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# Health to Match Her Dedication: A Progress Report on Health of Religious

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# HEALTH TO MATCH HER DEDICATION

*A Progress Report on Health of Religious*

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At the request of Reverend John J. Flanagan, S.J., Executive Director of the Catholic Hospital Association, Dr. William J. Egan, President of the National Federation of Catholic Physicians' Guilds, in 1959, appointed a Committee on Medical Care of Clergy and of Religious to initiate a modern health program. The first phase of this program was directed toward:

1. Improving communication with directors of responsible religious groups.
2. Appraisal of the current health status of religious.
3. Institution of remedial health measures.

Subsequently, the second phase of the program stressed:

1. The development of a standard health record system and the testing of this system through the Louisiana pilot project.
2. The establishment of a national office, serving as information center and statistical and reference library.

Current objectives in the third phase of the Religious Health Program are:

1. Education and research.
2. Organization of a comprehensive health program under religious control.

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## I. CURRENT HEALTH

Several surveys on current health practices among female religious led us to believe:

1. Health education, health counselling, periodic health examination, and health records are inadequate.
2. Psychological screening as part of the preadmission examination is the exception rather than the rule.
3. Two-thirds of religious communities have no hospital insurance.

Furthermore, 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 the age of sixty is approximately twenty. It is believed that this trend to longevity will continue, and that by 1975, one-third of the members of religious communities for women will be over sixty years of age, if the present rate of new members remains constant.

## II. GENERAL HEALTH MEASURES

We have prepared general directives on community health, emphasizing the role of the community physician, preadmission physical examination, admission standards, infirmary and hospital care, and disease preventive measures.

### 1. *Community Physician*

The community physician must think like a religious but act like a doctor; he must know the personnel rules and customs of the convent, and have the confidence and collaboration of the superior. The community physician must play a dual role—sharing the confidence of the patient, yet bound, as community physician, to submit a sincere opinion to the superior. He is morally and legally obligated not to share the confidence of the individual religious with the superior without authorization. He should learn from the industrial physician the economics of illness and the significance of religious hours lost. He should profit from the collected experiences of others rather than rely entirely on his judgment and past mistakes. The community physician should not be selected solely because of his piety or consanguinity to any member of the community.

### 2. *Preadmission Physical Examination*

Disease in general among the religious could be considerably reduced if standard admission requirements were used to eliminate those physically or mentally unfit for the strain of religious life. Admission standards, however, must change with medical advances, as heart surgery now rehabilitates patients with congenital or rheumatic heart disease. Nevertheless, if requirements too severe and inflexible were adopted, many true vocations might be lost. It is always well to bear in mind that the best medical regulations can never envision the efficacy of the grace of God.

### 3. *Annual Physical Examination*

Physical examination yearly is recommended for personnel over forty years of age and should include urinalysis, hemoglobin determination, electrocardiogram and chest x-ray. This examination should be repeated prior to advancement to greater responsibility in order to protect the community's investment in superior and executive personnel.

### 4. *Treatment*

In matters pertaining to their personal health, superiors should be required to report to specially designated members of the community, whose recommendations would be accepted as mandatory. Hospital care should be provided preferably in Catholic hospitals. Room accommodations should be private and with baths. Provisions must be made for insurance coverage in non-nursing communities. To facilitate future research, hospital records of clergy and religious should be filed separately and kept in a special, confidential file.

## III. STANDARD HEALTH RECORD SYSTEM

The standard health record system emphasizes standard forms kept and maintained in duplicate. These forms include:

1. Medical Form for Examinee

2. Medical Identification Card
3. Physician's Report on Communication Sheet
4. Annual Physical Examination Sheet
5. Instruction Sheet
6. Brochure on Health Care of Clergy and Religious

As health is an integral part of sister formation, the standard record system begins with the new applicant rather than with the less pliable professed members of the community. The community physician either performs the initial examination or passes judgment based on the recomendations and findings of the personal physician. The entire record is then submitted to the provincial with accompanying reports of x-rays and laboratory studies. The provincial makes the final decision as to the acceptability of the applicant into religious life.

After the candidate enters the novitiate, the medical identification card could be completed by the community infirmarian. The medical identification card provides information on immunization, drug sensitivity, laboratory studies, diagnosis and operations. The annual physical form supplements the medical form for examinee.

The physician's report form is designed to provide the community superior, or station superior or infirmarian, with authorized information on candidates and professed members alike. At intervals, the physician's report is supplemented by photostatic copies of the original laboratory records, either at the time of their completion, or at the yearly summary, or at the time of transfer to a new station. On completion of the novitiate and assignment to a mission, a duplicate is made of all health data. The original remains at the motherhouse and the duplicate health record accompanies the religious to the new station. These records are maintained either by the infirmarian at the new station or by the individual religious.

The health record system must of necessity be modified to fit the rules, assignments and individual characteristics of the community. It shows trends, makes possible estimates of recruitment, replacement, and infirmary needs; and provides for admission standards, synchronizing the mandates of canon law with the requirements of community rule.

### IV. EDUCATION AND RESEARCH

Most communities try to maintain a well balanced ratio between physical and spiritual well-being; however, individual religious occasionally resent physical examination. An educational program is necessary to secure personal acceptance of the need for annual preventative practices as well as adequate medical and dental care throughout the year. Educational efforts included:

1. Symposium on physical health of religious presented to the Conference of Major Religious Superiors of Women's Institutes of the United States of America, during the National Congress of Religious in Notre Dame, Indiana, August 18, 1961.
2. A continuous morbidity and mortality study in nuns by Dr. Con Fecher over the past several years.
3. An educational exhibit on Primary Carcinoma of the Lung in Nuns was presented at the American Medical Association Convention in June, 1962, at Chicago, Illinois.
4. An article on the anticipated effect of Increased Longevity on Religious Communities of Women appeared in the November, 1960, issue of THE LINACRE QUARTERLY.
5. A cytology center has been established at Xavier University in New Orleans, offering cytology studies for malignant cells on specimens collected from religious personnel.

The Health Committee of the Conference of Major Religious Superiors of Women's Institutes will soon complete a survey on the cost and current status of medical care.

The Catholic Hospital Association has inaugurated a course in Religious Personnel Management, incorporating the idea that an active apostolate, radiating spiritual and professional superiority, needs physical stamina.

In recent years religious communities for women have suffered from increased expenditures for drugs, infirmary care, and hospitalization. At present, most religious communities for women spend an average of $5.00 per month for medication per sister and have three percent of their members permanently confined to the community infirmary. The cost of drugs and infirmary care is expected to rise and the infirmary population expected to expand as the sisters enter the coronary, diabetic and geriatric age groups. In addition, adequate hospitalization coverage, for any individual sister teaching in the parochial schools, consumes ten percent of the remuneration the community receives for her services. In most areas of the United States, the income of six full time, full duty parochial school sisters is needed to finance one sister in a mental institution, and the income of twelve full time, full duty parochial school sisters is required to finance one sister in a general hospital. The institution of ameliorating measures depends upon the appraisal of the problems through continuous research and study; accordingly, the Health Committee of the Conference of Major Religious Superiors of Women's Institutes is collecting data on the cost of pharmaceuticals and hospital insurance as its initial project.

The Committee on Medical Care of Religious of the Catholic Physicians' Guilds is primarily interested in improving the health and extending the usefulness of our sisters—to give them health to match their dedication stamina for the apostolate. However, scientific research is necessary to determine the diseases and conditions responsible for disability and death in nuns, and to open up avenues of financial support for the health care of religious. Accordingly, the Committee has appealed to the American Cancer Society for a grant to conduct a study on the cause of death of religious. An appropriation of $37,000 has been awarded,

of which about one-fourth will be utilized by the Conference of Major Religious Superiors in carrying out their part of the program. Research into the cause of death in nuns will make possible the institution of preventive measures, as this grant supports the study of the relationship of environmental factors to the type and frequency of cancer causing death in women.

This grant has made possible the provision of secretarial services for the Health Committee of the Conference of Major Religious Superiors of Women's Institutes at its office in Webster Groves, Missouri, and also the establishment of an information center, library, and expanded office facilities for the Committee on Medical Care of Clergy and of Religious in New Orleans. Our pilot project will be a survey of cholecystectomies performed on nuns during the year 1961. The National Federation of Catholic Physicians' Guilds hopes to present the results obtained in the form of an exhibit at the 1963 Convention of the American Medical Association. Furthermore, preliminary plans have been completed to collect and verify the cause of death of all nuns in the United States during the calendar year 1963.

The cooperation of every individual Catholic Physicians' Guild is vital if either of these research projects is to succeed. The Chairman of each Health Committee can be of invaluable assistance by encouraging guild members to complete and mail the cholecystectomy cards. During the year 1963 the Committee on Medical Care will receive notification of death of religious from the mother provincial of the respective community. The Health of Religious Chairman of the local Catholic Physicians' Guild will then be contacted to complete a Data Collection Card embracing past illness, terminal illness, hospital admission, and autopsy findings. In order to avoid any undesirable publicity that might endanger the whole health program, all publicity on any phase of this activity, emanating from either the local guild or the national office of the Committee on Medical Care, should be approved, prior to release, by representatives of the National Federation of Catholic Physicians' Guilds, the Catholic Hospital Association, and the Conference of Major Religious Superiors of Women's Institutes.

### V. A MODERN HEALTH PROGRAM

A central agency has been established, coordinating efforts and providing channels of communication between religious communities and the Catholic laity in medical and allied fields. Comprehensive health care must reflect united action, nationwide participation, central direction, community liaison, and religious control. With completion of the organizational phase, the religious health program has been transformed from dream to reality. The Committee on Medical Care of Clergy and Religious of the National Federation of Catholic Physicians' Guilds and the Catholic Hospital Association feels strongly that future efforts should be under religious direction and control and welcomes the privilege of serving the Health Committee of the Conference of Major Religious Superiors of Women's Institutes, in any capacity, to secure the common goal—stamina for their apostolate. Future development of this program of such gigantic scope will require time, education and the cooperation of countless individuals and groups. In our eagerness to speed its progress, we are inspired by the words of Cardinal Larraona, "Don't try to go faster than the Holy Spirit, but keep up with Him."