 in March. The majority (13) of these volunteers are Catholic doctors who are married with wife and children. Their classifications, ages, etc. are grouped as follows:

Classifications: 7 general practitioners, 2 surgeons, 1 internist, 2 dentists and 1 pathologist.

Age: 2 under 30 years, 10 between 30 and 50 years, and 1 just 64 years.