The Linacre Quarterly

Volume 40 | Number 3 Article 18

August 1973

The St. Petersburg Diocesan Health Program

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Doctors Ezzo and Barker describe the health program for religious that has been in operation for several years in the St. Petersburg, Fla., Diocese. The article offers a blueprint to diocesan officials and doctors in other parts of the country who are concerned about the health care of religious personnel in their areas.

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The St. Petersburg Diocesan Health Program

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In an effort to render our priests and sisters better health services, Catholic guilds in some areas have instituted programs for periodic physical examinations and follow-up care. Programs vary from mass screening to intensive, individual diagnostic surveys, but few of these attempts have been successful. We believe the program that started in 1968 in the St. Petersburg, Fla., Diocese is meeting with reasonable success and we are outlining it in *The Linacre Quarterly* as a guide for other guilds.

The objectives of our program:

1. To get a comprehensive history and physical examination documented on all religious in the diocese.

2. To establish doctor-patient relationships with all of them.

3. To detect asymptomatic disease and advise therapy as indicated.

4. To orient the religious to their health needs.

Health Kit

To do this, a "health kit" has been produced and distributed to every priest and sister in the diocese. It contains three essential components:

1. An explanatory letter of direction. Essentially this explains the program and asks the examinee to fill out the enclosed health questionnaire; to make an appointment with the physician of his or her choice in the month of birth; to bring a urine specimen (clean-catch, first-voided morning specimen) and to report to the doctor's office in a fasting state.

2. The health questionnaire. This is a comprehensive 12-page questionnaire (similar to the Cornell Medical Index) that seems best suited to our purposes. "Confidential" is printed in large let-

ters on the front page to remind the patient that the doctor-patient confidence is not violated. The last page is the physical examination form to be filled in by the examining physician, with the back of this page reserved for laboratory values, X-rays, ECGs and additional studies.

3. The final components of the health kit are lab supplies: Four vacuum test tubes (for SMA-12 profiles), sterile needles, Pap smear slides and containers, urine specimen containers, gummed labels for identification, and identification cards to be mailed to the laboratory with the specimens. These supplies are contained in a mail-away container that is pre-addressed and need only be dropped in the mail.

Physician's Role

When the physician sees the patient, he can quickly evaluate the questionnaire which is the yes-no answer type before soliciting further history and discussing any problems with the patient. Pap smears are done on all nuns, and sigmoidoscopies are suggested for those patients over 40. Chest X-rays are taken either by the examining physician or a radiologist. Electrocardiograms are done during the first visit at the discretion of the examining physician. The doctor, his nurse or technician then draws four vials of blood. With the Pap slides, this material is put back into the original containers and mailed to the laboratory. The urine specimen may be examined by the physician or it may be sent along to the laboratory for examination.

The physician either kee the completed health questi aire for his personal records and low-up or — retaining pertinen data for his files — mails it to o cen-tral records library where i s re-viewed for abnormalities fore filing. This is done only by hysi-cians. Similarly, results the SMA-12 studies, the chest -ray, electrocardiogram and Pap nears may all be kept by the ex ining physician or mailed to our ntral library. In either event, all f the material is kept in the stri st of confidence and no one but e ex-amining physician and atient knows of the examination sults.

Shortcomings

The program has som built-in shortcomings. First, si e the examining physician may t for-ward the health records to e col-lection point, there is diffi lty in knowing how many of the igious have actually had their e mina-tions; this requires rather equent follow-up reminders to the . Sec-ond, since the material is c nfiden-tial, the physician may n reveal his findings, making it im ossible to collect enlightening s tistical information. Third, there is no way of knowing that pati ts who have physical problems ar receiv-ing adequate medical a tention.

Obviously, the advan ges of this system outweigh the several drawbacks, and indeed, perhaps the only significant shortcoming is the one relative to collecting statistics and has nothing to do with good patient care. The small number of cases involved make for no statistical value; however, it should be noted that of the first 30 nuns examined, one breast cancer and one ovarian carcinoma were found. These were both surgically corrected at an asymptomatic phase of their disease.

Patient Education

A major problem that arises in this type of program is that of educating the patient-to-be. It is important to distribute the health kits and information about the health program to every religious in the diocese and to maintain awareness with periodic follow-up letters. Many of the religious spend only the school year teaching in the diocese and return to their motherhouses in the summer. They have become accustomed to getting their annual examinations there, and consequently we do not have information on the results instantly available.

It is desirable for health records to follow the priest or sister to assignments in other dioceses. This is arranged if the patient writes a letter asking that his or her health jacket be forwarded to the chosen physician.

Summary

Following is a summary of our thoughts regarding periodic medical examinations:

Just how often should a well patient be examined? It is our opinion that physician efficiency and patient health maintenance are both served if this rule is observed: The well patient with an absolutely negative history and no abnormalities should be examined every two years if between 20 and 30 years of age and every year if over 30.

Those individuals who do have medical problems should be examined as frequently as the examining physician feels necessary. For example, an individual with a history of colonic polyps should be examined at least yearly or more often should symptoms arise; a 35-year-old brittle diabetic can be expected to have more problems than his non-diabetic counterpart, and therefore he should be seen at more frequent intervals.

In addition to the history, the head-to-toe physical examination, and the necessary basic laboratory profile, what else should be done routinely? It is important to educate the female patient in self-examination of the breast, giving her an opportunity to learn about the feel and consistency of her breast tissue in order to detect changes and get help at an early stage. Mammography has taken its place in the physician's armamentarium. Its use should probably be limited to those patients who have breast problems difficult to evaluate, such as nodular fibrocystic disease; those with a family history of breast carcinoma; and those patients who have been treated for carcinoma of the breast — evaluation of the remaining breast by mammography is quite useful.

Pap Smear

With regard to vaginal and cervical cytology by means of the Pap smear, we feel that women who have three consecutive negative Pap smears should have routine Pap smears every three years,

provided there is no visible abnormality or history of abnormal vaginal bleeding. In those women who present physical characteristics accompanying endometrial carcinoma — obesity, hypertension, diabetes and menses into the late 40's or 50's — endometrial cell washings are helpful in early detection of endometrial cancer. In order to detect carcinoma of the ovary at its earliest state, bi-manual pelvic exams should be done on a yearly basis on all women over 35 years of age.

The chest X-ray is an important part of the physical exam because of the information it yields (as regards heart size, etc.). It should be repeated every three or four months for those who smoke three or more packages of cigarettes a day, every six months for two-package-a-day smokers, and at least yearly for patients who smoke a package daily.

The rectal examination should be a routine part of all periodic examinations. Using simplified tests, available stool guaiac studies should also be done. Ideally, proctoscopy should be a part of the periodic examination; however, it may be reserved for those with positive guaiac studies, those with a family history of carcinoma of the gastro-intestinal tract, and those with a history of colonic polyps or other significant history.

Cost and Progress

The initial costs of the program are considerable since health kits must be purchased, costing about $3 per kit. It is best to have them produced on an as-needed basis, since vacuum test tubes lose some of their negative pressure during long term storage. Costs thus accrue as the Diocesan Health Office is billed by the laboratory for profiles done and for any X-ray, ECG or physician fees. The diocese has a self-administered health insurance program, and any doctor's fees submitted are paid directly to the physician by the insurance office.

There are an estimated 600 to 700 priests and sisters in the St. Petersburg Diocese, but the number involved in the program hard to estimate. Some patients refer that their own doctors keep their health records instead of forwarding them to the Diocesan Health Office; they may also fail to return questionnaires asking if they have had their yearly checkups. By July, 1972, an estimated 60 to 75 per cent of the priests and sisters in the diocese had undergone at least one comprehensive physical examination. About 50 per cent had yearly follow-ups and any indicated diagnostic tests or therapy.

A significant development in the program was the appointment of Sister Gladys Sharkey as diocesan health director. The administrator of St. Anthony's Hospital in St. Petersburg, Sister Sharkey is acutely sensitive to the medical needs of religious and has a long and excellent background in health care. A qualified diocesan health officer and staff, along with much time and effort — primarily by participating physicians — are keys to a successful diocesan program.