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We live at a time when law — both the law of God and the law of man — is respected. Consider, if you will, the numbers of murders, personal and bodily assaults, grand larceny, robbery, breaking and entering, rape, etc., that are reported each day in each locale throughout the United States. Recall, if you will, the monthly reports of the incidence of crimes in the United States by the Federal Bureau of Investigation. Then, ask yourself, if this criminal behavior on the part of thousands of our citizens can be a reliable guide for the formation of anyone's conscience as to what is right or wrong, good or evil.

You make reference to the use of can rather than may, and the frequent use of must in the text of the article, and indicate that these suggest "coercion to conformity." These words were used deliberately and not accidentally, and were used to indicate that we can only be Christians and true followers of Christ only if we accept Christ and His Teaching on His terms — not on the basis of our own subjective and personal thinking of what Christ should have said or might have said, and we can become His followers only if we take up His Cross and follow Him. As indicated in the article, neither Christ nor anyone else has ever indicated that being a Christian is easy or comfortable or self-serving. The article also indicates that Christ vehemently and tenaciously insisted on His Doctrine in the face of disagreement, dissent and threat to turn away from Him.

In your reference to the "scrupulous physician" and to the fact that "none of us is perfect," I find the oft-repeated error of confusing authentic doctrine with personal guilt or innocence. What I have strived to present is the authentic, authoritative and official teaching of the Church of Jesus Christ with reference to contraception and I have endeavored to demonstrate the serious responsibility of Catholic hospitals and Catholic physicians to accept this doctrine and to abide by it. I have totally and completely abstained from making any reference to the subjective guilt or innocence of any physician or of any hospital if either violates this official, authentic and authoritative teaching. Each physician must stand before God and God will make the final judgment as to guilt or innocence.

I fail to appreciate your conclusion that the National Federation of Catholic Physicians' Guilds may become a group of "closed-minded physicians" and your effort to separate this Federation from "the sincere, groping, inquiring Catholic physician." Is not a member of the National Federation, who accepts the authentic and authoritative teaching of the Supreme Pontiffs, a sincere, Catholic physician? Why must the physician who forms his conscience by personal, subjective, situational and existential criteria be the only physician who is considered to be sincere and Catholic? Is there not here an effort, however unintentional, to separate Christ from His Doctrine and Christ from His Church?

It appears to me that one, be he bishop, priest, religious, physician or non-professional layman, can only be a real Christian and a true and faithful follower of Jesus Christ if he accepts Jesus Christ and His Doctrine as authentically and authoritatively taught by the visible Vicar of Jesus Christ, the gloriously reigning Supreme Pontiff. Unfortunately, there are in our midst persons who wish to be known as Christian and to be considered as followers of Jesus Christ but wish both of these be on their own terms. This is impossible. Those who are not with Jesus Christ are against Him and this by His Own Words.

**The Present Status of the Ethical and Religious Directives for Catholic Health Facilities**

Rev. Anthony R. Kosnik

At their annual meeting in November, 1971, the Catholic Bishops of the United States approved the Ethical and Religious Directives for Catholic Health Facilities as the National Code. The promulgation and implementation of these Directives on the local level was subject to the approval of the Bishops of the individual dioceses. This study is an attempt to survey what has happened to these Directives since their approval in November, 1971. The study reflects the results of a questionnaire sent to the Catholic Health Representative of each diocese requesting information: (1) regarding the promulgation of the Directives in the diocese, (2) regarding any educational program connected with their promulgation, (3) regarding any new policies or procedures that may have resulted from the Directives, and (4) regarding the establishment of Medical Moral Committees to implement these Directives. Approximately 50 dioceses out of 156 responded to the questionnaire and, though the survey is in that sense incomplete, it does indicate some of the general patterns and trends occurring across the country. It should be noted that among the respondents to the survey are most of the major dioceses in which Catholic health facilities are found. A probable reason for the number of dioceses not responding is simply that they may not have any significant number of Catholic health facilities. It is hoped that the sharing of these results will enable all of those involved in any way with the Directives to be enriched and profit from the experience of others.

**Promulgation**

In view of the overwhelmingly...
affirmative vote (232 to 7) that the Directives received from the Bishops on the national level, one would expect that the Directives would be immediately approved and promulgated by the local Bishops in their individual dioceses. Although this has been generally the case, it is interesting to note that nine of the dioceses reporting did not follow through with any formal promulgation on the local level. In most instances, no reason was given for the failure to promulgate the Directives. In a few instances, however, there was an intentional withholding of promulgation because the Directives were seen as unsatisfactory. Even where the Directives were promulgated, the letters of promulgation often contained a cautious reserve indicating that the Directives needed further study, updating and suggesting recourse to the Bishop or Diocesan Review Committee when such inadequacies with the Directives were encountered. This lends some credence to the view explaining the overwhelmingly favorable vote of the Bishops not as a resounding approval of the Directives but rather as a necessary response to various groups in the health care apostolate clamoring for an updated medical code. The fact that the preamble provides a procedure that calls for continuing study, review and updating of the Directives enabled a number of Bishops to vote favorably for the Directives even though they may have entertained serious reservations regarding certain aspects of the document.

Most of the letters of promulgation from local Bishops simply indicated that the Directives were approved as official policy for the diocese, but a number recommended that local hospitals incorporate the Directives as part of their by-laws and one diocese requested that the Chancery be informed regarding the day of the adoption of these Directives as official policy for the hospital.

The most elaborate promulgation included, not only an official letter from the Ordinary of the diocese, but a detailed recommendation: (1) that the Ethical and Moral Guidelines for Catholic Health Facilities be incorporated into and made part of the by-laws of the medical staff, (2) that, at the time of original appointment and at the time of regular annual reappointment, each member of the medical staff by signing a statement indicate his willingness to assume the obligation and responsibility of subscribing to the Directives and agree to conduct his practice in accordance with them, and (3) that each patient be advised that the Catholic hospital is operating by official hospital policy in accordance with the Ethical and Religious Directives. It was further advised that this latter be accomplished by posting such a notice in a conspicuous place in the admitting office, by asking each patient at the time of admission to sign an approved form whereby there is recognition of this policy and, finally, by posting notices to this effect in conspicuous locations throughout the hospital.

Adoption

In addition to the recommendation of some local Bishops that hospitals formally adopt the Ethical and Religious Directives as part of the by-laws constituting the official policy of the hospital, the Catholic Hospital Association strongly urged its membership to do likewise.

It is not known how many of the 734 Catholic hospitals in the United States have formally adopted by resolution of the Board "The Ethical and Religious Directives" as official hospital policy, but a study of the situation is currently underway by Father Kevin O'Rourke, recently appointed Director of Medical-Moral Affairs of the Catholic Hospital Association, and the results should be forthcoming in the near future.

Education

The survey indicates that in most of the dioceses the Directives were promulgated without any serious attempt through an educational program to prepare those who would be implementing the Directives. In many instances, the hospital administrator was expected to see that the Directives were properly explained and observed. In some instances, the Bishop or his representative arranged for a meeting on the diocesan level to discuss and explain the Directives. Several state-wide conferences (Michigan, Ohio, Massachusetts, Minnesota, Wisconsin) open to various representatives from the health care field, were held to explore the meaning of the Directives.

Apart from the above indicated educational programs on the hospital, diocesan or state level which were generally limited to one or two-day sessions, the overwhelming majority of those reporting indicated no educational program whatsoever accompanying the issuance of the new Ethical and Religious Directives.

Medico-Moral Committees

One of the surprising results of the study is the number of Medico-Moral Committees that have been established accompanying the promulgation of the new Directives. Perhaps one of the reasons for this was the recommendation coming from the January, 1972, meeting of the Diocesan Coordinators of Health Affairs where the establishment of dioecesan Medico-Moral Review Committees was strongly urged. Another possible reason may be the hope that such a committee could undertake the educational task so desperately needed if the Directives are to be implemented effectively. These committees range from special committees on the hospital level through Diocesan Review Committees to state-wide Medico-Moral Committees. The task of such committees appears to be: (1) to address themselves to the problem situations that occur in the practice of health care, (2) to interpret the Directives in particular situations, and (3) to refer unresolved problems either to the Ordinary or to the National Bishops' Committee on Health Affairs.

One of the problems that occurs repeatedly in regard to Medico-Moral Committees is the difficulty in finding adequately prepared and competent theological advisors to serve on them. This is the reason given in several instances why local
hospitals did not institute a committee, and even some individual dioceses preferred to resolve such matters through a state-wide Medico-Moral Committee where competent membership could be ensured. Most of these committees included representation from all areas of the health-care field: theological, official diocesan, legal, medical, hospital administration, Catholic chaplaincy and nursing personnel.

In connection with this, it is important to note that an Advisory Committee has been appointed to the Bishops' Committee on Health Affairs to assist the Bishops in carrying out the recommendations contained in the preamble to the Directives: that "the Committee on Health Affairs of the United States Catholic Conference" (with the widest possible consultation, should be regular consultations, should be periodically discuss any reasonable need for an updated revision of these Directives." Any revision or updating of the Directives will eventually be processed through this Committee and presented to the U.S. Catholic Conference for approval. In view of this, it would seem that if the Dioceses are to become instruments for providing effective direction to those involved in the health-care apostolate, the hospital, diocesan and state-wide Medico-Moral Committees must provide the kind of input that would make the members of these Bishops' Committee sensitive to existing problems and able to respond with Directives that are relevant and effective. This appears to be an area of crucial importance in the formation of such committees. Members of these committees should be made aware that their responsibility is not limited to presenting immediate solutions to particular problems, but, perhaps of greater importance, includes relating their experiences to the National Bishops' Committee in order that all involved in the health care apostolate may profit from it.

Problems
The promulgation of the Directives by the American Bishops in November, 1971, met with a sharply critical theological reaction by some highly respected members of the American Catholic theological community. In June, 1971, the Catholic Theological Society of America appointed a study commission to reflect on the matter of Catholic hospital ethics. The report of this CTSA Commission on Ethical and Religious Directives for Catholic Hospitals was completed in September, 1972, and published in the November, 1972, issue of Linares Quarterly. It is the most detailed and comprehensive evaluation of the Directives available.

The principal charges against the Directives are that they are theologically outdated, and insensitive to the changing nature of the Catholic hospital in America today. The Catholic Mind of May, 1972, the Linares Quarterly of February, May and August, 1972, published the November and February issues of Hospital Progress and the July, 1972, issue of Chicago Studies are readily available sources that document this ongoing theological debate. The net result has been a hesitancy on the part of those involved in the health care apostolate to subscribe to the Directives wholeheartedly until further clarification and consensus within the theological community is achieved. Even where the Directives have been adopted there is a growing uncertainty on the part of administrators as to how particular Directives are to be interpreted.

The most pressing, immediate problem posed by the Directives concerns the matter of sterilization and the interpretation of Directive 20. The terminology of Directive 20 is ambiguous and subject to widely diverse interpretation among moralists. The precise meaning of such words as "immediately directed," "pathological condition," and "directly contraceptive" are not readily understood by administrators and medical men and are also given varying interpretations by theological experts. The matter is urgent for medical men who insist that concern for the welfare of the total person as well as the practice of responsible medicine requires recourse to sterilization procedures in some instances. Diverse interpretation of this Directive 20 has led to widely divergent practices and applications with regard to sterilization procedures in Catholic hospitals. In one diocese it was indicated that prior to the promulgation of the Directives a policy had been in effect that permitted sterilizations for medical purposes, including psychiatric reasons, under the principle of totality.

As a result of the Directives, an attempt has been made to restrict the sterilization procedure to those instances clearly stated in the Directives and prohibit even the medically indicated sterilizations that were previously allowed. Very few dioceses have given any specific direction to hospitals regarding the implementation of this Directive. Some hospitals, in an attempt to implement Directive 20, have set up a sterilization committee whose purpose it is to interpret Directive 20 and review particular requests for sterilization that are submitted to it.

Because of the crucial importance of this matter, it might be profitable to share several models of guidelines for implementing Directive 20 that have been proposed. All three have been in operation in Catholic hospitals for nearly a year with no major complications or difficulties.

Model I
POLICY STATEMENT FOR PROCEDURES THAT INDUCE STERILITY

A. In the implementation of the revised Ethical and Religious Directives for Catholic Health Facilities of September, 1971, the following policy has been approved by the Bishop for use in this hospital. The following statement pertains to Number 20 in the Directives relating to procedures that induce sterility which states:

"Procedures that induce sterility, whether permanent or temporary, are permitted when:
1. they are immediately directed to the cure, diminution, or prevention of a serious pathological condition and are not directly contraceptive (that is, contraception is not the purpose) and
2. a simpler treatment is not reasonably available. Hence, for example, oophorectomy or irradi
tion of the ovaries may be allowed in treating carcinoma of the breast and metastasis therefrom; and orchiectomy is permitted in the treatment of the prostate."

B. A committee will be appointed by the Board of Directors to aid in the implementation of this policy at this hospital. The committee will consist of representatives of Obstetrics, Gynecology, Internal Medicine, Surgery, Psychiatry, and Clinical Psychology. Hospital Administration and a Church Representative — Hospital Chaplain or Diocesan Coordinator of Health Affairs. Each case is to be reviewed by a panel selected from the above committee. A physician is not to review his own case.

C. The following procedure will be used when a physician judges that a tubal ligation seems indicated:

1. The attending physician shall make a written application. This application should be signed by the patient and patient and contain the following information:
   a) Medical reason for the tubal ligation;
   b) Summary of medical history and pertinent laboratory findings.

2. The physician should also submit an informed consent which is signed by the patient and spouse or legally responsible guardian. It should be duly witnessed.

3. The application and consent form are then submitted to the Hospital Administrator.

4. The Administrator selects the panel as indicated in "B" above and submits a copy of the request to each person.

5. Members of the panel shall review the request and affix their separate reports to the application and return it to the Administrator. A unanimous recommendation of the panel is necessary for approval.

6. The attending physician will then be informed of the decision and he may proceed with scheduling the case.

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Model II

STERILIZATION COMMITTEE

The Board of Directors believe there are a number of medical conditions affecting female patients which should be marked by tubal ligation to prevent reproduction. Physicians of the board will be asked to see the patient and make a final determination.

The entire committee shall meet quarterly to review overall policy matters and for mutual guidance as these policies are established.

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Model III

POLICY STATEMENT FOR PROCEDURES THAT INDUCE STERILITY

A. THEOLOGICAL PRINCIPLES:

1. The revised Ethical and Religious Directives (1955) approved by the National Conference of Catholic Bishops in November 1971, issued the following Directive regarding selective sterilizations:

2. "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 directly contraceptive (that is, contraception is not the purpose); and b) a simple treatment is not reasonably available. Hence, for example, oophorectomy or irradiation of the ovaries may be allowed in treating carcinoma of the breast and metastasis therefrom; and orchidectomy is permitted in the treatment of carcinoma of the prostate."

3. Decisions regarding selective sterilization in Catholic Health Facilities are to be made in the light of the above policy.

The Directive is to be understood and implemented in accordance with sound theological interpretation and acceptable medical practice. Where a legitimate diversity of theological opinion exists regarding the interpretation of the Directives, the recommendation of the 1955 edition of the Ethical Religious Directives for Catholic Hospitals is to be observed.

"In questions legitimately debated by theologians, liberty is left to physicians to follow the opinions which seem to them more in conformity with the principles of sound medicine."

B. COMMITTEE FOR IMPLEMENTATION:

1. To ensure the proper implementation of this Directive, a Selective Sterilization Committee will be appointed by the Board of Directors (or by the Chief of Staff and approved by the Board of Directors).

2. Adequate theological orientation will be provided Committee members to ensure correct understanding and application of the Directive within acceptable theological limits.

3. The Committee should be composed of the following members: Chief of Obstetrics, Gynecologist, Surgeon, Internist, Psychiatrist, Chaplain or Moral Theologian, Administrator and Nurse.

4. Each member must have an alternate.

5. Each case is to be reviewed by a panel consisting of a minimum of three medical staff members selected from the above Committee. A physician is not to review his own case. The Administrator, Chaplain and Committee Chairman will be standing but nonvoting members of every such panel.

6. A favorable recommendation must be made by the majority of the panel before the procedure can be approved. The Committee Chairman, Administrator and Chaplain may veto a favorable decision by the Committee. In the event of a veto, a written explanation of the reasons for the veto decision must be submitted to the Committee. A physician or Committee may then forward the case to the Archdiocesan Medical-Moral Committee or the Bishops' Committee on Health Affairs for further consideration.

C. PROCEDURE:

The following procedure will be used...
when a physician judges that a tubal ligation seems indicated:
1. The attending physician shall make a written application. This application should be signed by the patient and should contain the following information:
   a) Medical reason for the tubal ligation.
   b) Summary of medical history and pertinent laboratory findings.
2. The physician should also submit an informed consent which is signed by the patient and spouse or legally responsible guardian. It should be duly witnessed.
3. The application and consent form are then submitted to the Committee Chairman.
4. The Chairman selects the panel as indicated in "B" above and submits a copy of the request to each person as well as to the Administrator and Chaplain.
5. Members of the panel shall review the request and affix their separate reports to the application and return it to the Chairman.
6. The attending physician will then be notified of the decision and he may proceed with scheduling the case.

D. EXCEPTIONAL CASES:
All patients recommended for sterilization shall have their cases reviewed by a panel prior to surgery. Emergencies are recognized whereby time would not permit an appointment and convening of such a panel by the Committee Chairman. In these exceptional cases, a panel will be appointed to review each case retrospectively. Abuse of this protocol may result in the restriction of the physician's privileges.

Diverse Interpretations

The Advisory Committee of the Bishops' Committee on Health Affairs is well aware of the great diversity with which Directive 20 is interpreted and applied. It is attempting to face the problem by formulating an authoritative interpretation of the Directive as it now stands and by considering the possible revision of the Directive if the evidence so indicates. Father Thomas O'Donnell and John Connelly, both of whom served as advisors with the original Bishop Committee that drafted this Directive, have indicated that the Directive as it stands would allow for sterilization in the instance of repeated Caesarean sections that have resulted in a weakened uterus that would make a future pregnancy precarious. Beyond this instance and the explicit examples cited in the Directive, it simply is not clear at the present time what constitutes the pathological condition mentioned in the Directive and to what other situations permission for selective sterilization indicated in the Directive may be extended.

(Editors note: Asked to comment on this point, Father O'Donnell replied: "It is perfectly evident that Directive 20 does not permit any sterilization that is 'directly contraceptive.' The term 'directly contraceptive' or 'contraceptive sterilization' means, in the directive (as in its accepted usage in moral theology), the suppression of the generative function for the purpose of preventing pregnancy, or that this done merely as a means of birth control or even if it is supported by considerations of clinical expediency. Thus when pregnancy would be expected to have a deleterious effect on some serious pathological condition outside of the generative system, such as cardiac decompensation, chronic kidney disease, etc., a tubal ligation or any other procedure to suppress fertility is contrary to Directive 20 and, of course, likewise contrary to the official teaching of the Church. If the purpose of the procedure is to prevent pregnancy, it is a contraceptive sterilization, whether or not there is a medical reason for it, and this is contrary to Catholic teaching. This was spelled out in extremely clear detail by Pope Pius XII in his address to the Italian Society of Urologists, Oct. 8, 1953 (Acta Apostol. Sedis, 44, 1953, pp. 674-675).

The reference to the uterus so severely damaged by Caesarean sections that it cannot safely support another pregnancy brings us to a very difficult point which is often misunderstood. The theological basis of the problem is the boldly probable opinion that the removal of this uterus is permitted precisely because the damage in the uterus itself makes it a functionally dangerously pathological organ — and that, as such, it can be removed even though it is a uterus — and that because of the consideration of the dangerous damage in this organ itself, its removal need not be viewed as a contraceptive sterilization.

The next step is the very tenous opinion (which has nevertheless received recognition by some very reliable theologians) that, in view of the fact that the first step in this clinically justified hysterectomy would be the freeing of the uterus at the tubal adnexa, one could simply do this, by way of isolating the damaged uterus, if the total operation would be contraindicated by the condition of the patient.

The question is — can this procedure be viewed, not as a contraceptive sterilization, but as a legitimate and less drastic substitute for the indicated hysterectomy?

Some physicians would violently disagree with this approach on purely clinical grounds, while others would disagree on moral grounds — saying that they see it as nothing more than a contraceptive tubal ligation. Let me add that those who do see it that way obviously cannot do the procedure in good conscience.

The point here is that the isolation procedure is a very unique situation, and can in no way be extended to justify tubal ligation in the presence of cardiac complications, kidney disease, or any other clinical entity apart from the dangerously damaged uterus.

Another problem area reported by some of the respondents dealt with the Directives regarding contraception. Doctors, nurses and administrators in Catholic health facilities wrestling with the problem of responsible parenthood and a respect for individual conscience wonder what bearing Directive 19 has, for instance, on teaching family planning values and methods, especially to members of outpatient clinics. The present policy in most Catholic hospitals is felt to be a hindrance to an effective program of responsible family counseling, as well as a disadvantage for medical interns applying for training at Catholic hospitals because of the limited options available within the Catholic hospital context.

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A third area that is sure to cause increasing concern in Catholic hospitals in the light of the recent Supreme Court decision is that of abortive procedures. Many Catholic hospitals have formally reaffirmed as hospital policy the position on abortion stated in the Directives, but it is feared that attempts may be made to force Catholic hospitals by court order, especially in those areas where they are the only health facilities serving the community and where they have received community funds, to permit abortive procedures within the guidelines allowed by law.

**Other Factors**

Other issues which have been raised concern questions regarding the moment of death, euthanasia, organ transplantation, genetic counseling, experimentation, experiment guidelines, medical fees and expenses, and the delivery of health care for the poor and needy. From these indications it is quite clear that the present Ethical and Religious Directives for Catholic Health Facilities promulgated by the American Bishops are far from being regarded as a finished product, but rather mark the beginning of what will hopefully be a continuing and cooperative effort among all involved in the health care apostolate to work towards a more adequate and comprehensive summary of guidelines for medical care in Catholic health facilities.

In light of the available evidence, the following recommendations seem to suggest themselves as appropriate regarding the present Directives: (1) that local Bishops promulgate and individual hospitals formally adopt the Directive as official policy even while recognizing the limitations of the document and thereby acknowledging their responsibility to be part of the continuing process of updating an renewal, (2) that serious and continuing education programs be arranged on the hospital, diocesan, and state-wide levels for all members involved in the health care apostolate in order that the Christian moral values and theological principles that underlie the Directives and that are crucial to the proper understanding and implementation might be better grasped, (3) that medico-moral committees be established on the hospital, diocesan, state, and state-wide levels comprising representatives from all areas, the health care apostolate to create the necessary bridge that will translate the abstract Directives into responsible, concrete decisions, sensitive and responsive to the particular circumstances of the individual case, and (4) that clear channels of communication be established to forward local experience, questions and difficulties to the Bishops' Committee on Health Affairs whose responsibility it is to make the Directives ever more responsive to the realities of the Christian experience. Only when the above elements are more widely and effectively realized at all levels can we expect the Ethical and Religious Directives for Catholic Health Facilities to be revised and to reflect more clearly a Christ-like concern for the sick and suffering.

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**Population, Rhythm, Contraception and Abortion Policy Questions**

**Andre E. Hellegers, M.D.**

The recent Supreme Court abortion decision has caused a great deal of anguish in Catholic circles as well as in some others. It is too soon to judge the effects, but it may be confidently predicted that attempts to amend the Constitution will be made. Since that is a long process, and since it is likely to be tried again and again if it does not succeed at first, it is clear that for several years there will be much public bitterness in the entire area of human reproduction. Yet while the abortion debate will rage in all its bitterness, we cannot avoid other issues in human reproduction. In fact, it may be the very best of times to reflect on what should be done and to recognize that many things should have been done long ago. Our past negligence comes out all the more clearly and our future needs seem all the more obvious.

We must recognize first of all that the world is presently undergoing an unprecedented rate of population growth. In a sense it is a gigantic medical success story, overwhelmingly due to a massive international reduction in infant death rates. We used to bury the problem by burying our children. Now we save them and they become the parents of further children. The very rate of the success is the problem. Death rates of 10 per 1000 and less are now widespread in the developing countries, excluding parts of Africa. Obviously if birth rates continue at levels of 40 per 1000, typical of countries where family planning is not yet in vogue, growth rates of 30 per 1000 or three percent will, and do, occur. This yields a doubling of populations in less than 25 years. Common sense tells us that this cannot long continue.

It may be argued that this is of no concern to the United States — that recent figures clearly show we have our reproduction under control.

Two points are to be stressed in this regard. The first is that average family size in the late 1920's and 30's was no greater than today, yet it was followed by the baby boom of the 1950's. What we are seeing today may simply be a delay in the having of a first child.

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Dr. Hellegers is the Director of The Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics. He suggests positive steps that the Catholic Church can take in dealing with the problem of overpopulation and reproduction.