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Narcotherapy in Catholic Hospitals

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I believe that Fathers Bihler and O'Brien have brought out excellent points. However, in stating my conclusion in some kind of formula, I should like to keep it a little more general and make allowance for competent medical judgment that may go somewhat beyond the conclusions just stated. For instance, good psychiatrists have told me that in some cases psychoneurotics can be cured by the operation. These psychiatrists have also assured me that the operation is sometimes beneficial in cases of chronic schizophrenia, which, if I am not mistaken, is not technically classed as an affective psychosis. I think we can make due allowance for such competent medical judgment by the following rule:

Lobotomy is morally justifiable as a last resort in attempting to cure those who suffer from serious mental illness. It is not allowed when less extreme measures are reasonably available or in cases in which the probability of harm outweighs the probability of benefit.

The italicized statement was recently included in a number of propositions submitted for criticism to a fairly large group of theologians and physicians. No one took exception to it. Catholic hospitals may take it as a guiding norm for competent physicians, and may allow the physicians to apply the rule in particular cases according to their own expert knowledge and experience.

NARCOTHERAPY IN CATHOLIC HOSPITALS

Question: What is the official attitude of the Catholic Church on the examination by a psychiatrist of a patient to whom sodium pentothal has been given? In particular, may such treatment be allowed in Catholic hospitals?

The use of sodium pentothal for the cure of mental illness is graphically described by Doctors Grinker and Spiegel in their book *Men Under Stress*. A typical example of the treatment, as recommended and practiced by these doctors, would be somewhat as follows:

Suppose the psychiatrist's patient is suffering from some neurotic illness. By means of interviews the psychiatrist first establishes a relationship of confidence with his patient and learns all that he can about the repressed emotional situation or situations that brought on the neurotic condition. When the psychiatrist realizes that further recall would require too much time or that it is too difficult, or perhaps impossible, he resorts to the pentothal treatment. Pentothal is given intravenously, and the patient is told to count backwards from 100. When the counting becomes confused the injection is discontinued. In this narcotic condition the patient usually talks freely about himself. Sometimes his talking will spontaneously follow lines pertinent to his illness; sometimes he must be skillfully directed by the psychiatrist. Very often the patient will literally relive an entire frightening experience, verbally, emotionally, dramatically. Often, too, as the effects of the drug begin to wear off, the patient begins unconsciously to gain an insight into his troubles and to make appropriate readjustments. After that, the psychiatrist's task is simply to aid the patient to a completion of the insight and readjustment.

The use of some artificial means to get patients to talk freely is not something new in psychiatry. Hypnotism was long used for this purpose; and, at least in the last decade or two, sodium amytal has been commonly used. The advantage that Doctors Grinker and Spiegel appear to have noted in the use of sodium pentothal is that it not only enables the physician to diagnose the patient's illness, but also helps the patient to self-understanding and readjustment. Thus, they use the term *narcosynthesis* instead of *narcoanalysis*. Both these treatments would be included under the general term narcotherapy, which we might define here as the use of narcosis for the diagnosis and cure of mental illness. In answering the questions proposed, we need not confine ourselves to the specific problem of using pentothal; we can consider the entire subject of narcotherapy.

There is no "official" position of the Church in the sense of an authoritative pronouncement on narcotherapy. And I doubt if there ever will be such a pronouncement. In all likelihood, the Church will simply allow the Catholic moralists to solve the problems as they are presented and will not officially intervene except for some very special reason.

Though not exactly new in psychiatry, narcotherapy seems to be too recent for treatment in moral theology manuals and medical ethics books. The only printed discussion of the morality of narcotherapy I have seen is by Father Francis J. Connell, C.SS.R., in *The American Ecclesiastical Review*, CXIII (December, 1945), pp. 448-49. (Father Connell also mentions the subject briefly in *Morals in Politics and the Professions*, p. 127).

Father Connell thinks that the morality of narcotherapy should be judged according to principles analogous to those applicable to hypnotism; and he stresses two conditions: the consent of the patient or his guardians, and the strict observance of professional secrecy. I believe that all theologians would agree with this estimate, and I am including Father Connell's points in my answer. However, since the questions proposed here concern not only the morality of narcotherapy, but also its use in Catholic hospitals, I am calling attention to certain factors not mentioned by Father Connell. A complete statement of the conditions justifying the use of narcotherapy in Catholic hospitals would include the following points:

1) *If the patient has the use of reason, the treatment should not ordinarily be used without his explicit consent.*

We must remember that in the ordinary psychiatric interviews, the patient is always free to refuse to answer a question. He may be unreasonable in thus refusing to cooperate in his cure, but this refusal is his natural right. Under narcosis he loses this freedom; hence the induction of such a state without his consent is ordinarily an invasion of his rights.

I have stressed the word "ordinarily" here, because I think there may be occasions when the psychiatrist may legitimately presume the patient's consent to the treatment: for instance, when the psychiatrist knows that the patient really wishes to do everything necessary to get well but would nevertheless shrink from narcotherapy because of some exaggerated and unfounded fear.

If the patient has not the use of reason, the consent of his natural guardian or guardians should be obtained before the treatment is used. Ordinarily this consent should also be explicit; but I be-

lieve that such consent might be legitimately presumed under the same circumstances that would justify the treatment without the explicit consent of a rational patient. Furthermore, from a merely moral point of view, a guardian's explicit refusal might even be ignored if it were manifestly unreasonable and therefore detrimental to the health of the patient.

2) *There should be no unjustifiable risk of harm for the patient.* This condition hardly needs explanation, as it is always necessary for the licit use of drugs or surgery. I include it here merely for the sake of completeness.

3) *The psychiatrist must take the necessary means of protecting himself, and particularly the hospital, from harmful effects.*

I am referring to the danger of unsavory lawsuits and of derogatory gossip. For instance, in certain cases of presumed consent of patient or guardian, or in cases of extraordinary risk of harmful effects to the patient, there might be serious legal complications. And if the patient is a woman, certain precautions may be called for to prevent harmful gossip. The hospital has a right to know of such risks and to refuse to become involved in them.

4) *Professional secrecy must be rigidly observed concerning the information gleaned in the course of the treatment.*

Here again we list a condition which pertains to all medical practice, nevertheless the point deserves special emphasis for several reasons. In the first place, the patient under narcosis is unable to direct the course of his speech; hence his revelations are even more inviolable than those made in a wakeful state. Furthermore, we live in an age of "case histories," and this is particularly true of social work and psychiatric practice. Perhaps I am too meticulous, but I certainly get the impression that many of these case histories are veiled so thinly that anyone who really wanted to do so could easily identify the subject. If that impression is correct, I can see no justification for the recounting or publishing of the histories without the consent of the patient.

Finally — a third reason for stressing the need of professional secrecy—we live in a "clinic" age. Patients are examined before large groups of specialists, students, and so forth. Perhaps this is necessary for the advancement of science; yet one wonders at times if the poor are not unduly humiliated in the process. With regard to narcotherapy, the examination of a patient before a group means the revelation of the patient's secrets (sometimes very embarrassing secrets) to the entire group. An examination of this kind should never be forced on the patient; and, if such an examination is judged useful and permissible, all who are present should keep in mind that they are bound by the professional secret.

Generally speaking, if the four conditions I have just explained are observed, narcotherapy may be considered as morally unobjectionable, and the treatment may be allowed in Catholic hospitals. Before concluding the subject, however, I should like to mention two other factors that are sometimes brought up for discussion.

For instance, I have been asked if there is any danger that a patient under narcosis might re-enact some sexual sin that he had committed. I can give no definite answer to the question; but several psychiatrists have told me that, in their opinion, this will not happen.

The second factor is indicated by these words of Father Connell: "The patient may submit to the

treatment at the hands of a competent and *conscientious* physician who believes that it will probably be helpful." I have italicized the word "conscientious." Readers who are familiar with Catholic moral treatises on hypnotism will probably recall that these usually specify that the hypnotist also be conscientious. The same idea would very likely be included in any Catholic statement of the morality of psychotherapy.

Why this insistent demand that the psychiatrist be conscientious? As I understand it, there is no intention here of discriminating against the psychiatrist. As a matter of fact, it is dangerous to consult other physicians, especially obstetricians, who are not conscientious. Nevertheless, there seems to be a special need of such emphasis with regard to psychiatrists, because not infrequently psychiatric help must include the influencing of the patient's conscience: for example, in cases of scrupulosity. Where such influence is called for, the psychiatrist can hardly avoid applying his own standards of morality to the case—at least, so it seems to me.

Psychiatrists will say that they do not try to influence the conscience of the patient—that they merely try to aid him to understand his own problems and to solve them according to his own conscience. I am willing to concede that this is generally true; but it does not apply to all psychiatrists, and it can hardly apply to the treatment of all patients.

The presumption is that all physicians who belong to the staffs of our Catholic hospitals are sufficiently conscientious; and this presumption includes the psychiatrists. Hospitals may act on this presumption unless there is a positive reason for suspecting some morally harmful practice. And I might add that much of the suspicion and difficulty that is apt to arise with regard to various medical practices can be avoided by fostering sympathetic contacts between priests and physicians. In my own experience with physicians of various special fields, including psychiatry, I have found that even those who have no personal religious convictions are quite willing to respect the conscience and religious tenets of their patients and that they welcome the friendly advice and cooperation of priests in treating Catholic patients. Perhaps this experience is not typical; but there is no sound reason why it should not be.