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Care of Religious

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PHYSICIANS who think in terms of spiritual values rather than in terms of material ones find that a practice devoted in part to the care of religious is quite rewarding.

Priests, nuns, brothers, seminarians and postulants all present special phases of illness and special problems in diagnosis and treatment that are not encountered in lay people. One of the most common errors that we make in the care of religious is our tendency to regard them as something other than human. An old priest once pointed out to me that the habit doesn't mean that the individual wearing it is "confirmed in grace." The Very Reverend Monsignor with the biggest parish in town, and the peptic ulcer that goes with it, is just as ill as his counterpart in business with the same disease. Similar factors of fatigue, tension, worry and diet are operating to produce the same pathology in both duodena. Treatment, likewise, is the same and cooperation with treatment is just as difficult to secure in both patients.

In taking histories from religious we sometimes give them credit in our own minds for a good deal more knowledge of symptoms and signs than they possess. This probably stems from our childhood in the parochial school when we were firmly convinced that Sister Mary Anastasia knew everything, and what she didn't know, Father Kelly surely did. It sometimes requires some rather deep probing, and the use of basic simple terms to secure a complete and detailed history of obscure illness. In cases where we suspect that factors of emotional tension or anxiety are part of the cause of an illness, we are apt to encounter considerable resistance to our attempts to expose them. It is often necessary to get a detailed account of the patient's daily routine, and a record of his hours of rest, recreation, duty and devotion, as well as the type and quantity of food served and the hours of meals.

A little reflection will show that the life of a pastor is far less confining and much more self-directed than is the life of a Trappist novice. Different Orders have different rules and customs. Superiors, being human, show a wide variation in the way they interpret the specific duties of their offices. A superior in robust health sometimes finds it difficult to cooperate with treatment of those who require an abbreviated schedule, special diets and expensive medication.

An individual in community life is beset with all the abrasive failings of human nature in his contacts with other members of the community. The normal personality clashes that occur among lay people are magnified by constant association. These tensions can produce real illness, if the individual represses them instead of accepting them as part of his vocation.

The excessive zeal of some imprudent seminarians, who seem to think that they are expected to achieve perfection overnight, is one of the causes of the rash of peptic ulcers in some of our seminaries.

A thorough review of these factors, as well as a detailed appraisal of the location, severity, and duration of the present complaint, and a review of the patient's past illnesses and family background, will produce a medical history with important value.

Religious are entitled to as thorough a physical examination as other patients. Many, before they approach a doctor, have already considered that their symptoms are evidence of hypochondriasis. Any assumption on our part that their complaints are imaginary is as false as it is dangerous. And to try to save a nun embarrassment by examining her heart and lungs through four layers of habit, a crucifix and a scapular is just as foolish as to "watch" a breast lump for a few months. The same physical signs of disease will be manifested in a religious as in any other patient, and they should be searched for as diligently in each case.

Laboratory work and x-rays that can be fitted into a busy schedule will confirm the diagnosis, and then treatment begins. Here again we are dealing with a human who will respond to treatment in the same way any other person would. It is a fine demonstration of faith to hope for divine intervention in the recovery of these patients, but as doctors we are more familiar with the therapeutic tools of our trade.

In any illness the first line of treatment is to prescribe rest for the injured area. The physician who merely advises a religious to "take it easy" is doomed to failure. It is often necessary to write down a revision of the patient's normal daily schedule so that he is not burdened with the decision as to hours of activity and rest. A graduated scale of activity that coincides with community life can be worked out with the infirmarian and recorded for future use. This is quite useful in prescribing activity following illness or surgery.

Special diets should be carefully tailored to the ability of the community to supply them. Drugs should be prescribed, if possible, so that there is little or no waste. Consultation with the infirmarian can save the community a great deal of expense. Medications on hand should be used rather than prescribing other prepared products of like nature.

One of the most difficult problems that presents itself to the physician who takes care of religious is presented by the individ-

ual who feels compelled to change his vocation because of health. The Superior, before applying for a dispensation from [final] vows in these cases, attaches great importance to the recommendation of the attending doctor. These recommendations should always be made with full recognition of their gravity, and with complete conviction that there is no other way to solve the problem. Many religious in delicate health are able to remain with a community and survive if their daily schedules can be revised in accordance with their physical ability and if they are spared some of the daily routine reserved for those in good health.

The rapidly disappearing tendency of doctors to dissemble or make false statements to patients with fatal malignant disease is to be condemned generally in dealing with religious. Their lives are devoted to attaining heaven, and ours are devoted to detaining them here as long as we can. When a religious is finally beyond our ability to postpone his final hour, he has a right to know, and we have a duty to tell him that preparations should be made for that event. Even the most apprehensive nun will react to the news that she is "going home" with composure and peace. She will face death, armed with faith and a lifetime of devotion, and the help of the prayers and sympathy of her community.

This, then, is the rich reward of those of us who are fortunate to know these people in time of illness in their lives. The reward comes not in a fee or material return, but in the benediction of a priest in a hospital bed or the note from a nun at Christmas with a spiritual bouquet of more Masses than we'll attend in months, in appreciation for some slight service or bit of advice we have long since forgotten.

FEDERATION EXECUTIVE BOARD MEETING SCHEDULED

The Executive Board of the Federation of Catholic Physicians' Guilds will meet at 9:30 a. m., June 13, 1956, at the Sherman Hotel, Chicago, Illinois.

The Board comprises the elective officers of the Federation and one delegate from each active constituent Guild.