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## From the Editor's Desk

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## From the Editor's Desk



As most of us know, the old health planning agencies have been replaced by federal mandate through passage of the Health Systems Agency legislation in 1975. Anyone who has taken the trouble to read through this legislation which is now law knows that the blocks are in place for the total control of the delivery of health care from the hospital right down to the doctor's office.

What are we seeing now as a result of this law? At the present time, the Health Systems Agency for your area is concentrating on all of the hospitals and how they function in serving the health care needs of your area. The overriding consideration of the HSA is total dollars spent in their area and how best they may conserve these dollars and get the best yield on them for the benefit of the most people. On the face of it, it seems to be an extremely laudable goal because we all know how expensive medical care can be. However, concentrating on cost and cost alone with cost-benefit ratio as the bottom line of the decision-making process of the HSA demonstrates one clear fact to this observer, namely, that the utilitarian ethic is the underlying, pervasive, philosophic value system motivating the individuals who comprise these agencies. Undoubtedly, they may not be consciously aware of this philosophic bias either because of lack of philosophic insight or by lack of concern as to the long implications of their "practical" cost benefit judgments. In any event, succinctly stated, the utilitarian ethic states that society must provide the greatest good for the most people without concern for the natural rights as given by God to the individual member of that society. Examples of the utilitarian ethic abound in our present day society and the most pernicious effect in recent memory has been demonstrated to the entire world when this philosophy was made state policy in Nazi Germany. This policy led to the

extermination of mental defectives, socially undesirable and political dissidents. In these United States, with the underlying bias of the health planners who focus their efforts on cost containment with the Health System Agencies as their instrument for enacting their policies, we must be alert to how these individual agencies which will ultimately "control the purse" will erode the individual citizen's right and hospital commitment to the dignity of the individual.

How does this apply to the Catholic hospital? *The Ethical and Religious Directives for Catholic Health Facilities* has proved to be a stumbling block to the efforts of some HSA's which would like to centralize all obstetric and gynecologic services. Because Catholic hospitals cannot provide "full services," viz., abortions, sterilizations, etc., they should be closed down and merged with hospitals which do provide these services.

In other words, the HSA's with their economic clout can run roughshod over the ethical concerns of the people and the hospitals they should be serving. Evidence for this has been communicated to this editor. The December, 1977 issue of *Hospital Progress*, pp. 18-19, has an excellent summary of the difficulties Our Lady of Lourdes Memorial Hospital in Binghamton, N.Y. is facing. Sister Geraldine Coleman, administrator, predicted that "the guideline requiring 2,000 deliveries per year, if implemented 'would force the closing of Lourdes' obstetric service and the closing of obstetric services in at least 23 more Catholic hospitals in the state of New York.'" In addition, Sister Helen Kelly, CHA president, in a 12 page written commentary, pointed out that the proposed guidelines raised some very deep concerns for CHA member hospitals. The standards, rather than being offered as guidelines, would be imposed as "final and absolute standards that would inhibit effective community planning and would have a negative impact on the quality of health care delivered."

Sister Helen also pointed out, and I would concur, that there is a lack of available, trained and experienced health planning personnel to apply standards in the HSA's. We recommend that our readers refer to this issue of *Hospital Progress*.

This is the time for the Catholic Hospital Association, the American Medical Association, the state and county associations to join with the various specialty groups and physician and lay members of the HSA's to take a long, hard look at what the health planners of HEW are doing to override the corporate and individual concerns and consciences and who are implementing the utilitarian ethic which, I think, is destructive of the dignity and freedom of each and every individual of this country.

We hope that the NFCPG and the Catholic Hospital Association will be in the forefront of this battle and will mobilize every influential group to register its protests at the congressional hearings to be held in Washington, D.C. Efforts are already underway at this time to

codify and document the efforts of the HSA's to compromise the ethical stance of the Catholic hospitals and their personnel. We invite our readers to provide any evidence of such efforts to our editorial office where it will be processed and referred to responsible groups who will present this to the appropriate congressional committee.

— John P. Mullooly, M.D.  
Editor

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## Letters...

### Pregnancy After Rape

#### To the Editor:

In your issue last August you not only published my article "Medication to Prevent Pregnancy after Rape" but a formal comment by Dr. William Lynch and a letter to the editor by Dr. John J. Brennan. I am unaware of other reactions but I do appreciate the concerns and objections of these two physicians.

To Dr. Lynch I would reply that I don't believe his citations from Drs. Morris and Greep prove the thesis he proposes, that DES has been shown simply not to work as an ovulation preventive. As I understand the clinical data it indicates that DES works either as a contraceptive or an interceptor but the data does not rule out the contraceptive role. My consultant, Dr. Richard Schmidt, who is currently president of the American College of Obstetrics and Gynecology, believes there is strong presumptive evidence that DES in this application can have an anti-ovulatory effect. As with all contraceptive drugs, it is difficult to prove absolutely that ovulation has been blocked in each individual cycle despite their known contraceptive effects.

To Dr. Brennan I would reply that the familiar analogy he cites about the hunter who should not fire at a figure which may be a man or a deer limps badly when applied to the DES question. The hunter is acting only for reasons of sport and is exposed to no kind of threat from the unidentified moving target.

But the woman who takes DES after rape is trying to protect herself from a grave injustice. To be sure of that protection she assumes a very minimal risk of destroying a nascent human being which may not even as yet be fully individualized with a spiritual soul. If we factor these special circumstances into her decision — her self-defense from grave injustice and the minimal risk to human life — we may not be so quick to refuse her the right to pull the DES trigger.

So I think the question I raised still merits attention: can a pro-life physician use DES when this provides a very slight risk of destroying a fertilized ovum if his or her intention is to prevent fertilization and protect the rape victim from grave injustice?

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