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The Impact of Aging on Religious Communities for Women

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A RECENT comprehensive health survey[1] of 90,000 members of religious communities for women has shown that from 1905 to 1950:

1. The average age of sister population has increased from 37.6 years to 45.3 years.
2. The percentage of sisters 45 years of age and older has increased from 27.4% to 51%.
3. The percentage of sisters over 60 years of age has increased from 7.7% to 21.6%.
4. The percentage of sisters between 17 years and 29 years has decreased from 31.9% to 18.4%.

Medical advances have reduced deaths from acute infectious diseases among female religious in the past half century; the decreased chance of dying from infectious disease has inevitably resulted in a changing age pattern of sisters and an increased chance of dying from a chronic disease. At present, the average number of years of life remaining for a sister at age 60 is approximately 20 more. It is believed t t this trend to longevity will c tinue, and that by 1975, one-thir of the members of religious com nities for women will be over (years of age. The decreased pe ntage of sisters in the youn r age groups probably reflects l th decreased vocations and i reased longevity of community r mbers. It is believed, however, th in the last five years the numb s have increased 16% and it is hc d that they will continue to inc ase as the population bulge no comes into the high school age racket.

As golden age may pr e to be a liability rather than an a et, this study attempts to antic ate the effect of aging on the ad inistrative, economic and medic life of religious communities for women. The ever increasing lon vity of female religious will sev ely dislocate the operation of m ny religious communities for women. However, the intensity of impact of aging on any individual community will be directly proportionate to the percentage of sister members over 65 years of age. We anticipate that 5% of the sisters between the ages of 65 and 74 years will be completely inactive, and that 20% of the sisters 75 years of age or older will be completely inactive. In all probability, sisters 65 years of age and older will have three times the number of days per person, per year, of disabling illness with restricted activity, as the sisters in the 15 to 44 years of age group.

As the rate of increase of the sister population has not kept pace with the expansion in Catholic schools and hospital services, and as older nuns are limited both in work load and manual activity, community productivity is expected to decline. Furthermore, more community infirmarians will be required to care for the disabled members of the community. In addition to decreased productivity, the community must be prepared to assume increased expenditures for drugs, infirmary care, and hospitalization. At present, most religious communities for women spend an average of $5.00 a month for medication per sister, and have 3% of their members permanently confined to the community infirmary. The cost of drugs and infirmary care is expected to rise, and the infirmary population is expected to expand as the sisters enter the coronary, diabetic, and geriatric age group. In addition, adequate hospitalization coverage for any individual sister teaching in the parochial schools would consume 10% of the remuneration the community receives for her services; in most areas of the United States the income from six full-time, full-duty parochial school sisters is needed to finance one sister in a mental institution, and the income from twelve full-time, full-duty parochial school sisters is required to finance one sister in a general hospital.

Community physicians throughout the country have recently noticed an increase in chronic and degenerative diseases in our sister population, that is, coronary artery disease, cancer, senility, diabetes, and ruptured disc, etc. As chronic medical diseases are commonly handled in the community infirmary, the ever recurring need for additional infirmary beds is envisioned. Furthermore, analysis of the admissions of female religious to general hospitals shows a disproportionately large number of surgical cases and a rising volume of breast and gynecological surgery.

The impact of age may be blunted by the joint efforts of the Mother Provincial, Catholic physician, Catholic psychiatrist, and Catholic hospital. The institution of ameliorating measures depends upon appraisal of the problem through a continuous morbidity and mortality study. Only a nationwide health program for religious will make it possible to estimate future medical, surgical, hospital, and other needs of the aged. Such a program[2] has been outlined by the Committee on Medical Care of Clergy and Religious of the National Federation of Catholic Physicians' Guilds and The Catholic Hospital Association. This program embraces a Standard Health Record System, including an Entrance Physical Examination Form, a Medical

[1] Fecher, Con J., Ph.D.: "Mortality and Morbidity Studies of Religious," THE LINACRE QUARTERLY, November, 1960.

[2] Nix, J. T., M.D., Ph.D.: "Health Care of Clergy and Religious," THE LINACRE QUARTERLY, August, 1960.

Identification Card, and a Communication Sheet for transmission to the Mother Provincial. This program, if accepted by the communities and executed by trained community physicians and infirmarians, will show distribution of trends of morbidity essential to evaluate the health needs of all communities. United action will make possible estimates of the recruitment and replacement needs of religious bodies and provide facilities for sick and disabled sisters of all communities. Accurate and complete medical records will result in prompt diagnosis and provide data for standards of admissions, clarifying the mandates of Canon Law, and satisfying the requirements of community rule and the specific needs of missionary and contemplative religious life.

The combined efforts of clergy, religious, and laity alike are needed if aging sisters are to achieve their full work potential. This is emphasized by the results of several surveys on current health practices among female religious that lead us to believe:

Health education, health counselling, periodic health examination, and health records are non-existent or inadequate.

Psychological screening as part of the preadmission examination is the exception rather than the rule.

Overwork is the rule rather than the exception, and in many communities retreats and attendance at conventions are synonymous with vacation.

Half of the communit infirmarians have no nursin training.

Two-thirds of religious mmunities have no hospital in rance.

The Catholic Hospital sociation could train infirmaria in the mechanics of the health ecord system, standard emerge routines, and in the treatmen f accidental injuries. Dietitians rained under similar auspices, c ld reduce the absentee rate am g their sisters at the individual tations by preventing avitamino obesity, and food poisoning. nsideration should be given t elaxation of some of the c munity rules conflicting with the cepted management of diabetic d duodenal ulcer patients.

While the relationshi of diet and obesity to longevity ould be the subject of continuing search, more immediate benefit v uld follow instruction of all si rs, and particularly the elderly eligious with lowered cardiac r rve, in the dangers of obesit Some special privileges regar ng the community habit migh ecrease the morbidity rate amor old sisters with cardiac disor rs, who are unable to tolerate xcessive heat. The design of new community buildings should consider the limited physical reserve of our aging sisters, as well as the customs of the community.

The Guild of Catholic Psychiatrists could provide a program of psychiatric screening and psychiatric evaluation to eliminate the poor risk postulant. In the past, because of time, expense, and embarrassment involved, the psychiatrist has been consulted infrequently and as a last resort. The morbidity of tension could be lessened by minimizing anxiety resultant from overwork, inadequate educational preparation, the pressure of certification, and too frequent change of station. Control of self-medication would result in the lowering of morbidity and mortality of all sisters.

Insufficient financial resources and inadequate staffs have resulted in overwork. No person, even if religiously motivated, is able to work a 16-hour day, 7 days a week *ad infinitum*. Particularly in the aged, overwork is false and fatal economy. Unfortunately, in the past overwork has been the rule rather than the exception, and vacations and days off have been the exception rather than the rule. Retreats and attendance at conventions should not be synonymous with vacation. Older sisters need recreation, in fact as well as in name, and at least one week vacation yearly in addition to retreat. Seven hours continuous sleep in each 24-hour period should be mandatory and not subject to desires or work load. Many disabled members of the community could be salvaged for limited yet productive service by intensive rehabilitation and occupational therapy. Although we realize that the sisters labor for God, Church, and community, many sisters teaching in the parochial schools are unable to afford this or any other health program, much less the cost of hospitalization on their current stipends.

Finally, as community personnel can reasonably expect an increased length of life, prolonged training in the novitiate of sister specialists could provide a more productive life for the sister and community alike. As the value of sister specialists of the community increases with age and experience, and as their contributions would be mental rather than manual, they would be physically able to be productive members in supervisory assignments far into the golden age. The changing age pattern of nuns will demand increased productivity to compensate for a shortened work week. Many provincials are already exploring the possibility of late vocations, labor saving devices, and lay personnel. Delegation to the laity and dedication to efficiency may well be the order of the day. The provincial should evaluate future commitments in the light of these new social, economic, educational and health problems. Old age cannot be prevented, but it can be deferred. Sisters may be chronologically old, yet productive, if spiritually and physiologically young.