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Dr. Diamond's survey reaffairms the traditional medical approach that is used by most physicians when dealing with a pathological uterus. It is also interesting to note the actual practice that most physicians use when dealing with the situations described in this survey.

The Committee on Medical Directives of the National Federation of Catholic Physicians' Guilds has been delegated to develop commentary on certain issues of medical interpretation related to the new Hospital Code. In approaching this assignment, we accept certain premises as background for our deliberations, as follows:

1. There does exist a concept of authentic teaching authority within the hierarchically structured church. This has been reaffirmed on the Documents of Vatican II, particularly *Gaudiam Spes* (the Decree on the Bishops) and *Lumen Gentrium* which reads, in part, "This religious submission of will and mind must be shown in a special way to the authentic teaching authority of the Roman Pontiff even when he is not speaking ex-Cathedra."

2. The most recent au entic magisterial teaching on th subjects of contraception, st ilization, and abortion is *H anae Vitae* where one reads: "W must once again declare that th direct interruption of the ge ative processes already begu and, above all, directly willed a procured abortion, even if fo hera-peutic reasons, are to b absolutely excluded as a licit n ns of regulating birth.

"Equally to be excluded s the teaching authority of the urch has frequently declared, direct sterilization whether perp ual or temporary, whether of the an or of the woman. Simularly cluded is every action which, e her in anticipation of the conju l act, or in its accomplishment, in the development of its natu l consequences, proposes, whether as an end or as a means to render procreation impossible." Thus, one must inevitably conclude that, in the objective order of things, artificial birth control, sterilization, and abortion are morally evil acts.

3. These morally evil acts which are explicitly prohibited for Catholics are not implicitly permitted for others. Furthermore, it is not permissible for Catholics to cooperate, formally or materially, with those who would wish to perform the objectively illicit moral acts for whatever reason, however good they may conceive it to be.

4. Notwithstanding certain differences of opinion regarding pastoral problems of conscience, all national conferences of bishops in the world have subscribed to the Papal viewpoint on the objective immorality of contraception, sterilization, and abortion.

5. The phenomenon of dissent within the church is not only desirable but necessary insofar as it promotes dialogue, research, the understanding of nuances of meaning and the development of modern insights into traditional ethical norms. However, dissent does not necessarily imply that any group of bishops and/or theologians may substitute its moral judgment for that of the magisterium. If a local ordinary and his advisor on moral theology can independently promulgate their viewpoint (as more prudent and better reasoned) even if it is clearly contrary to that of the magisterium, then the Vatican II concept of an authentic teaching authority would cease to exist.

This committee will, in light of the above mentioned principles, address itself to certain factual medical questions currently confronting physicians and administrators. We will gather and assimilate expert medical opinion regarding the conformity of certain procedures to the letter and intent of the Directives. Judgments will be made on the basis of the Directives as they are and will not necessarily involve opinions of individual members as to whether the Directives should or will be changed. Peripheral to our primary purpose, we will develop some commentary on possible problems created by the adherence to or the disregard of the current Hospital Code.

How the Panel Was Selected

The method for randomizing the selection of the panel was as follows. The president of the National Federation wrote to the eight Regional Directors of the National Federation. Each Regional Director was asked to nominate Guild members from his region who, in his judgment, would be knowledgeable about medico-moral issues raised by the recent Directives and their promulgation locally. The eight regions of the National Federation include all fifty states, Puerto Rico, and certain Canadian provinces. Some individuals nominated by the Regional Directors in turn nominated others in their area or of their acquaintance. No limit was placed on nominees from any region. The total number of individuals who responded by completing the questionnaire, in whole or in part, was 93. This group was composed primarily of obstetrician-gynecologists, but also included internists, surgeons, family practitioners, pediatricians, psychiatrists, public health physicians, urologists, and priest-theologians. The panel included at least five members from each region to insure a geographic spread.

The results of this questionnaire are meant to portray the viewpoints of this panel, however, and while the method of selection would strongly suggest that the panel comprises a representative selection of Guild members, no claim is made that the panel is a scientifically selected sample. Given the present information available to the National office about Guild membership, it would be impossible to select a representative sample other than by random sampling. In order to broaden the response, a copy of the questionnaire will be mailed to subs bers of the *Linacre Quarterly*, th offi- cial publication of the N onal Federation, in order to s it a response from all membe who are inclined to complete th uestionnaire. This larger mple would not be expected to lude the composite expertise the present panel.

Below is a copy of the uestionnaire which was mailed o the panel, listing the questio that were asked and the perce that responded to each questi .

The Questionnaire

The Committee on Medical Directives of the National Fe ration of Catholic Physicians' Guilds is currently in the process of ga ering medical opinion on the concept of "physiological isolation f the uterus." We are interested in medical facts primarily and thical opinions secondarily. To be tested is the hypothesis that, given situation of a uterus damaged by repeated Caesarean sections, i might be licit to perform the "first stage of hysterectomy" by separa g the oviducts and adnexae from the uterus without actually per rming the hysterectomy itself. Following is a hypothetical case to il strate this situation.

I. A 35 year old woman is having her fifth Caesarean se ion. It is noted that she has had a small rupture of the uterus hrough an old scar and that the bladder has become incorpora ed into the scar. What procedure would you recommend?

1. 58.7% Hysterectomy including partial bladder resection, if necessary.

2. 6.5% "Physiological isolation of the uterus," followed by hysterectomy at a later date following post-natal involution of the uterus.

3. 8.7% No operative procedure beyond usual Caesarean section. Counsel couple against future pregnancy including specific instructions on sympto-thermic rhythm.

4. 21.7% Same as #3, with additional option of removal of uterus at some future date.

5. 4.4% Other procedure (Explain) Scar excision Fimbriectomy

II. Do you accept the notion that hysterectomy would be indicated in certain instances of "irreparable uterine damage" due to repeated Caesarean sections?
94% Yes 6% No

III. In your opinion, would the performance of "physiological isolation" of the uterus (above) be:
A) 67% Direct contraceptive sterilization.
B) 33% Indirect sterilization (The "lesser first stage" of a hysterectomy indicated by presence of damaged uterus).

IV. The performance of "physiological isolation" rather than a complete hysterectomy in cases such as the hypothetical case above might be justified on the basis of the greater risk of mortality and morbidity from the latter procedure. In your opinion would the added risk of performing the rest of the hysterectomy after separation of the adnexae be:
A) 10.4% Great
C) 40.1% Small
E) 13.1% Nil
B) 18.2% Considerable
D) 18.2% Negligible

V. Is the performance of a tubal ligation to prevent pregnancy in a woman with chronic nephritis: A) 88% Directly contraceptive; B) 12% Indirectly contraceptive (using the principle of totality).

VI. Is tubal ligation an accepted modern treatment for any disease? (Do not include diseases aggravated by pregnancy where purpose of tubal ligation is to prevent pregnancy).
87% No 13% Yes

VII. Is directly intended abortion an accepted modern treatment for any disease?
89% No 11% Yes

VIII. Directive 20 of Ethical and Religious Directives for Catholic Health Facilities reads as follows: "Procedures that induce sterility, whether permanent or temporary, are permitted when: a) they are immediately directed to the cure, diminution, or

prevention of a serious pathological condition and are not ect-ly contraceptive, that is contraception is not the purpo b) a simpler treatment is not reasonably available. Hen for example, oophorectomy or irradiation of the ovaries n be allowed in treating carcinoma of the breast and met asis therefrom; and orchidectomy is permitted in the treatm t of carcinoma of the prostate."

In your opinion, is this directive: A) 82% Perfectly clear r B) 18% Confusing.

IX. Directive 18 states "Sterilization, whether permanent o tem-porary, for men or for women, may not be used as a m is of contraception." In your opinion what is the mode of ac n of the following contraceptives?

1. Oral progestins (sequential).
   a) 37.3% Temporary sterilization by suppression of vula-tion.
   b) 6.8% Mechanical contraceptive through act on cervical mucus.
   c) 3.4% Abortifacient through effect on endom rium and resultant interference with nidation.
   d) 10.2% All of the above.
   e) 38.9% Any one or combination of the above dep ding on dosage.
   f) 3.4% Other

2. Oral Progestins (Combination).
   a) 42.3% Temporary sterilization.
   b) 5.8% Mechanical contraceptive.
   c) 5.8% Abortifacient through interference with ni ation.
   d) 13.4% All of the above.
   e) 32.7% The above depending on dosage. (Any ne or combination).
   f) Other

3. Intrauterine devices.
   a) 65.2% Abortifacient (mechanical effects on endometrium or stimulation of phagocyte response).
   b) 13.4% Effect on tubal motility with accelerated passage of unfertilized or fertilized ovum.
   c) 17.4% Combination of the above.
   d) 4.0% Other

Discussion

The members of the panel overwhelmingly accept the concept of irreparable uterine damage due to repeated Caesarean sections, but comments indicate that no specific number of Caesarean sections should be used as the sole criterion for establishing the state of irreparable damage. Rather, the judgment that irreparable damage has occurred should be based on individual clinical factors.

When presented with an example of a situation where there is a choice between hysterectomy and "physiological isolation" of the uterus, approximately 80% choose hysterectomy, either at the time of Caesarean section or after an interval. Only 6.5% choose "physiological isolation" as the therapy of choice. Two-thirds of respondents would define the "physiological isolation" procdure as directly, rather than indirectly, contraceptive. Perhaps most importantly, 71.4% of the respondents would define the increased risk of performing the hysterectomy as compared with "physiological isolation" as being either "small," "negligible," or "nil" rather than "great" or "considerable." If the procedure of physiological isolation is to be justified on the basis of its being, medically, the "lesser first stage" of a major procedure, it is clear that the panel would not accept the hysterectomy as a procedure carrying a much higher risk of mortality and/or morbidity. One typical comment was that the procedure of physiological isolation could only be justified if "after clamping the tubes and broad ligaments, any further procedure would endanger life."

The performance of a tubal ligation to prevent pregnancy in a woman with chronic nephritis was defined as *directly* contraceptive by 88% of the panel. As a corrollary, the theory that such a procedure would be indirectly contraceptive using the principle of totality was overwhelmingly rejected.

The vast majority of respondents rejected the use of tubal ligation as a therapy for any disease. The small percentage who accepted tubal ligation as therapeutic mentioned instances such as salpingitis due to tuberculosis or gonorrhea where tubal ligation might prevent direct spread to cause pelvic inflammatory disease. Most physicians mentioning these procedures indicated that such therapy would be rarely, if ever, indicated in modern therapeutics. The obvious inference to be drawn from these responses is that the vast majority of tubal ligations are performed not to treat disease, but to prevent pregnancy, usually for socio-economics reasons.

In a similar vein, 89% rejected the claim of therapeutic benefits from the performance of a directly intended abortion. Eleven per-

cent indicated that therapeutic abortion would be indicated for chronic nephritis. One respondent listed numerous other indications. None claimed that therapeutic abortion was the sole method of therapy for any disease. In other words, the woman aborted for chronic nephritis might also be managed through her pregnancy.

Eight out of ten respondents stated that they found Directive 20 regarding sterilization to be "perfectly clear" as written and contained in the most recent code. The majority of those whose answers indicated that they disagreed with Directive 20, nevertheless, described the language of the Directive as "clear."

Question IX was related to the mode of action of various modern methods of contraception. This question was included to clarify the distinction between the traditional mechanical or spermicidal chemical methods of contraception as contrasted with the methods, now more widespread in usage, which act by way of temporary sterilization or abortifacient action. Only 6.8% thought that sequential oral progestrus were primarily mechanically contraceptive through action on the cervical mucus, but an additional 49.1% thought that this was one of the multiple effects of the pill. A strong minority (37.3%) thought that the sequential oral progestrus were solely responsible for temporary sterilization through suppression of ovulation. Only 3.4% considered the sequential pill to be primarily abortifacient through an e ct on the endometrium resultin n an interference with nidatio low-ever, an additional 49.1 felt that the abortifacient effe f the pill was one of its multipl fects in preventing pregnancy. e figures for combination type f oral progestrus were similar w n minor variations.

From these responses, i an be stated that over 50% of th nem-bers of this panel belie that both combination and se ential oral progestrus may have abortifacient action either s ly or in combination with othe fects. Most of the remainder the panel feel that pills are p narily sterilizing agents throu sup-pression of ovulation. The find-ings are extremely impor t for physicians recommendi oral progestrus as well as f con-fessors who are approvi their use. Obviously, an abor acient cannot be recommended w h the same impunity as a non- borti-facient method.

Whereas there was so e disagreement as to the prim ry action of oral progestins, a tal of 82.6% of respondents thought that the intrauterine device was either solely abortifacient or abortifacient in addition to its effect on tubal motility. The remaining 17.4% believe that the IUD acts solely on tubal motility or by way of interference with sperm migration or sperm capacitation.

There were numerous suggestions for consideration, by committees of the National Federation, of other parts of the Ethical and Religious Directives for Catholic Health Facilities. These suggestions will serve as a basis for future deliberations and publications.

Summary

1) A panel of 93 persons was selected through nominations from the eight Regional Directors of the National Federation of Catholic Physicians' Guilds.

2) This panel was polled by questionnaire regarding the views on various issues raised by the recent revised Ethical and Religious Directives for Catholic hospitals.

3) 80% of respondents chose hysterectomy rather than "physiological isolation of the uterus" as the treatment of choice for a theoretical case describing a uterus damaged by repeated Caesarean section.

4) 67% thought that the procedure of physiolgical isolation was directly contraceptive and 71.4% denied that it would significantly reduce mortality or morbidity as compared with hysterectomy.

5) 88% of respondents would describe a tubal ligation to prevent pregnancy in a woman with chronic nephritis as *directly* contraceptive.

6) Almost 90% of respondents rejected both tubal ligation and abortion as modern methods of therapy for any disease state.

7) 80% found Directive 20 regarding the performance of sterilizing procedures in Catholic hospitals as "perfectly clear."

8) Approximately 90% considered oral progestrus to act as sterilizing agents either solely or in combination with other effects in preventing conception.

9) Over 52% of respondents considered that oral progestrus were abortifacient either primarily or in combination with other effects in preventing conception.

10) 82.6% considered intrauterine devices to be abortifacient in action.