

5-1-1992

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## Recommended Citation

Diamond, Eugene F. (1992) "[Book Review] *Manual of Guidelines on Clinical-Ethical Issues Catholic Health Association of the United States, St. Louis, Mo.*, edited by Diana Bader, O. P. Ph.D.," *The Linacre Quarterly*: Vol. 59 : No. 2 , Article 14.  
Available at: <https://epublications.marquette.edu/lmq/vol59/iss2/14>

## BOOK REVIEW

### Manual of Guidelines on Clinical-Ethical Issues

Catholic Health Association of the United States, St. Louis, Mo.

Diana Bader, O. P. Ph.D., Editor

In its Statement of Policy regarding the Relationship between the Catholic Health Association (CHA) and the Roman Catholic Church, the CHA recognizes that the bishops have "primary authority and responsibility in decisions relating to religious and moral issues and practices." The Association, however, appealing to its own "expertise in health and social welfare" calls for a dialogue "founded upon mutual trust and respect." In recent years, some publications sponsored by the CHA such as the disastrous *Apology for the Value of Human Life* have indicated a tendency for CHA to go its own way on some Medical-Moral issues and to encroach on the "primary authority" of the Magisterium with some positions derived more from local competitive marketing pressures than from authentic teaching.

The recently published *Manual of Guidelines on Clinical Ethical Issues* continues this trend. Its purpose is described in the introduction as a response "to requests for guidance in the formation of policies and guidelines on ethical issues in the clinical setting." The Manual has three sections. Section I is devoted to Institutional Ethics Committees from an overall view and Section II presents procedural Mechanisms for Developing Policies and Guidelines. There is much in these first two sections that would be helpful to hospital administrators and ethics committees in carrying out their functions with relationship to staff bylaws and Joint Commission requirements. It is in Section III entitled "Topics" that the usefulness of the Manual is called into question. The aforementioned Statement of Policy describes the CHA as having a "serious obligation to develop and administer policies" but to carry out this obligation "in concert with the Church's teaching Magisterium." The treatment of several of the topics in this Manual would raise serious questions as to the CHA's commitment to authoritative teaching or, for that matter, its adherence to the NCCB's *Ethical and Religious Directives for Catholic Health Facilities*.

One issue which has been a source of continuing conflict in various dioceses is that of surgical sterilization in Catholic hospitals. The threat of geographical morality on the subject of sterilization has led to a series of explicit clarifications such as "Reply of the Sacred Congregation for Doctrine of the Faith on Sterilization in Catholic Hospitals" (March 13, 1975) and the 1977 "Commentary on the Reply of the Sacred Congregation for the Doctrine of the Faith" by the NCCB. Both of these documents painstakingly develop the application of the principles of material and formal cooperation to sterilization in Catholic hospitals. The inescapable conclusion of both statements is that *institutional* approval and consent for the performance of contraceptive sterilization in a Catholic hospital would be formal cooperation and "absolutely forbidden."

The Manual, nevertheless, suggests an institutional policy based on what it describes as "Material Cooperation" in which the Catholic health care facility judges tubal ligation to be permissible based on 1) the need to provide comprehensive health care for women, 2) avoidance of the loss of qualified medical staff, 3) harmful competition from other providers in the community, 4) maintaining the obstetrical-gynecological service, 5) survival of the hospital as a full service facility. A disclaimer is then added that "tubal ligations will be permitted only when certain indications are present." A list of twelve "indications" is then appended in which the medical-obstetrical and psychiatric justifications for sterilization read like chapter headings from a textbook (e.g. "heart disease", "renal disease", "malignant disease", "diabetes mellitus", "genetic disease"). As has been pointed out (*Linacre Quarterly* 42:6, 1975), surgical sterilization is not a treatment for any disease. The indication for sterilization in all of the long list of indications in the manual is the prevention

of future pregnancy which is a directly contraceptive purpose explicitly condemned by both the Sacred Congregation and the NCCB. It is interesting to note that the old chestnut of repeat Caesarean section and so-called "uterine isolation" also makes the list of indication for tubal ligation. When the Archdiocesan Medical Ethics Commission in Chicago issued an advisory opinion condoning "uterine isolation" in local Catholic hospitals, Cardinal Bernardin was specifically advised by the Holy See that such permission should be withdrawn in the Chicago Archdiocesan hospitals forthwith.

The topic of the post-treatment of rape also includes some ambiguous and scientifically questionable language. The inclusion of post-coital estrogen administration in rape protocols has been a thorny issue for many Catholic institutions. The Manual states "In cases of doubt as to whether ovulation has occurred within the current cycle, the use of post-coital contraception is permitted because the probability that fertilization has occurred is minimal." It is to be expected that a state of "doubt" as to whether ovulation has occurred would be almost universal. Secure knowledge as to the absence of ovulation might be available to the 2-3% of Catholic couples and the 1-2% of the general population who were keeping track of ovulation by sympto-thermic natural family planning. Even for those on oral contraceptives such as minipills or progestin-only pills, break-through ovulation would be a possibility. For the rest it might be no more than an educated guess based on timing within the menstrual cycle.

There is serious question also as to whether suppression of ovulation would be a primary effect of the administration of estrogens following rape. According to Blye (*Use of Estrogens as Post-Coital Contraceptive Agents. Am.J. Ob-Gyn.* pp 1044-1050, 1973) these agents act by 1) Prevention of tubal transport of the zygote, 2) Prevention of sperm transport, 3) Loss of sperm viability, 4) Prevention of embryonic viability, 5) Luteolysis, 6) Asynchrony of the uterine endometrium. The effects on sperm are not relevant to the situation of rape since post-coital contraceptive therapy is contemplated long after spermatozoa have reached the site of fertilization in the female reproductive tract. The remaining four effects are effects taking place after fertilization but before implantation. In other words, they are abortifacient effects. Where estrogens are recommended in rape protocols they are recommended for their abortifacient effects.

In addition to the highly questionable recommendation for the use of post-coital estrogens, the Manual recommends transferring the patient to another medical facility or another physician as an option (where abortifacient medication would be dispensed). This would clearly be formal cooperation in the use of abortifacient medication.

In the matter of Artificially Administered Nutrition and Hydration, the Manual admits "There is not yet a public consensus on issues related to the limiting, withholding or withdrawing of artificial nutrition and hydration." Not to worry, though, since in the next paragraph, it states that "artificial administration of nutrition and hydration qualifies in every respect as a *"medical treatment"*" (emphasis added). Such a statement obviously finesses the controversy.

The Manual was subjected to sufficient criticism that CHA put a stop order on the Manual until it could be revised, particularly in its treatment of sterilization.

The fundamental question about this Manual and some other recent publications from CHA is "Quo Vadis?" Is there a systematic plan to dilute the high-profile witness of Catholic health institutions in order to serve economic goals in a highly competitive market? If so, how does one justify the payment of thousands of dollars in annual dues to a separate Catholic organization which duplicates the functions of the American Hospital Association or the various state and local Hospital Associations? As the Catholic *Hospital Association*, a long and illustrious record of service to the Catholic health apostolate was built on the basis of uncompromising fidelity to the Church and its unique approach to medical moral values. Catholic physicians and nurses have relied heavily on that kind of organization and would be severely compromised in rendering their own personal witness if such an organization ceased to exist.

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