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Seminar on Medical Care of Religious

Catholic Physicians' Guilds

Seminar on Medical Care of Religious

Editor's Note: A Seminar on Medical Care of Religious in the Archdiocese of Chicago was held at Holy Family Hospital, DesPlaines, Illinois on November 16, 1965. Charles W. Pfister, M.D., President of the Chicago Catholic Physicians' Guild at that time, presided and Dr. Philip Sheridan moderated a most interesting panel discussion. The meeting is reported as recorded.

DR. CHARLES W. PFISTER: Dr. Philip Sheridan will moderate the panel discussion on Medical Care of the Religious.

DR. PHILIP SHERIDAN: We are happy to welcome you all to our round table discussion on Medical Care of the Religious in the Chicago Archdiocese sponsored by the Catholic Physicians' Guild of Chicago. Our audience of priests, nuns and doctors is not gathered by accident. We are here because of our common interest.

If I may at this time, I wish to introduce the results of a survey of the medical status of the women religious in the United States. This may help us to get to the root of the problem that exists today in medical care of the religious, not only in the Chicago area, but certainly throughout the United States. Dr. James T. Nix of New Orleans completed a survey of the medical inventory of the women religious, and came up with some rather startling conclusions, which I will read to you. They were five in number.

First: Health education and health counseling, periodic health examinations and health records are either non-existent or inadequate.

Second: Psychological screening as a part of the pre-admission examination is the exception rather than the rule.

Third: Overwork is the rule rather than the exception, and commonly retreats and conventions are considered as being synonymous with vacations.

Fourth: Half of community infirmarians have no nursing training. [I think this is probably too high, and probably more in the order of 1/8 to 1/5 have no training.]

Fifth: In two-thirds of religious communities there is no hospital insurance.

With these few ideas in mind, and I hope you will keep them well in mind, I will begin by calling on various members of the panel, after which we will throw the meeting open for discussion. I hope you will all enter into the discussion.

We certainly don't propose to give you hard and fast rules as to how to run your community. Our purpose is to give you some fairly definite ideas as to how medical care within the Archdiocese of Chicago can be definitely upgraded.

To begin, Dr. Robert L. Schmitz, who is attending surgeon at Cook County Hospital, and at Mercy Hospital, will speak on his experiences in overseeing the total health care of a community of sisters in the Chicago area, in addition to reporting on a study of the health insurance needs of this community

and the availability of health insurance programs for the religious community.

DR. ROBERT L. SCHMITZ: For a long time I have felt that the Catholic Physicians' Guild needed something, an objective to work toward, and a program formulated. We are finding out a few things. We had a very successful panel at Little Company of Mary earlier, and I hope we can have more like it, because over the years not nearly enough thought has been given to some very real problems that exist concerning the health care of those in religious life. Since many of these persons are under vows of poverty, there is little they can do individually to correct such problems.

Virtually anyone who has anything to do with the health care of religious has discovered that, as patients, they have several special aspects or features.

First, they are reluctant to take the doctor's time, especially since they are usually not charged.

Second, they are long-suffering and tend to tolerate early symptoms for a considerable period of time before seeking help.

Third, they are relatively ignorant or indifferent in matters of hygiene and preventive medicine.

Fourth, they can be prudish and are inclined to resist adequate physical examination.

Fifth, they are anxious to avoid any expense for their Orders.

Sixth, their daily lives are usually devoid of exercise and physical exertion and they are, therefore, prone to degenerative di es, especially of the cardiovascul nd musculoskeletal systems.

Seventh, they e perhaps more prone, under c in circumstances, to emotional ill s and less able to overcome it bec e of limitation of outlets, and

Eighth, in s of much professional courtes tended to them, their medical s can reach truly astronomical p ortions, and can be a serious pr em to the treasury of their Order

Because of or more of these factors, it is n ncommon to first see a nun or pri with an advanced illness, not no amenable to any curative therap which could easily have been cur if he or she had come in earlier.

What can b done to improve matters? There would seem to be four major needs:

1. Instruction in the essentials of hygiene.
2. A program of regular exercise.
3. Periodic health check-ups, and
4. Some type of insurance to cut the costs of hospitalization and medical care.

Religious Orders should provide instruction in the essentials of health care during the schooling of nuns, priests and brothers. The time would be well invested. In "post-graduate life," religious could be addressed from time to time by physicians or panels of physicians in matters of dental, medical and emotional well-being. An important part of such programs should be a question and answer period.

The Catholic Physicians' Guild could play a very significant role here. If the religious could be assembled in large enough audiences, the logistics should not be unmanageable.

The daily life of a religious is, in most instances, a well-ordered routine with a recreation period included. Why not during 15 minutes of the recreation period have organized calesthenics such as the Canadian Air Force Exercises? If this were adopted in the early ages, it could be continued for all, until some contraindication arose. Priests and brothers living more or less alone should work such a program into their daily schedules. The benefits would be considerable. The Canadian Air Force Exercises include movement and stretching of all major muscles and joints, as well as stationary running to condition the cardiovascular-pulmonary mechanism. One fault of isometric exercises is lack of such conditioning. Emphasis should be on range of motion and exertion rather than on muscle building.

The program of regular proper health care is a more difficult one. A few individual religious manage this through their own good sense and efforts. A few Orders (the Franciscans, the Dominicans, and perhaps others) arrange for their members to have annual check-ups with physicians of their own choosing. In at least one diocese, St. Louis, such opportunities are open to all religious at a clinical facility set up for this purpose in one of the hospitals, but the vast majority are without any good way to arrange for such care, and just fumble along as best they can.

I am well aware of the arguments for and against periodic health examinations, but as a physician with a modest experience in cancer detection examinations, I am convinced that in this one disease alone the benefits justify the expenditure of time and money. If we could apply early enough in the course of this disease only such prevention and treatment as we already have available, we could improve the five-year survival rates in the six major types of cancer:

From 40% in breast cancer to 80%,

From 5% in lung cancer to 75%,

From 40% in colon cancer to 75%,

From 40% in cervical cancer to 95%,

From 35% in oral cancer to 80%, and

From 65% in skin cancer to 95%.

In this problem, again, the Catholic Physicians' Guild could do much to help. The solution is not clear, but several possibilities have been suggested:

1. A clinical set-up with volunteer help to which the religious could come for complete physical check-up and advice.

2. A listing of doctors who would volunteer some time in their offices per day or week or month for such examinations.

3. A modest salary might be paid to such physicians by Orders to

younger physicians with time available to give such care in the motherhouses, convents, or monasteries.

Now we come to health insurance, which is most difficult. How can this be done for the religious? I am sure I will not solve the problem here. It may be that Social Security and/or Medicare will be of help. We will have to wait and see.

That health insurance is a very real need is easy to see, if we glance at the experiences of one community.

There are 336 nuns in this community. They range in age as follows: Under 20 = 27; 20 to 29 = 81; 30 to 39 = 65; 40 to 49 = 44; 50 to 59 = 45; 60 to 69 = 39; 70 to 79 = 30; 80 to 89 = 5. Note that while about three-fourths are under 65, 25% are over that figure. During a twelve-month period the medical expenses for these nuns were approximately as follows:

Hospitalization	$22,500
Doctor's Fees (incl. Dent.)	6,000
Laboratory and X-rays (outside of hospitals)	1,500
Drugs and Equipment (incl. eyeglasses)	10,000
Total	$40,000

This amounts to about $1,200 per nun. It is easy to see that such expenditures can bankrupt an Order.

The Catholic Physicians' Guild of Chicago has for two years had a committee of doctors studying this problem, and so far our efforts have yielded very little of value.

Also, for a year the author has been a member of such a committee for an Order of nuns. The other members of the committee are business executives who have made available for consultation their own insurance departments. The results here have been the same — nothing of consequence.

One soon discovers that religious, as welcome as they may be in most walks of life, are very unwelcome in the world of health insurance for several reasons:

1. Most religious are women, and women in general are much poorer insurance risks.

2. Religious usually require a private room and bath.

3. Religious have much longer hospital stays than do lay persons on the average, partly because most have no infirmary to go to and must be largely on their own once discharged.

4. Religious are always on the payroll — in contrast to lay groups who have termination ages and leaves of absence to ease insurance risks. We note again that in the illustration of one community 25% were over age 65.

5. With insurance, the hospital discounts and professional courtesy extended to the religious cease.

6. Historically speaking, the experience with health insurance for the religious has been discouraging. The Mercy nuns had hospitalization insurance with Blue Cross for the entire Midwest Province, and the experience was so bad the company cancelled after one year. When another company was asked to pick up the coverage it quoted a rate five times as high, probably to show no interest. Again, in an archdiocesan-wide coverage in the Pittsburgh area the costs have exceeded the premiums each year for three years by a large sum, and, therefore, the premiums have gone up significantly annually.

One insurance expert wrote our committee as follows: "I have explored Lloyds of London and all of the quality domestic companies in this field and have been unable to interest any of them in underwriting this particular group. I assure you that we have left no stone unturned in this effort."

If we got any offer at all it was apt to be exorbitantly high, apparently with the object of discouraging us. A business executive wrote when sending the report of his agent: "The attached copy of letter written by the manager of our Insurance Department is self-explanatory. I believe that he has covered the situation adequately, and from his standpoint, would be willing to help in any way possible. Am just a little staggered at the total bill that would be involved in securing the coverage for the entire community."

The best offers we received ran from $35,000 to $40,000 per year for the community whose expenses ran $40,000, and all offers involved various deductions such as the first $100 of expense or payment of only a percentage of total cost.

We might examine one offer in detail. "The medical plan, commonly referred to as a comprehensive major medical plan, will cover all types of medical charges including the full cost of semi-private room; other miscellaneous hospital charges; doctors' and surgeons' fees, including home, office or hospital calls; and prescribed drugs, dressings, or equipment purchased or rented from the local pharmacy or medical supply house used in the treatment of a given disability. The cost of a private nurse would be included unless the private nursing service is rendered by a nun. The proposed plan contemplates a $100 deductible for all medical expenses accumulated over a period of six consecutive months or less. The balance of all medical charges after the first $100 has been expended would be reimbursed at 80% for the balance of the calendar year. The maximum lifetime benefit under this plan would be $10,000 of reimbursed medical charges. The estimated cost of the comprehensive major medical plan would be approximately $7.50 per month per nun. Naturally the rate indicated is an estimate based on the current rate structure used by (blank blank) and assuming an average age of approximately 45.

"In addition to the medical plan, (blank blank) is requiring that $2,500 of group term life insurance be purchased for each sister. You may find that a greater amount may be needed when the training and replacement cost of a deceased nun is contemplated. The actual cost of the $2,500 insurance can only be estimated, as the final cost would be based on the ages of those insured under Illinois insurance law. A reasonable estimate for the full amount would be approximately $1.80 per month per sister."

A little arithmetic will show that the premium for the medical plan runs about $30,000 per year, and for the term life insurance a little over $7,000 per year, and this with the deductibles mentioned in the quotation. Remember also that these are just starting figures and would be raised promptly if the company felt the need. So we see that the problem is far from solved.

In further deliberations, one must consider the size of the community to be insured. The larger the community the better. Therefore, it would seem desirable to lump together all provinces of an Order on a national basis or to use local geographic boundaries and lump together all religious in a diocese or archdiocese. If these groups are too cumbersome, the parish might be a good unit, since all personnel, lay and religious, could be grouped, and, since almost all would be active employees, the older age members would be few.

Orders could help their own causes by building infirmaries and training enough nurses and practical nurses to care for their sick and aged. Thus hospital stays could be shortened and perhaps those over 65 could be excluded from insurance and cared for solely by the Order in its own infirmary.

Since ordinary hospitalization and medical care insurance is not available at an acceptable cost, other types of coverage should be considered.

Self insurance is one possibility, but it might be difficult for an Order to accumulate enough principal to make this feasible.

Group life urance could be used to defra neral and burial expense and e a residue that might gradua grow into a significant princ

Major med insurance could be obtained to t over when expenses exceed $300 0, $750, or $1,000, and perhaps iums on such coverage would manageable.

Workmen ompensation insurance can b plied and has been applied to w g religious such as teachers, bu course, it applies only to acc ts or illness which result at or f work.

Social Sec and Medicare will apply to ma ligious over 65 years of age effec January 1, 1967. However, m bers of communities subject to th ow of poverty are excluded fro participation under the provision the Social Security Act. They ma however, participate in Part B o Medicare under the Voluntary Supplementary Medical Insurance by paying a monthly premium of $3 which the government will match with $3. Such insurance may be of great value in caring for older religious and thus make the under 65 group a much more desirable risk.

It would seem there has been enough discussion and investigation into the general problems of health care of the religious. What we need now is a concerted effort on a large scale by people with experience in the matter to outline a plan of attack and see that it is fulfilled.

DR. SHERIDAN: Thank you, Dr. Schmitz. You certainly touched on a number of pertinent points. Two

the more, if not the most, pertinent were the upcoming Medicare help which may be a very extenuating situation insofar as the insurance problems are concerned. You also touched briefly on the responsibility of the local parish as far as medical insurance is concerned. It has been frequently and well said that if a Catholic family expects its group of nuns to accept responsibility for their children for from six to eight hours a day, bringing them up and molding their character, they certainly owe them a decent place to live and decent medical care. To date this really has not been the situation in most parishes, not because of inability to do so, but oftentimes it is a case of straightforward neglect. This has been recognized, and in some archdioceses efforts are being directed along that line at present, with acceptance of the responsibility at the parish level, and assistance of the individual over age 65 because of Medicare. I think perhaps we have a little brighter outlook.

Dr. Maslanka of the Stritch School of Medicine, will speak on the psychiatric aspects.

DR. STANISLAW MASLANKA: As with all endeavors of this type, my first step was to review the literature. I discovered that there has been a scant amount written about treating clergy, and I was unable to find any written reports on the out-patient psychiatric care of Catholic clergy.

The first published article was in 1936 by a Father Thomas Verner Moore who wrote on "Insanity in Priests and Religious." Father Moore found that the incidence of mental illness was far greater among the general population in the United States than among the religious. It was 22 years later that the next article appeared. This article was by Sister Mary William Kelley, who published a study on mental illness among religious sisters in the United States. Sister concluded in her study that mental illness among sisters was increasing, but that the rate was still considerably lower among women in religion than lay women. Sister Kelley pointed out that the incidence of mental illness seemed to be greatest in the domestic sisters and that the next group comprised the cloistered nuns, the third group were the teachers, and the smallest incidence was in the professional hospital personnel group. A surprising thing is that, according to her, the domestic service sisters constitute only 4% of all sisters in America, and yet the incidence of mental illness among them is much higher.

Dr. McAllister and Dr. Vandervelt published articles in January, 1961 and March, 1965, which are detailed studies on psychiatric illness in hospitalized Catholic religious. Some of their findings are interesting. For example, they mentioned that there were 2½ times as many religious patients as lay patients hospitalized for misuse of drugs, alcohol or sexual acting out. Deviant behavior accounted for one-quarter of the religious group. Alcoholism was present as a major symptom in 32 of 100 priests, and misuse of drugs in six of the sisters. A higher group hospitalized for deviant behavior is probably accounted for by the fact that the religious

community is far less tolerant of deviant behavior, plus the high aspirations of the religious and the danger of scandal to others.

Sixty-three per cent of the religious patients came from the lower socio-economic group as compared to 39% of lay patients. This may be due to the fact that the religious have more problems adjusting to the professional status which comes to them through the mere fact of religious profession. There was also a lower scholastic level of the religious than the lay patients.

Among the nuns, sisters with late vocations had a greater frequency of psychiatric disorders. This may be due to the fact that being older they are less flexible and probably in the past were unable to make adjustments in their lay life.

The religious often had an attitude that they were forced to come to the hospital as a form of punishment and many were actually not referred by physicians. The lay patients were better motivated for therapy. It was also found that the religious had longer hospital stays. This possibly is accounted for by the fact that the medical staff would have higher standards for the religious group out of respect for their position, plus the financial burden to the lay patients was a factor which did not affect the religious in the same way.

Their conclusions were that psychiatric evaluation and treatment of religious candidates could do much to relieve the unhappiness that results from a commitment that creates conflicts. Healthier attitudes toward psychiatry on part of the religious superior could do much to relieve the guilt and scorn incurred by those who seek such care.

The following is a summary of my experience in treating Catholic religious on an out-patient basis. It is not an attempt to provide a detailed study of the various factors that relate to the presenting disorders. It is merely an accounting of what went on.

I reviewed the records of 40 sisters who had been referred to the office. It was found that the majority were in the age group of 40 to 60. The age group of 40 to 60 comprised 15 nuns, 60 and over comprised 9 nuns, age 30 to 40 comprised 7 nuns, age 20 to 30 comprised 7 nuns. Many of the sisters had been in the order for at least 20 years or more. There was no one particular Order represented, since there was a sprinkling of at least eight different religious communities. The most common presenting complaint was a disturbance on the somatic area. The diagnoses ranged as follows: Anxiety reaction, 13 patients; depressive reaction, 4; conversion reaction, 2; involutional depression, 3; paranoid schizophrenia, 8; alcoholism, 1; drug addiction, 4; chronic brain syndrome, 5. The interesting thing was that no phobics or obsessive compulsives were encountered, a diagnostic category which is common among the lay patients, especially the phobic group. The majority of the sisters were referred by the Order itself, only 8 of the group were referred by physicians and only 2 self-referrals. The majority of the sisters felt that they were forced to make the visit and were not motivated for any sort of psychiatric care. As a result, the majority of the group made one or two visits. It was a common finding that a request was made for a written report or else a companion came with the sister who wished to discuss her particular problem. I suspect that the problem with confidentiality had some bearing on the motivation and subsequent course. In the sisters who remained in therapy, a common statement and finding of theirs was the fact that they felt rejection, received no understanding, plus implications were made that they were gold-bricking. There was also reported by some of the patients concern of the superiors who did not want everything to be revealed about the functioning of their house. It was especially difficult for the chronically ill psychoneurotic. The sisters who were 60 years and over had the usual problems of old people of finding a place in their particular home and community.

The next group treated were the priests who comprised a smaller outpatient group. The priests were usually self-referrals or referred by doctors. As a result, their motivation for therapy was considerably better than was found among the sisters. The priest would usually continue with his visits until treatment was terminated. The problem about confidentiality with the priests was easily settled, probably because of the priests' customary use of this method. The diagnostic categories were a sprinkling of the usual groups that are seen among male lay patients.

The four sisters with drug addiction had a long history of somatic complaints with multiple surgical procedures with eventual habituation to drugs and finally, after all somatic possibilities were exhausted, they were referred on for psychiatric care. I would suspect that somatizations among the religious would be a much more acceptable route than the other neurotic forms which are seen among the lay group. It is difficult to visualize how a phobic or obsessive compulsive could exist in a religious community.

A large problem with motivation presented above perhaps might be eliminated if the referrals were more carefully done and explanations made by a medical source. Perhaps the lack of financial responsibility for treatment may have some bearing on the lack of involvement in the therapeutic process. Tolerance and dissemination of information on psychiatric disorders might be helpful in alleviating the difficulties with acceptance that the ill sisters find in living in their particular community. I suspect also that it must be difficult for some of the religious patients to differentiate between problems which are spiritual and psychological, and whether their particular kind of help should come from a priest or a doctor. It is true that it would take a person who is familiar with the principles of religious life in order to make any attempt to deal with this group. Any good doctor could take care of the religious group as such, but I do not

believe he could do so without accepting these principles.

DR. SHERIDAN: Thank you, Dr. Maslanka. Your remarks were directed primarily to out-patient care of the religious and do not take into consideration the hospitalization of individuals with mental aberrations which require inpatient care. Would you care to say something about your impression of the incidence of mental illness? Is it true that the incidence of psychosomatic illness among the religious is about the same as in the average population?

DR. MASLANKA: No. I would say from my own personal observations it seems to be considerably lower. That is, the religious hold out better than the average lay person does.

DR. SHERIDAN: We will now hear from Dr. Robert Lappe of Holy Family Hospital, who is in a unique position of overseeing the medical care of a group of religious, that is, priests. He will relate his experiences in taking care of this group.

DR. ROBERT LAPPE: Let me introduce my remarks with two statements. First, as I sat listening to these two speakers, I was surprised to find that my experience, although totally apart from that of these two gentlemen, is virtually identical with theirs: the religious community which Dr. Pfister and I care for is a true sampling of the religious community in general.

Second, many of the people whom Dr. Pfister and I saw this year were dreadfully ill. So much so, that I, myself, was appalled to see that supposedly intelligent men had allowed certain diseases advance to such a degree that presented elective as quite

In the past Dr. Pfister and I have accepted medical responsibility for a community of teaching pries Our objective has been to offer a member of the community opportunity for a complete med evaluation once a year, or more if indicated.

The medic valuation of these 44 or 48 pri accomplished on the initial vis here is a complete history, phys xamination, urinalysis, blood t and EKG. This requires the part of one hour. These gentlem are then reevaluated at the n office visit, and, if necessary, mor information secured in order to cor to some conclusions as to the pre nce or absence of disease.

Some of the ecent problems seen in the mem rs of this small community include the following: malignancies including leukemia; arteriosclerosis; generalized peripheral vascular disease — both arterial and venous; chronic bronchitis and emphysema; other pulmonary diseases; arthritis and rheumatoid states, including degenerative arthritis and "slipped disk"; arteriosclerotic heart disease, compensated and uncompensated, with or without high blood pressure; a variety of disease states of the kidney; over and under active thyroids, including one case of myxedematous heart disease, which is rare, complicated with severe thrombocytopenic purpura, possibly related to amphetamine habituation; there was one emergency colostomy for acute perforation of the colon in a 29 year old man; a number had nutritional liver disease. Indeed, the whole spectrum of disease states, usual and unusual is harbored by this small religious community, and would remain undiscovered until too late unless an active approach to ferret out these problems was made by a physician.

We have been left with a number of impressions and even prejudices. For the latter I alone assume responsibility. There is no doubt in my mind that the clergy, particularly those sequestered, direly needs periodic health examinations, quite similar to those done for business executives and captains of industry. The analogy is obvious. Surprisingly, some of these men accept our medical consultation in an undisciplined fashion. There are many who eat too much, smoke too much, drink too much — and still do; on occasion of the next visit the priest or the nun wants to see the "other doctor," who may not be "so hard on him." In the past fortnight we recommended to one man that he retire from active teaching because of a progressive cerebrovascular state with impaired cerebral function. His superior was grateful to us for this advice because the superior had already recognized the man's flagging teaching efforts. The superior could not bring himself to relieve the man of his duties. The patient, however, cannot or will not accept this, and he plans on returning to his classroom following further convalescence, much to the consternation of his superior and to the detriment of his teaching schedule. Some of the parents will resent this if they think their children are receiving a truncated educational experience from an incapacitated old man.

In summary, we find that clerics are just like people: they become sick in body and in soul. They need medical attention. Better still, they need prophylactic medical care so that incipient disease may be dealt with long before the clergy person is prematurely incapacitated. The clergy is in short supply. Let's keep them around for a while.

DR. SHERIDAN: Thank you, Dr. Lappe. Your remarks about the clergy being in short supply and the value of preventive medicine brings to mind a short notation in the journal put out by Dr. Nix relative to medical care recommended in a few areas of preventive medicine, which he feels might add on the average of up to five years in general to the life of every member. If we have a community of 2,000 sisters and could add five years to the life of each member, we would gain 10,000 years. On the basis of 40 useful years of life for every vocation, that community would gain 200 new vocations. This is one of the significant factors which comes to light.

Sister Mary Felicia, sister of the Order of the Holy Family of Nazareth, is Health Director of the Sacred Heart Province in Illinois, Wisconsin and Indiana. There are roughly 600 members. She has been director of the program for four

years, and it has been in existence in the Province since 1958. Sister Felicia will discuss the problems encountered in overseeing the health care of the religious, that is the medical care and the broad activities in the Province of the Holy Family of Nazareth.

SISTER MARY FELICIA: When I was asked to discuss the sisters' health program before such a distinguished audience, I shuddered at first, but gladly consented to do so. For days and weeks I thought of just how I would do this in a limited time. Since my topic is to deal with the development and function of the health program for our congregation, I find it appropriate to give my theme some type of introduction.

Aside from the general introduction, the following highlights will be presented: A cumulative health record, infirmarians, convent physicians, the first preventive and active programs, yearly physical examinations and follow-up, educational and mental health programs, and, finally, general problems encountered and what has been done to solve them.

At this time, the question may arise, "When did the Health Care Program for Religious originate?" The Church, confronted with a critical shortage of sisters, suggested a united action in regard to a health program for religious in the United States effected through the Catholic hospitals and centrally directed nationwide participation. Since the Catholic Hospital Association was asked to implement such a program, the assistance of the National Federation of Catholic Physicians' Guilds was sought. In 1959, Father Flanagan, Executive Director of the Catholic Hospital Association, and Dr. William [illegible], President of the National Federation of Physicians' Guilds, appointed a central committee on the medical care of the religious and clergy for the purpose of setting up a modern health program, with impetus placed on reduction of morbidity and an increase in productivity and longevity of religious personnel. The first action of the central committee was to appraise the health of individual members of a community through the first call for physical examinations. The committee then set up a standard record system, and later these activities were centered upon education and research and organization of a comprehensive health care program under the auspices of religious superiors.

It would be difficult to find a period in history in which the need for leadership in health is more urgent than in our time. The sister of today, so to speak, is under mental pressure because of insufficient time to fulfill the heavy requirements of the apostolate and the numerous obligations of the religious state. Naturally, the adverse health consequences of a lack of time result in tensions, frustrations, aggravations, curtness and a sense of failure in completing the spiritual as well as the mental and physical demands. Those who are aware of the existing problems for health purposes, encourage improvement and change.

Pope Pius XII, Pope John XXIII, and Pope Paul VI have stressed the

need for adaptation to the needs of the present day, for modernization of religious communities, and for the development of the sisters' highest potential.

Admittedly, amazing progress has been made in personnel management in Catholic hospitals due principally to the influence of the Catholic Hospital Association. There is an ever-growing sense of responsibility on the part of hospital administrators. Secular employees are limited to 40 hours a week. They have generous fringe benefits, including vacations, sick leave, legal holidays, annual physical examinations, immunizations, continuing health service, retirement, hospitalization, and in-service education. This is justified on the basis of better adjusted employees, higher morale, a sense of security, better health — both mental and physical — and, therefore, better patient care. Seemingly, comparable progress has not been made in the school apostolate. Sister M. Gerald, CSC., at one time administrator of the Holy Cross Hospital in Salt Lake City, Utah, has this to say. I quote:

"Sisters are human beings, too! What is good for the mental and physical health of the secular employee is good for the sister also. A well-adjusted, healthy, professionally competent sister will be a religious whose influence for good can change much that needs changing in this world of ours. Her influence can be incalculable. On the contrary, a sister who lives and works under tension, a sister who is not at peace with God, with her neighbor or with herself, can tear down the work of the Church and nullify the efforts of the other religious in the hospital or school. The health care of the sisters is as real an obligation on the part of the superiors as is the responsibility of providing clothing and food. Teaching sisters should not become charity patients when they enter a hospital. Superiors should not expect the local citizens, through the hospital, to underwrite the health program of the religious congregation. Instead, superiors should encourage bishops and pastors to provide health insurance for teaching sisters. If they are unsuccessful, however, superiors should undertake this responsibility themselves."

I am assuming that this background material which I have presented will help explain earlier and later developments in the field of medical and surgical care in our congregation. The emphasis by the Catholic Hospital Association is the demand for a well-formulated health program by every community in cooperation with the hierarchy of the Church, and, perhaps, the natural motherly concern for the conservation of the sisters' health, led Mother M. Aloysius, former Provincial Superior, in the summer of 1958, to investigate the health needs of her community and to find out how much illness existed among the sisters. To this effect, a survey was conducted upon a firm decision to establish, organize, and implement a future health program to include the Sisters of the Holy Family of Nazareth in the Chicago area and vicinity. This included Wisconsin, Indiana, and at that time, areas of Texas and New Mexico.

This survey was begun by taking a complete history, including present complaints and past medical and surgical histories. After a system review was made, it was followed by a complete physical examination. Each sister had her weight, pulse, and blood pressure taken and re-

corded. For the initial work, Mother Aloysius engaged a competent female physician and two registered nurses. Totally, 650 sisters were examined. Though a simple record was used, this record served well when one of the 650 sisters called to report a problem or to seek advice. Afterwards, a composite of major health problems was made, indicating the number of sisters having each condition, with management and comments.

A year and a half later, all of the previous findings were investigated and treated, the second survey was in order for August, 1960, which Mother M. Getulia, the next Provincial, so gladly recommended. In addition to routine eye and routine lab tests, it was decided that an EKG should be done for all sisters over 45, a Pap smear on all sisters over 40, and more thorough examinations of the legs and feet, with proper referrals for surgery, supports, or shoes when indicated.

In 1962, Mother Getulia furthered the advancement of this health program by doing her utmost to comply with the requests and demands of the central health committee. To this end, a medical director known as the community physician, was employed for the entire Province.

In 1963, a central office under the name of the Sisters Health Service had been established at St. Mary of Nazareth Hospital to provide a better communication system and where all official health records, various reports, etc. are kept in strict confidence.

Next under consideration was the selection of 30 sister-infirmarians—one for each convent, with formal training in home nursing which included basic instruction in bedside care, tray service, temperature and blood pressure reading. For proper care and health instruction, each infirmarian has in possession of a *Health Manual*. The infirmarian acts as an intermediary between the physician and health directress. She is of service to shelling sisters and also helps those who continue their recovery at home after surgery or acute illness rather than prolonging their hospital stay unnecessarily. Fortunately, there is a full-time registered nurse at the Provincial house who not only exercises professional care toward the individual patient, but also teaches home nursing and first aid to the junior professed sisters, novices and postulants.

Part of the function of the health program was the choice of a regular physician for each convent, whereby a sick sister could turn for diagnosis, treatment, care, advice and help. Preference was given to the physicians on the hospital staff and to those whose office was closest to the convent, provided these doctors actually cared to give the sisters medical care. Preference for a certain doctor, if desirable and necessary, was honored when requested. Remuneration for services rendered remained with the doctor's decision.

Since sickness is, to a large degree, preventable, as a part of the preventive health program, the following measures were undertaken:

1. For sisters under 35, a regular physical examination is desirable every two years. For those age 35 and over, a routine annual check-up is required, including cancer detection examinations. A sister is encouraged rather than forced to undergo a physical. Any sister who is admitted to the hospital is automatically excluded from a routine physical examination.

2. Routine laboratory tests including urinalysis and a complete blood count are done. Other diagnostic tests are made, depending on what the doctor finds on physical examination and the history given.

3. An electrocardiogram is made when the doctor considers it desirable.

4. A chest x-ray is done yearly on all sisters at the time of the retreat at the Mother House.

5. For sisters age 65 and over, for known cardiacs, diabetics, and other sisters, who ran a positive Mantoux (test for tuberculosis), a large chest x-ray is taken and repeated in six months.

6. Periodic dental, ear, and eye check-ups are also in order.

7. Also keeping tab on the appetite I.Q., that is, cutting down on calories in order to reach or maintain normal weight is stressed. The consumption of proteins, vegetables, and fruit and the avoidance of refined foods are suggested, and ways to balance exercise, rest, and relaxation are recommended. Overweight has proved to be a potential threat to health and longevity and is closely connected with specific health hazards such as heart and circulatory disorders, diabetes, and a host of daily discomforts. Prevention is the best answer. Life is much easier in many ways for people who are not too fat. They feel and look better, they are less likely to suffer from backaches, foot troubles and constant fatigue. Normal weight is worth the effort it takes to reach and keep.

Another important phase of the health program is to see that the sisters receive necessary immunizations against preventable and communicable diseases. During the past two years, the screening program for tuberculosis and the immunization program against smallpox, diphtheria, tetanus, and polio were carried out with the full cooperation and authorization of Dr. Edward Piszczek, Field Director of the Public Health Service in Cook County. Seasonal booster shots against flu are administered to the sisters annually at the hospital.

The hospitals carry out this portion of the health program. All follow-up care rests with the convent physician with referrals if necessary. The sisters are usually advised to see the doctor, by appointment, either at the hospital's outpatient department, medical center, health clinic, or doctor's office. Through the courtesy and cooperation of the convent physician, all arrangements for hospitalization are made. For hospitalized or seriously ill sisters, whenever possible, replacements are being made. Because of an acute shortage of teaching sisters, such replacements are made with difficulty. A sister who is in need of a simple follow-up

is encouraged to phone the Health Directress or the physician in order to give progress reports or to discuss new problems and medication refills. The sisters are strongly urged to follow doctors' orders and to use medicines as prescribed.

To keep abreast of current research in areas relating to medicine and public health, to have a working knowledge of the functions of the body, and to conquer ignorance which blocks the intelligent use of medical knowledge and know-how, extensive health education programs are occasionally conducted.

In the summer of 1964, at retreat time, the sisters had access to a book display, received literature on Mental Health, heart trouble, cancer of the female organs and immunizations, and about tuberculosis. They also viewed films about the human body, hypertension, cancer of the female organs, prevention of tuberculosis and preventive health. This time also proved advantageous for lab work on the sisters and for preparation for the physicals, after which each sister received lab reports and a physical exam form to take to the convent physician. The educational program for the past summer comprised the following: Films and lectures on good dental care, on eye conditions prevalent today, and means of prevention of eye diseases, a film on ulcer, and a lecture on the ulcer personality, and a lecture on poise and personality. Physical fitness included a program of calesthenics and games. At this time, routine chest x-rays and lab work were done also on the sisters.

Medical lea recognize that man cannot b parated into parts for care and tr ment of his illness. They are awa psychosomatic illnesses. Emoti tensions can and do play a pr ent role in many physical ailm Since man is a whole being health is affected by physical, tual, mental and social factors in ill health he requires tota e and treatment. Every person an innate desire to become a lete human being, hence the lor rocess of education and maturing ich gradually prepares him fo wholesome life in this world so t he may become truly complete union with God in the next. Wh meness is achieved by the health evelopment of all three dimensio of the human personality; the p siological, the psychological, b intellectual and emotional, and piritual. Since mental health is far more than merely the absence of mental illness, it has to do with everybody's everyday life. Mental health means the overall way that people get along — in their families, at school, on the job, at play, with their associates in their communities, and the sisters in their convents. It has to do with the way each person harmonizes his desires, ambition, abilities, ideals, feelings and emotions, and his conscience in order to meet the demands of life as he has to face them. To learn more about this business of keeping mentally healthy, a two-day Mental Health Institute with instructional workshop, was held in November, 1964 at St. Mary of Nazareth School of Nursing. Lectures on Mental Health in Our Affluent and Changing Society, Teachers' Attitudes and Their Effects on Child Development, Well-Balanced Ratio between Mental and Spiritual Well-Being, Mental Health and the Modern Religious Women, and Dehumanization of Man were presented. There was also a display of appropriate books. In February of 1965, this program was followed by Father Anthony Becker, a psychologist.

One of the functions of the health program is recommending a practical and effective method of treatment of mental and nervous disorders and treatment by a capable person or persons. During the past year, there was a marked increase in referrals by the convent physician for sisters to visit a psychiatrist or psychologist. At least three sisters were admitted to the hospital with a working diagnosis of anxiety-neurosis. A special service unit was established for psychiatric needs of our sisters. There is a full-time registered psychiatric nurse, assistant nurse, and a regular consultant psychiatrist.

The program, such as has been outlined, is in itself extensive and costly. If we did not have our own hospitals, we would find it difficult to finance such a program. I could readily appreciate the many financial problems encountered by those communities who haven't hospitals. I express gratitude to the many good and dedicated doctors and hospital personnel who willingly contribute their time and services to our sisters.

As I observed the health program of our community in its initial stage, I marveled at my predecessor's endless and persevering call to the endless work of appointments for physicals, follow-up care, looking for doctors for acutely-ill sisters, and for those who needed surgery. On the other hand, too many sisters wanted the services of the same doctor who already had a big patient load. Waiting periods for sisters were long. Doctors, at times, would forget and leave the hospitals. The sisters were often seen waiting at the entrance to the hospital just to catch the doctor so they could receive his care. This situation called for some organization. To this end, a full-time health directress and regular convent physicians were scheduled, as well as regular visits to the convent physician.

To make the new health program effective there was a further need to formulate its philosophy, main objective, chief functions, and policies. To convince the sisters of the need for an organized program such as this, my personal visit to each convent proved necessary. There is still general apathy towards certain aspects of the program such as immunizations, physicals, convent physicians, and organized activities. To conquer the attitude of indifference, ignorance, and prejudice, educational health programs are being held. In spite of the attitude of indifference among the religious, the educational health programs should continue.

DR. SHERIDAN: Thank you very much, Sister Felicia. I was especially interested in your comments by Sister Gerald, which were touched upon by Dr. Nix, and are quite pertinent because we hear time and

time again from doctors who have the responsibility for the health care of the religious, that the first phase is the overwork which, so frankly, is almost a disease of the religious because of their zeal to do the work to which they have dedicated themselves, and this frequently results in friction which invites psychoneurosis, as pointed out by Dr. Nix in his book.

Also, as has very well been said, why should nuns have been singled out as objects of charity when it comes to medical care? I think this is an absurdity, and yet the economics of our life in the Church in America dictates this. Yet, hopefully, there will be some recognition of the facts by the administration of the Chicago Archdiocese.

We would welcome remarks or questions or criticisms and observations directed to any panel member.

DR. ROBERT SCHMITZ: I might say I am overwhelmed by what the sisters at Holy Family of Nazareth have accomplished. I was totally unaware of their program. I think we have all been working in our own little areas, and there has been no national effort, or, if so, reports of efforts have never filtered down to the individual chapters. I also reviewed some of Dr. Nix's work, and that is why we have to have some sort of forum for bringing together these ideas. But more than that, somebody has to know about these good sisters. They have really done a job.

DR. SHERIDAN: Out of all that has been said, I think we could begin to draw some conclusions.

If there are y questions while we go over the you are more than welcome to as em. Generally, I would gather f the remarks made here tonight at the following would certain e in order for the religious, whe male or female.

First of all, ere has to be psychological or ychiatric screening of all postul . Second, physical screening is ually important. Third, a ph l exam with Pap smears for y member female over age 35 t 0. That was a factor just touch on, but I think this is of real sig ficance. Fourth, a unified record ould be useful for research, that s a unified record where the ini l physical examination, history a evaluation would be kept. Th would be two or three copies f each nun, and it has been well pointed out that each nun should have her own copy of this record in spite of the overprotective attitude of the superior who wants to keep undesirable information from her.

Number five on our list is recommendations, and some of these things are so obvious that we hesitate to mention them. However, we do, and one is the avoidance of overwork. Psychoneurosis is the commonest illness of nuns in the United States, and is almost always directly related to overload of mental and physical effort. Sixth, the corollary of this is that each individual should have a real, true, legitimate vacation, certainly every other year if not every year. This does not mean to attend conventions or retreat.

Seventh, insistence that part of e just due of any nun religious or le religious, is adequate medical alth care, and if adequate medical e has not been possible in the t, then some way has to be found r it.

Eighth, we should aspire to have l infirmarians trained at least in rsing.

Ninth, free choice of physician is ndatory.

Tenth, prevention by immunizaon of communicable diseases such tuberculosis, polio, etc.

This is a rough outline, and certainly does not outline what is necessary in the over-all medical care of a religious community. We hope they give you some concept of what we have in mind in the Catholic Physicians' Guild. It is a very humble beginning and we anticipate there will be more attention paid to this not just by doctors, but by the hierarchy of the Church, where some attention has been lacking.

DR. SCHMITZ: Dr. Maslanka, I'd like to ask how far a psychiatrist can go because of the attitude which is put forth. I'd like to know what he thinks he can bring about in the way of teaching people to accept hard work rather than running away from it. These matters are individually regulated. What does this person consider overwork or hard work?

DR. MASLANKA: Apropos overwork, it has been more or less our feeling that hard work never makes you ill. All of this is the manner in which the work is pursued, affected by the intensity with which the individual labors and the standards he applies for himself. The commonest thing is the degree of perfectionism, and the ultimate goal that he expects as a result of it. The usual thing is that it is good for people to get to work and keep busy, and I think this is a great step toward the preservation of mental stability and making a good adjustment.

DR. SCHMITZ: You are saying in effect that hard work never killed anybody, but we would like to hear more about the vacations.

DR. SHERIDAN: I am sure we would agree that hard work is not synonymous with overwork.

Relative to vacations, this is something I am sure will be in the future, but if you don't reach for the stars, you will never get there. Vacations for the nuns are desirable. There is no shortage of doctors taking vacations, and it is just as desirable for the nuns. As Dr. Lappe said, they are people too.

Are there any remarks from the audience?

QUESTION: I would like to suggest that in this Archdiocese they put into effect the insurance program they began in St. Louis, where the parish did assume responsibility for insurance for those working there. I think it ran to $8.65 or $8.95 for the pastors of the parish. I don't know the exact amount, but it in-

volves both Blue Shield and Blue Cross.

DR. SHERIDAN: Your point is very well taken, Sister. I can assure you that at least the head of the Catholic Board of Education is urging this. He wants this. How far it has gone beyond there I do not know. We had a meeting with Cardinal Meyer on this very subject, but discussions were concluded by his untimely demise. Now we will have to begin again in this same direction. It may be as a central Archdiocesan project because there are parishes that just can't carry the burden. There will have to be some compensation for them.

Perhaps, Father Marren, you would like to close with a prayer.

FATHER JOSEPH W. MARREN: Almighty God, we wish to glorify You by the effort we put forth each day. We ask You bless on all we do. We ask You accompany the healing works of our hands with the consoling and strengthening graces of Your goodness and mercy. We beg that You bless us, all our families, and all who work with in the end to eternal happiness with You. Amen.

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