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Catholic Physicians' Guild

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## REVISING THE HOSPITAL CODE

Within the past year steps have been taken towards revising the "Surgical Code of the Catholic Hospital Association of the United States and Canada." This is a matter of great importance; and the present time seems opportune for replacing our regular discussion of a specific medico-moral problem with a consideration of some of the more general questions and problems pertinent to the revision of the code.

### Why a Code?

The first obvious and fundamental question is this: why should we have a code at all? One answer to the question is suggested by this opening paragraph of "Along Highway and Byway" in *The Linacre Quarterly*, VII (April, 1939), 27:

"Catholic physicians do not sufficiently appreciate the wonderful guidance which they receive from the Church on the ethical matters of our profession. It is pointed out to us in clear reason and in high morals, and not in mawkish sentimentality, what our proper attitude must be in the many controversies raised by our less favored confreres."

I presume that the paragraph was written by Doctor Joseph A. Dillon, who was editor of the quarterly at the time. It indicates the first reason for having a definite medico-moral code in our hospitals: namely, to give clear guidance in a world of confusion. Certainly the obscurity and uncertainty that prevail among those who do not have some authoritative and trustworthy norm to follow are ample proof that such guidance is needed.

This need becomes even more apparent when we reflect on the practical status of those who make up the medical personnel of our hospitals. Many of them have never had a course in medical ethics; for these a statement of correct moral principles and sound applications is certainly necessary. And the need is not confined to this group; even those who have studied medical ethics are prone to get "rusty" and to be at a loss without some handy summary to which they can refer.

Actual need, therefore, is the first reason for a code. A second reason was implied by Doctor Joseph L. McGoldrick in his answer to Mr. Blanshard's charges against the Catholic Church. Doctor McGoldrick insisted on the right of Catholic physicians and nurses to be taught correct morality by Church authorities, and he intimated that the Catholic members of the medical profession expect such guidance. (For Doctor McGoldrick's article, "Mr. Blanshard in Medicine," see *The Homiletic and Pastoral Review*, XLVIII [Feb., 1948], 358-64; and *Hospital Progress*, XXIX [May, 1948], 181-84.)

### A Revised Code

Granted that a code is needed and expected, it might still be asked why we should have a *new* code. I could answer this in a practical, personal way by saying that anyone who had been in my position for the last ten years would know from experience that a revised code is imperative. Again and again I have been consulted on questions that were not answered by the code. For example,

let me point out that of the six problems already treated in this column during the current year, only one (ectopic pregnancy) is explicitly mentioned in the old code.

Of course, the old code was limited to surgery; it did not attempt to cover other fields. This very limitation seems to indicate the need of revision, at least to the extent of including moral problems of a non-surgical nature. I shall say more about this later, when discussing the content of the code.

That my experience is not an isolated phenomenon may be inferred from the fact that in recent years several dioceses have taken it upon themselves to formulate a new and more extensive code for their own hospitals. The diocesan authorities would hardly do this if they judged the old code to be sufficient for their needs.

As a matter of fact, these arguments from experience are confirmed by a consideration of the nature of a medico-moral code. Such a code cannot be static; it must grow as the progress of medical science opens up new problems and sheds new light on old ones. *This does not mean that moral principles change.* It simply means that the applications of such principles can multiply, that principles not yet expressed in a code might have to be added, and even that old principles may admit of more accurate formulation. Take, for instance, the problem that we discussed in our January number—ectopic operations. It is definitely erroneous to state — as some are wont to state — that the Church has changed her stand on any principle pertinent to ectopic operations. On the other hand, it is quite correct to say that opinions of theologians concerning the application of principles have been modified as medical facts became

better known, not only by the theologians, but also by the physicians themselves.

### How Revise?

In setting out to revise the code we are confronted with many problems. It will be my purpose in the remaining paragraphs of this article to outline some of the problems we have already faced and our tentative solutions. Since subject-matter of this kind could readily become dull for the reader, I shall confine myself to a mere sketch of the problems.

The first problem concerns *content*. The old code was limited to *ethical* directives, whereas the recently composed diocesan codes usually contain something concerning the *religious* care of the patients (for example: baptism, preparing for death). Again, the ethical directives of the old code were limited to *surgery*, whereas the more recent local codes include such matters as X-ray treatments, artificial insemination, the giving of birth-control information, and so forth. These more extensive plans followed by the local codes seem to have distinct advantages; hence our present purpose is to include in the revised code a section on the religious care of the patients and an ethical section which will not be limited to surgery.

A second problem concerns *arrangement*, especially with regard to the ethical section. Should the ethical directives be grouped together in one general section or should they be "departmentalized" according to various specializations: for example, "Internal Medicine," "Obstetrics and Gynecology," "Radiology," "Urology," and so forth? Some who were consulted about the code suggested that an arrangement of the material according to such departments would be a distinct service to the

medical personnel of the hospitals. My own initial reaction to this suggestion was favorable; but after having worked at the plan for some time I have lost my enthusiasm. To be really useful to each specialist, the various sections must include many repetitions. This would make the code too bulky, and perhaps too complicated.

### Reference Section

A code must be brief; I think there would be general agreement on that point. But this imperative need of brevity poses what seems to me one of the most important of our problems: namely, that a succinct statement of an ethical principle or a summary indication of its practical applications can lead to serious misunderstandings. At the beginning of this article I cited two physicians to the effect that the Catholic members of the medical profession need and expect guidance; and I myself pointed to the fact that a fair percentage of our hospital personnel has had no training in medical ethics. Surely, it would be folly to expect the brief statements of a code to supply all the needed guidance. Rather, these statements would in many cases be either meaningless or misleading to those who do not know the background of the statements and who do not have at hand a more lengthy explanation of the matter. It seems highly desirable, therefore, if not actually necessary, to try to preserve the requisite brevity of a code, while at the same time offering something in the way of explanation.

How can we combine brevity and explanation? One suggested solution is a "combination code and reference book." In other words, we should prepare not merely a code, but also an explanatory manual to accompany it.

An example will illustrate this suggestion. Suppose each hospital

(or each department) were equipped with a copy of the code and the explanatory manual. The code might simply state: "Radiation of ovaries or oophorectomy is permitted to lessen or remove the danger of malignant metastasis from other organs. (See *Reference Manual*, p. 29.)" The reference manual, at the page indicated, would contain a full explanation of the topic, such as was published in *Hospital Progress*, XXIX (April, 1948), 147-48.

This suggestion appears to have great merit. It would preserve the brevity of the code, but would remove or greatly diminish the danger of misunderstanding. Incidentally, too, the manual might be made the substance of a practical course in medical ethics.

It would take some time to prepare a suitable reference manual; and the manual itself would have to be prepared in such a way as to allow for development with the code. Perhaps a loose-leaf manual, with yearly additions of pertinent problems treated in *Hospital Progress* would prove serviceable?

### Concluding Points

Several times during the course of this article I have mentioned recently-composed diocesan codes. Someone might ask: "Why should not each diocese prepare its own code? Why should we have a uniform code for the entire Hospital Association?" To the first question, we might answer that it seems to be a needless multiplication of labor to have each diocese prepare a code; and in answering the second question we might point to the fact that our hospital personnel changes occasionally from diocese to diocese. Differences in the arrangement and wording of the codes would be very confusing, to say the least. Hence it seems incumbent on the Hospital Association to try to prepare a code that

can be made available to all dioceses. Obviously, since each bishop is the authentic religious and moral teacher in his own diocese, he has a right to supply his own code if he wishes to do so.

One final point: In my introductory paragraphs it was said that the *Catholic* members of the medical profession need and expect the guidance of Church authorities. What about the *non-Catholic* personnel in our hospitals? This question has its delicate aspects; and I can hardly deal with it adequately in this brief conclusion. However, I think I can safely say that many of the non-Catholics are just as eager as Catholics to consult Catholic moralists and

to follow their guidance, especially when treating Catholic patients. The extremely delicate problem concerns only those who may feel that they are being forced to conform to specifically Catholic views, even when treating non-Catholic patients. The correct solution to this problem lies in the fact that, at least with regard to the ethical directives of our codes, the principles enunciated pertain not merely to Catholic teaching, but to the moral law. At any rate, that is the way the Church and her theologians look on these principles; and, such being the case, we could not admit a double-standard—one for Catholics, the other for non-Catholics—in our hospitals.



## NON-CATHOLICS AND OUR CODE

*Question: In the July number of Hospital Progress (XXIX, 259) you stated that, with regard to the ethical directive of our codes, the principles enunciated pertain not merely to Catholic teaching, but to the moral law, and for this reason a double standard (one for Catholics, the other for non-Catholics) is not admissible. Some of our non-Catholic personnel would appreciate it if you would explain this more fully.*

The Catholic hospital codes that I have seen consist mainly of three classes of regulations:

1. *Provisions for the religious care of patients:* These include directives concerning the administration of the sacraments, the care of the dying, Christian burial, and so forth.

2. *A statement of some moral principles and practical applications:* A moral principle would be,

for example, that the direct killing of an innocent person is never permitted; and a practical example of this principle is the forbidding of craniotomy of a living child. That contraceptive sterilization is against the natural law is another moral principle; and one of its practical applications is the prohibition of fallotomy for the purpose of rendering conception impossible. Still another example of a moral principle is the statement that mutilation of the human body is permitted insofar as it is required for the well-being of the patient, and a practical application of this is the allowing of orchidectomy in the treatment of carcinoma of the prostate gland.

3. *Certain precautionary regulations,* for example, that excised organs be sent to the pathologist, that surgeons give notice of the operation they intend to perform, and so forth.