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INTRODUCTION TO STUDY OF OCCUPATIONAL DISEASES OF RELIGIOUS

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Editor's Note: Many of the physicians who read THE LINACRE QUARTERLY *have patients who are priests, seminarians, brothers, or sisters. These physicians should find the following study interesting and valuable; and they may be able to supplement his conclusions with practical suggestions of their own and pass all of these on to priests and religious who can make good use of them. Dr. Nix is particularly eager to inform others of the "Health Profile" card described in the last part of this article.*

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. As a physician and surgeon, I am, in this instance limiting my observations to physical rather than spiritual health. Concern and solicitude are not enough. Health is a recognized commodity and should be treated as such.

Scientific studies of occupational habits and environment in many fields of industry have proved that individuals and groups can acquire pre-dispositions to some diseases and relative immunity to others. It would be interesting and valuable to have similar scientific appraisals of what, if any, occupational diseases or immunities can be associated with religious as such, and, as a result of data evaluation, to determine what can be done to further the usefulness of our much needed and limited number of these dedicated men and women. The field of such a study is, to my knowledge, completely untouched. Scientific approaches to the occupational diseases of religious remain in the limbo of half-forgotten things. More attention has been placed on plant maintenance than on "religious" maintenance. It is my hope that some day a thorough study will remedy this neglect. To hasten that day, and to awaken interest in a totally unexplored field, this preliminary report is presented. It is by no means meant to be a scientific survey, but merely an introduction to a sorely neglected subject.

The scope of this presentation is limited to three aspects:

1. Survey of records.
2. Tentative classification of factors possibly conducive to predispositions and immunities.
3. Analysis of a "Health Profile" card.

1. SURVEY OF RECORDS

Records from my late father's files and more recent ones from my own office furnish a basis for this report.

During my father's practice of more than thirty years, he was privileged to be consulted by and to treat several thousand religious. These were men and women belonging to various orders as well as diocesan priests. The ages ranged from fourteen through ninety years. I have limited information abstracted from the records to the following two categories:

A. Type of operations
B. Causes of death

Operations

For this report, 692 operations were reviewed. Findings below are listed according to sex: 228 operations were performed on brothers and priests; 383 on sisters. The findings are merely indicative of a possible pattern. For. without studies of comparable groups, without controls, scientific evaluation is impossible.

The most common surgery performed on priests and brothers was:

Removal of appendix	91
Repair of hernia	30
Removal of pilonidal cyst	16
Circumcision	7
Removal of varicose veins of scrotum	5

From my clinical experience with both religious and lay groups, I have the impression that varicose veins of the scrotum and pilonidal cysts are more common in priests and brothers than in corresponding lay groups. Whether or not this impression could be consistently confirmed would require further study.

The most common surgery on nuns was:

Removal of appendix	121
Conditions of uterus, tube and ovaries	70
Conditions of the breast	33
Repair of hernia	10
Repair of housemaid's knee	10
Removal of gall bladder	10

Of the 70 above mentioned operations on the uterus, tube and ovaries, only one case of cancer of the ovaries and one case of cancer of the uterus were noted. In no instance was cancer found originating in the mouth of the uterus. Of the operations for breast conditions, approximately one-half were complete removal of the breast for cancer. Again, judging solely on the basis of my experience I believe that breast surgery is more common in female religious than in corresponding groups of lay women. I have the same impression concerning housemaid's knee.

Causes of Death

The causes of death of the religious naturally vary with the geographic location and the date of death. For example, the most common cause of death among the French clergy is pulmonary tuberculosis, yet not one instance of lung tuberculosis as the primary cause of death was noted in a review of the causes of death of one hundred American religious. Prior to 1900, yellow fever wiped out many communities in the Southern States, and before the use of antibiotics, pneumonia accounted for 30% of the deaths of the American clergy.

Records of 100 religious male and female were reviewed and the primary causes of death were:

Heart failure	34
Cancer	31
Pneumonia	8
Rupture of gall bladder	3
Accidents	3
Miscellaneous	21

Of the deaths due to cancer, the locations of origin were:

Stomach	7
Breast	6
Large intestine	4
Pancreas	3
Lung	2
Ovary	1
Body of uterus	1
Brain	1
Undetermined origin	6

2. TENTATIVE CLASSIFICATION

In the absence of needed scientific data, it might prove helpful to make a tentative classification of those factors of religious life that could lead to occupational pre-dispositions and immunities. I offer six categories:

1. Community regulations
2. Celibacy
3. Diet
4. Dress
5. Accidents
6. Neglect and overwork

Community Regulations

Because of the close personal contact in a community, the spread of colds and other contagious diseases is likely. For that reason, community members with a cough of more than one month's duration should be x-rayed in order to protect other members of the order from possible tuberculosis of the lungs. Contact between a community member with a suspected contagious disease and others of the community should be restricted as much as possible.

Smoking is prohibited to female religious. In my clinical experience with scores of these dedicated women, I encountered only one case of lung cancer, and that was in an 81 year old sister who died of the malignancy. Further study would surely shed light on whether female religious are virtually immune to lung cancer. Priests, for the most part, are not forbidden to smoke. It would add greatly to our scientific knowledge to have a study comparing the health of smokers and non-smokers among male religious.

Drinking of alcoholic beverages is likewise prohibited in some religious communities; in others, especially among nuns, the use is limited to special feast days. This may account for the very low incidence of cirrhosis of the liver I found among nuns. Many of the male religious do not have as strict a prohibition against alcoholic beverages; consequently, the danger of excessive use of alcohol must be constantly faced and guarded against by those priests and brothers exposed to social drinking.

The kneeling position is an integral part of religious life. Prepatellar bursitis, or housemaid's knee, is seldom seen in the laity because modern appliances make prolonged work on the knees unnecessary. Housemaid's knee is a "disease of supplication." I have found it

more common in novices; they have not developed the callouses of older members of their community. I have seldom encountered it in priests.

I believe that most communities try to maintain a well-balanced ratio between physical and spiritual well-being. However, there are few who believe that physical disease should be ignored or endured. It is my impression that severe inflammation of the bladder, frequently intractable, is more common among religious than among lay people. This may be due, in a measure, to the habit of rigidly adhering to community bells (prayer, recreation, meals, etc.) which might lead to forced rather than reflex control of urinary habits. It is not my intention to encourage religious to become hypochondriacs; but, at the same time, I would strongly discourage placing such undue emphasis on religious orders or directives that warnings and signals of the body are ignored or pushed aside. A ruptured appendix cannot be sublimated.

Celibacy

It is medically known that painful menstruation is greater in virgins than non-virgins. It is also medically known that cystic disease of the breast and cancer of the breast are greater in women who have never nursed children. The incidence of painful menstruation and breast cyst or cancer in those religious women under my observation would seem to bear this out. In addition, as there was not a single incidence of cancer of the cervix, it would seem that female religious might be immune to this type of cancer.

I am in no position to comment on the possible relationship between male celibacy and predispositions or immunities; priests and brothers suffering from prostatic and allied disorders are usually referred to an urologist.

Diet

My experience leads me to believe that the high incidence of constipation, diarrhea, vitamin deficiency and peptic ulcer in many of the religious I have examined is attributable, in a great measure, to diet. Because of change of diet and habits on entering a novitiate, constipation is a common disorder of novices and postulants. The low-cost high-carbohydrate diets of many communities may account for frequent instances of vitamin deficiency. Probably because of the inability of most refectories to provide special diets and because of the inordinate work-load of most religious, incidence of intractable peptic ulcer is usually high. Diabetic diets likewise are seldom followed scientifically; foods are usually selected by an appointed rather than a trained dietician, and chosen frequently because of cost rather than nutritional value. Reheating of previously prepared meals often leads to outbreaks of diarrhea.

How prevalent obesity is among religious is a matter for speculation. Obesity could be due to the fact that religious have given up so much that their attention is acutely directed to the palatability of food. Or again, obesity could be due to a diet too high in fats and starches, as previously mentioned. A comprehensive analysis of the problem might even suggest other explanations.

A final word on diet merits reference to what could be called the "Mother Provincial syndrome," or the recurrent acute gall bladder. When the Mother Provincial makes visitation of her houses, each community furnishes her with delicacies of a high fat content. She is unable to follow any dietary restrictions in her travels to the various houses, and operative removal of the gall bladder frequently results.

I have had no occasion to observe whether or not a similar "syndrome" exists among Father Provincials.

Dress

How far the voluminous robes of nuns contribute to poor posture, round shoulders and curvature of the spine remains to be determined accurately. Similarly, those postural and low-back disorders of nuns whose teaching in the lower grades requires much bending, could profitably be studied in relation to comparable groups of lay teachers.

Headdresses present a problem, especially if they are of flammable material. Sisters working in the kitchen or laundry have suffered serious, and occasionally fatal, burns due to flammable headgear. Apart from the fire-hazard aspect, I have noted that young sisters who wear their headdresses exceedingly tight are more subject to ear infections and blood vessel compression headaches than older members of their order.

Fungus infections such as athlete's foot, and dermatitis of the arm-pits seemed to be more frequent among religious than among lay groups. This makes one wonder whether insufficient aeration and constant use of black clothes play an unusually important role in the health of religious—a speculation that should be pursued further.

Accidents

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

Neglect and Overwork

Neglect can be manifested in many ways. Buildings constructed with long flights of stairs aggravate heart disorders. Inaccurate or incomplete medical records maintained by the community on the individual religious often result in poor and late diagnosis. Work can and is often carried to excess. Insufficient financial resources and inadequate staffs, often mean burden of overwork.

Psychiatric care is often delayed because of the time, expense, and embarrassment involved. Psychiatric disturbances, if judged solely by my experience, have not been very frequent among nuns, and less frequent, although more severe, among priests and brothers.

An entire thesis could be written on the subject of neglect of colored religious by Catholic hospitals and Catholic physicians and surgeons. Many Catholic doctors do not treat colored religious. Others reserve a special time for the latter, when white patients are not in the office. As a result, colored religious who go to these doctors must be "sick on schedule" (to borrow a good old army phrase) or remain uncared for until symptoms reach the emergency stage. There are Catholic doctors who receive in their offices and treat colored religious on the same basis as white patients; but these doctors encounter an almost insurmountable obstacle in the matter of admitting colored religious to Catholic hospitals. There are simply no beds, much less private rooms, for these dedicated men and women. In general, as private medical and hospital facilities in Southern States are inadequate for the negroes, treatment of their religious is largely in the public hospitals. Colored religious are naturally reluctant to be hospitalized in a ward with eight or ten lay people; for that reason they postpone visiting the doctor.

3. HEALTH PROFILE

Widespread use of a Health Profile System would furnish data enabling a scientific appraisal of the occupational hazards of a religious life, and the establishment of control values for comparison. The figures "I" and "II" appearing below represent both sides of a health profile card which I have devised. This card is now being currently used by several large communities in this area. The profile card is kept in triplicate, one copy reserved for the provincial, one copy for the community's physician,and one copy accompanies the individual religious. The face of the card (Figure I) shows immunization and medical screening; all measures referred to are performed either by the infirmarian or by the community physician. The medical screening at yearly intervals aids detection of early rises in blood pressure, change in sight, onset of diabetes, tuberculosis and other diseases. Drug sensitivity is listed in order that severe allergic reactions to penicillin, tetanus antitoxin and other drugs can be avoided. Extreme allergic reactions induced other than by drugs are also noted. Some day physicians will regard religious as we presently regard military personnel, and see that immunizations have been recent and maintained. On the reverse side of the card (Figure II), positive laboratory and x-ray studies, diagnosis and operations are to be noted. This information is to be filled out on the transfer of religious from one locality to another, or from one doctor to another, in order that the new physician may be fully cognizant of previous diseases and operations, thus facilitating emergency treatment, if necessary, and avoiding useless, repetitious, and expensive diagnostic tests. The new community is advised of any dietary restrictions or limitations of activity. The provincial is kept informed of the capabilities of individual religious, and is thus better able to control assignments to full or limited duty.

The community physician can learn from the industrial physician the economics of illness and the significance of religious hours lost. As industries require yearly check-ups to protect their investment in supervisory and executive personnel, so religious in similar capacity should be examined prior to and after appointments. If serious deficiencies are noted, replacements could be trained on the job to perform their designated duties.

Although "Entrance Disability" is noted on the card (Figure I), disease in general among religious could be considerably reduced if standard admission requirements were used to eliminate those physically or mentally unfit for the strain of religious life. At present, each community has different medical requirements, and many have practically none at all. Competent medical opinion could help to evaluate the suitability of candidates. However, if requirements too severe and inflexible were adopted, many true vocations might be lost. I have personally known exceptional cases of competent religious who were victims of congenital syphilis, epilepsy, tuberculosis, to mention only a few of those diseases which might have induced a doctor to make an adverse recommendation. It is always well to bear in mind that the best medical recommendations can never envisage the efficacy of the grace of God.

In summary, the health of our religious is a matter deserving serious study and more intensive medical research. While awaiting conclusive data, I believe it is fair to predict that the health of religious can best be served by a combination of good medical records, good preventive care, an interested physician, and an alert superior.

HEALTH PROFILE CARD

NAME:

DATE OF BIRTH:

ENTRANCE DISABILITY

DRUG SENSITIVITY:

OTHER ALLERGIES:

MEDICAL PROFILE:

IMMUNIZATION

MEDICAL SCREENING

Date	Smallpox	Polio	Small Pox	Date	Wt.	Blood Pressure	Teeth	Eye	Ear	Sugar Urine	Chest X-Ray

(Figure I)

TO BE FILLED OUT ON TRANSFER

POSITIVE LAB. & X-RAY STUDIES

DIAGNOSIS AND OPERATION

Date		Date	

DIETARY RESTRICTIONS: YES NO

LIMITATION OF ACTIVITY: YES NO

CIRCLE ANSWER—EXPLAIN IF YES

(Figure II)