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President's Page: Going Onward, Ever Growing

William G. White

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A Clarification, A Compliment

To the Editor:

In the May, 1985, issue of the Quarterly, Dr. Robert O'Donoghue, in his Letter From Ireland, makes the point that "When President John Kennedy was here in 1964 he was able to walk apparently unprotected among the people on many occasions." I expect he was, being invisible. As I remember, the President died tragically in November, 1963. Ah, well, even love needs law and again.

May I compliment you on a thoroughly excellent Quarterly — a very valuable service.

Mrs. L.M. Cushing
Ontario, Canada

A Priest/Pharmacist Comments

To the Editor:

The medical profession frequently raises questions about the safety and effectiveness of the so-called "contraceptive" pill. But often its real harmfulness and true physical effect are ignored.

For instance, many people continue to think that the pill is a contraceptive, but that is no longer true. Since the late 70's, the so-called "new pill" is in fact not a contraceptive at all, but an abortifacient. That is, it causes the death of the conceived embryo.

More accurately, what is called "The Pill" is really aminoditory, which means that the woman taking it still ovulates and conceives, but the fetus can't "nest." (Nidatory comes from the Latin word nidus, which means nest.) It's as if her womb had an ejector spring in it that automatically triggered as soon as something... a fertilized egg, an unfertilized egg, whatever... were to try to nest in it. That is the physical effect of the pill. Or to use another example, the womb can be compared to a catcher's mitt.

Under normal circumstances, the mitt holds the ball (the egg or fertilized egg) when the catcher catches the pitch. But the womb of a woman on the pill is like a catcher's mitt with a lining of cement. The ball hits the mitt and bounces right out again.

Of course, that's no way to play base ball, and certainly no way to deal with human life. The literature included with any bottle of the pill clearly states: "prevents implantation." Although the term "contraceptive" is used in the loose sense, it is really a misnomer.

By using today's so-called oral contraceptive, therefore, some people could be destroying one fetus a month without knowing it. And the situation becomes more tragic since the entire process is so cold, painless, and implacable.

Registered Pharmacist
Oak Park, Ill.
Former Spiritual Director — National Catholic Pharmacist Guild of the United States

November, 1985
Message from the Spiritual Advisor

Image of the Good Shepherd

Skilled craftsmen universally have captured the scriptural image of Christ, the Good Shepherd, in their works of art. They portray the loving, compassionate Lord Jesus with His rod and staff, surrounded by docile sheep awaiting His next move. This theme of Psalm 23 is applied to both bishops and priests in their evangelical apostolate. Could a modern physician be cited as a shepherd also?

In our highly technological society, agricultural scenes of sheep and shepherds are hardly compatible with busy cities, speedy ambulances and ultra-modern hospitals. Therefore, one can readily ask, is the metaphor of shepherd and sheep relevant today?

The physician’s responsibility to leave those who are healthy and care for the sick, abandoned, confused, diseased and unprotected is indisputable. His authority to insure ways to bring about recovery and his uplifting of those in the depths of despair to the green pastures of hope certainly entitle him to be seen as the Christ-like Good Shepherd. His willingness to take time out and, with confidence, bring his patients close to him is surely in keeping with Him Who lifts His sheep, lost and afraid, on to His shoulders as a loving sign of His genuine concern for them.

The gospels (John 10:11-18) speak of two characteristics which define a good shepherd. One is that he know his sheep, and the other that he be willing to die for them. Knowing your patients and giving of your time (your life) for them certainly qualifies you for this honor which permits you to "dwell in the house of the Lord for years to come."

Your stethoscope is your rod and staff. Present before you is the "lamb", helpless on his bed. However, you are not afraid to walk "in the shadow of death" as the Lord is with you, "to give you courage". People, like sheep, need to be guided, to be given leadership, direction and hope. They will follow the loving, concerned shepherd whom they can trust.

The psalm concludes with comforting words from its author, King David, who prophesied in the name of the Lord that, "Your goodness and kindness shall follow Me all the days of My life".

As you shepherd your patients, your "flock", your goodness and kindness follow the Lord. It is true you will become humble and exhausted, but it is also true that in the mystery of ministering, your servant status becomes regal.

—Msgr. Dino J. Lorenzetti
As Catholic physicians we are particularly sensitive to this obligation. Happily, we have the wealth of Catholic philosophy, ethics, and social teaching to sustain us in our efforts to serve the needs of our patients.

We know, for example, that truth is one, that there can be no real conflict between faith and reason, between the moral teachings of the Church and good medical practice. We know that the Church’s teaching on contraception, for example, is not merely a sectarian tenet, inapplicable to those of other beliefs, but rather is based on the laws of nature itself, and therefore speaks to the heart of every human person, in which those laws are inscribed. Because of our understanding of human sexuality as a personal, not merely a biological, reality, we know that contraception is inevitably destructive of the integrity of the person and of the stability of the marital relationship.

When we counsel a family, therefore, we go beyond the mere refusal to fit a diaphragm or prescribe the Pill “because it is against my religious beliefs.” Our demurral is based not on private beliefs, but on our commitment to our patient’s total personal well-being. We don’t dismiss our patient’s request with a simple refusal, still less with a referral to someone who will accede to their request. Would we refer them to a quack or charlatan? Of course not. Nor shall we refer them for a treatment which would be detrimental to them, even if they request it. Instead we try to initiate a dialogue. A deeper history will often reveal that one or both spouses really do not object so strongly to another child, but may be anxious about their ability to rear or support a family. As Christians, we can communicate hope—a hope that transcends the anxieties of the moment.

We can try to give young fathers a longer perspective on life. We can remind them of the experience of older couples, who struggled financially early in their married lives, but achieved at least moderate material security by middle age. We can inform them of the surveys of the elderly which reveal the prevalency of a heartrending regret at not having had more children. To paraphrase Kierkegaard, we learn life looking backward; unfortunately we have to live it forward. Or as an old Yiddish proverb has it: “Too soon old, too late smart.”

We can reassure young mothers that parenthood will not forever be as daunting as it seems at first, that it is a job one can grow into, that expertise in parenthood is not infusible, but learned by experience. We can share the observation of many mothers of large families who have found that, after the total transformation from childlessness to parenthood with the arrival of their first, and after the increasing demands and exhaustion that come with the second or third, the “hump” is over, and although motherhood remains busy and demanding, it becomes more rewarding and less overwhelming as the family grows.

We can point out the marvelous design of nature in child-spacing through breastfeeding: that families who practice natural breastfeeding generally have families about every 1½ to 3 years, that nature’s subtle mechanism tailors each interval to the needs of each child in a way that no method of planning can achieve (i.e., the more dependent child nurses longer and more
frequently, thus prolonging his mother’s natural infertility and (postponing the arrival of the sibling who will displace him from his mother’s arms); that babies come more frequently (1½ to 2½ years) when parents enjoy the energy of youth and less often (2 to 3 years or more) as parents enter their late twenties and thirties; that with natural child-spacing, through breastfeeding, the inherent infertility of the human species was kept the average family size to about four or five well-spaced children. The 12 and 14-child families of a generation ago were usually associated with bottle-feeding). We say these things not as preachers, moralists, or professors, but merely as physicians who care for our patients in their social being.

In this way, we bring to bear on the solution of practical problems in the lives of our patients our special knowledge, which is grounded in the Church’s teaching on the inherent benignity and universal accountability of human behavior of the natural law and, with God’s help, we may save them from self-destructive decisions.

There are so many other areas of medical practice which can truly be enlightened by our faith: the care of the elderly, of the dying, of handicapped newborns, of infertile couples. In all these cases, the seemingly restrictive teachings of the Church actually liberates us and our patients, as we seek more humane solutions to difficult problems. Only by heeding these restrictions which, like warning labels, keep us from administering harmful poisons, can we truly be healers — givers of wholeness — to our patients.

Such a mission is impossible to each of us alone. We cannot know enough of what is truly good or harmful, or why it is so, and of how to communicate our knowledge effectively to our patients, without the instruction, counsel, and encouragement of our fellow Christian and Catholic physicians. This is the raison d’etre of the Catholic Physicians’ Guilds and the National Federation.

If you have a local guild, be active; if not, start one. Too little interest? How many members does it take? “Wherever two or three are gathered…”

Read this journal; discuss it with your friends. Come to one of the national meetings of the Federation held each fall at various sites. For the past several years, these meetings have been uniformly superb — nourishing for the mind, the emotions, the spirit.

“Pray always.”

— William G. White, M.D.

The Pill and Cancer

Kevin Hume

Doctor Hume, an Australian physician, prepared the following paper for a seminar on family planning at the Academy of Science, Canberra, Australian Capital Territory, in November, 1983, and updated it this past summer for publication in Linacre Quarterly. He notes that the three studies at the end of the paper, from the Centres for Disease Control Cancer and Steroid Hormone Study, are of particular interest to U.S. readers. They were not available until after the paper was completed, so Doctor Hume summarized them as they are presented here.

The DES Problem

Diethylstilbestrol, although a synthetic estrogen, is not a steroid and has a potency only 1/25 that of ethinyl estradiol, the estrogen most commonly used in the combined estrogen-progestogen Pill. Nevertheless the story of DES is very relevant in any examination of the subject of the relationship of oral contraceptives and neoplastic changes in women.

The combined Pill was launched in 1958 after very inadequate trials in Puerto Rico in the mid 1950s and was given limited approval by the Food and Drug Administrator (FDA) of the U.S. in 1960. The drug company mainly responsible for its early promotion, G.D. Searle and Co., conducted a tremendous advertising promotion campaign and very soon women on the Pill in the U.S. were being numbered in millions. This put indirect pressure on the FDA which, when the extent of the thalidomide disaster was revealed by the findings of McBride in 1961, should have called for caution. However, the Pill got the green light and, on the reassurance of the Family Planning Association that it was safe, was introduced into Britain in 1962. Since then we have seen a succession of new formulations of the Pill, each proclaimed to be “safer” and indeed “safer” than its predecessor. The dose of the ingredients has been progressively lowered till it is now only a fraction of what it was in the original Pill. Some of the ingredients have quietly disappeared altogether, as have the so-called sequential formulations, much hailed in the late ’60s and early ’70s. The reason, of course, is that the Pill, in practice, was shown to be not so safe. While
increasing animal experimentation was carried out to test new steroids, the real guinea pigs have always been the actual users, the women themselves. Generally speaking, the victims have been young, healthy women, although, needless to say, the casualty rate rose sharply in the older age groups.

The DES experience was very similar. However, as it has been pointed out earlier, there has been more time to see the long term results, giving a foretaste of things to come. DES was first synthesized by Dodds and colleagues in 1938. Its most prominent use followed studies in 1940 and 1941 by Smith, who suggested that DES was beneficial in the treatment of threatened abortions and the prevention of abortions in pregnant women who had previously had repeated pregnancy losses. Between the late 1940s and 1970, it is estimated that two to three million women (mostly in the U.S.), were prescribed DES during their pregnancies, thereby exposing 1 to 1.5 million fetuses to each sex to the drug. Later studies showed that DES was not only unsuccessful in benefitting women suffering from the disorders for which it was prescribed, but was actually associated with significant increase in abortion, neonatal deaths and premature births. In addition, serious long term consequences of in utero exposure to DES have continued to come to light.

In 1970, Herbst and Scully reported the occurrence of vaginal adenocarcinoma of the vagina in seven girls, aged 14 to 17 years. These seven cases exceeded the total of all previously reported cases of clear cell carcinoma in this age range. In 1971, an epidemiologic study demonstrated the link of vaginal clear cell adenocarcinoma to in utero DES exposure which had occurred 15 to 20 years earlier. In 1972, the Medical Journal of Australia published a statement from the Australian Drug Evaluation Committee outlining the danger of maternal DES therapy and also the risk of the DES content of the "morning after" Pill. DES Reference Centres have been set up in Australia at Prince Henry's Hospital in Victoria and King George V Hospital for Mothers and Babies in Sydney.

A recent study by Greenberg et al, supported by a grant from the US National Cancer Institute, compared the incidence of breast cancer in 3,033 women who had taken DES in pregnancy during the period from 1940 to 1960, with the incidence in a comparable group of unexposed parous women. They found a crude relative risk of 1.4 in the exposed group, which had a slightly higher breast cancer mortality (relative risk 1.1) than in the unexposed. The authors concluded that the incidence of breast cancer was moderately but statistically significantly increased in women given DES, and that we were unable to exclude the possibility that some unrecognized concomitant of DES exposure accounted for this increase.

The findings of this study showed that DES-exposed women clearly appeared to be at an increased risk of breast cancer which, while less than that associated with a positive family history of the disease, seemed to become more pronounced with time and may prove to be of greater concern in the future. The frequency of breast cancer among the controls in this study dropped after the age of 60 years, when the difference between exposed and unexposed women was most pronounced.

The long-term effects of DES exposure on mothers, daughters and sons are not known and there is a continuing need for well-documented and long­
terming studies to identify new problems and increased health risks associated with exposure to DES, as well as to allay anxiety among DES-exposed persons and their families.

In one recent study, Depue et al noted that testicular cancer was more frequent among males with in utero DES exposure (9 of 106 patients with testicular cancer vs. 2 of 107 controls had been exposed to hormones). However, in this series, five of the nine exposed mothers had received oral hormone pregnancy tests and only two had taken DES.
Endometrial Cancer — The Oracon Story

The incidence of cancer of the endometrium in women below the age of 50 years is quite low at 14 cases per 100,000 women. It is particularly rare in this age group where there are normal regular menstrual cycles.

Those at special risk are the obese and the infertile and especially in polycystic ovarian syndrome and in women having estrogen-producing tumors and failure of ovulation and dysfunctional bleeding. These conditions produce a situation where the endometrium is not exposed to prolonged stimulation by estrogen unopposed by progestogen.7

Women who ultimately develop endometrial adenocarcinoma have frequently shown signs of hypothalamic-pituitary-ovarian dysfunction in their reproductive years, manifested as oligomenorrhea, hyper- or hypomenorrhea, anovulation, and polymenorrhea. These dysfunctional bleeding patterns occur frequently because of failure to ovulate, causing problems of infertility in the triad of hypertension, obesity and diabetes is a common finding in these women with endometrial cancer.8

Estrogen, whether endogenous or exogenous may, over a long period of time, produce endometrial hyperplasia if not interrupted by progestosterone. This entity has been shown to advance to endometrial carcinoma. Postmenopausal estrogen use has also been associated with the occurrence of endometrial carcinoma. The overall risk has been shown to be six-fold for estrogen users as opposed to non-users. Long-term use of estrogen for five years carries a 15-fold risk. In 1963, sequential oral contraceptives were first marketed in the U.S. Their use was promoted, in part, by an effort to simulate more closely the natural sequence of estrogen, followed by estrogen-progestosterone, as found during the normal menstrual cycle. The scheme involved taking 80 to 100 mcg of estrogen alone for 14 to 16 days, followed by an estrogen-progestogen combination for five to six days, the progestogen content varying from as little as 3mg to 25mg.8

Silverberg, Makowski and Lyon, in 1975, first reported the occurrence of endometrial carcinoma in young women taking sequential oral contraceptives. These reports were quickly followed by others. By June, 1976, 30 cases of verified invasive carcinoma of the endometrium had been identified, occurring in women under the age of 40 who had a documented history of oral contraceptive use. Twenty had used sequential type preparations, nine had used combined formulations, and one patient used an unknown type. Nineteen of the 20 using sequentials had used one preparation containing 100 mcg of ethinylestradiol as the estrogen and 25 mg of diethisterone, a weak progestogen, and marketed under the trade name of Oracon. Before further studies could be carried out, the sequentials oral contraceptives were voluntarily withdrawn from the market by the manufacturers.9

Progesterone competes with estrogen for binding sites in the endometrial cells and may reduce the estrogen-stimulating effect. The exposure of the normal estrogen-primed endometrium to progesterone converts this tissue to the typical secretory type seen during the luteal phase of the menstrual cycle. This cyclic effect of progesterone prevents the normal proliferative endometrium from progression to hyperplasia. The addition of a potent progestogen to the estrogen produces a decidual pattern of endometrial response with a tendency to atrophy rather than progression to hyperplasia. This property of progestogens is used therapeutically in the treatment of endometrial cancer, which, incidentally, has a good prognosis with a cure rate of 90%. Depo-Provera, (Medroxyprogesterone acetate), in large and repeated doses, appears to be the drug of choice. However, predictions that the simultaneous administration of estrogen and progestogen might reduce endometrial cancer risk should be regarded with caution. While they do reduce the incidence of endometrial hyperplasia, there is no direct evidence that this applies to endometrial cancer as well.10

All estrogens seem to increase endometrial cancer risk, irrespective of their formulation or mode of administration. Initially it was thought that conjugated or “natural” estrogens, particularly estrone, were primarily responsible for the association, but recent work has implicated synthetic compounds such as DES as well. Similarly it was thought earlier that estrogens were more hazardous when given continuously rather than cyclically, but this, too, is unsupported by newer investigations.11

The addition of a powerful progestogen may protect women in older age groups who take estrogen for prevention of osteoporosis or prolongation of the “youthful look”, but it introduces all the hazards of thromboembolism, hypertension and myocardial infarction which characterize the taking of the Pill by women in older age groups. The mortality rate accompanying Pill use in this group is 22 per 100,000 women and this exceeds that of endometrial cancer by far.12

The Pill and Breast Cancer

In 1950, a trial was set up in England to evaluate the effects of large doses of stilbestrol (DES) and ethisterone, a progestogen, on rates of fetal loss in pregnant diabetic women. Eight women were allocated at random to receive the hormonal treatment and 76 to receive inactive tablets. The aim was to establish the efficacy of this treatment in reducing fetal loss, the rates of which were exceptionally high in diabetic women. Identical rates of spontaneous abortion (8%) and perinatal mortality (23%) were noted in both the hormone and non-hormone treated groups. Similar results were obtained for non-diabetic women in a randomized trial of stilbestrol conducted in Chicago. Both studies failed to show a beneficial effect of hormonal treatment during pregnancy did much to curb the administration of sex hormones to pregnant women, although the practice continued during the 1960s.
In 1978, Bibbo and colleagues reported the results of the 25-year follow-up of the mothers who had participated in the Chicago-based trial. They found an excess of breast cancer in the group treated with stilbestrol, although the difference was not statistically significant.13

In 1980, Valerie Beral and Linda Colwell, who was involved in the original English trial, reported on the long term follow-up of mothers who took part. Information about all but four of the women was obtained (97%). The overall mortality was 4.5 times that of comparable women in England and Wales. Most deaths being from complications of diabetes. More than half, mostly benign, were reported in the hormone-exposed than the non-exposed group (14.18% and 2.3% respectively). Four cases of malignant breast disease were reported in the hormone-exposed women and none in the non-exposed.

Beral and Colwell concluded that these findings supported the evidence linking estrogen treatment and breast cancer and suggested that the latent period before the tumor becomes clinically apparent may be 12-15 years or longer.

In a commentary on the findings of Beral and Colwell, M.E. Vance and Millington drew attention to the fact that most studies on oral contraceptives found no increase in breast cancer in Pill users and perhaps even a decrease. However, they pointed out that a delayed appearance of breast cancer, such as that noted by Beral and Colwell, might have been missed because younger women predominated in these investigations. They were prompted to review these studies and prepared a table summarizing data from follow-up-control studies of breast cancer according to "young" and "old" groups. Age categories differ among studies and for two studies, they assumed that premenopausal patients were younger than postmenopausal.

The data in their table indicate an increased risk of breast cancer among women with a positive history of oral contraceptive use, by only after they have passed into their fifth or sixth decade. Most Pill users have not yet reached the critical age.

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Breast cancer is more common among women who have never borne children than among parous women and the longer a woman delays her first pregnancy, the more she increases her risk of developing the disease. Recently, it has been suggested that prolonged use of oral contraceptives before the first full-term pregnancy may increase the risk of breast cancer, although after this pregnancy the risk is probably unaffected by taking the Pill. Clearly, the first full-term pregnancy does something to alter a woman's risk of developing breast cancer. Whether or not she breastfeeds is probably irrelevant, but there is good evidence that the breast epithelium is permanently changed by pregnancy. Although histological change occurs in the ductules, the physiological change in the epithelium, shown by its altered response to hormones, is more striking. Possibly the high progesterone concentrations of late pregnancy induce progesterone receptors which can then respond to the lower concentrations of a normal menstrual cycle. If these receptors are inadequate before the first full term pregnancy, then during normal cycles, the breast will therefore be exposed to "unopposed" estrogen, despite the presence of normal concentrations of progesterone in the circulation.15

The effects of the Pill may be different among nulliparous and parous women as is now being suggested by epidemiological surveys. Although the combined Pill provides estrogen balanced by progesterone, if the breast of the nulliparous woman cannot respond to the progesterone component, then a young girl taking the Pill is exposing her breast epithelium to "unopposed" estrogen, although in a low, but steady, concentration. Early menarche, nulliparity and late menopause are also important risk factors in the development of cancer of the breast. The sooner the cycles begin, the sooner the "unopposed" estrogen begins to act on the breast epithelium. In the menopause, there is an increased frequency of anovular cycles, again exposing the breast to "unopposed" estrogen. A further, but as yet unconfirmed, risk factor, is that identified by Pike and colleagues, namely an early miscarriage before the first full-term pregnancy. Although concentrations of both estrogen and progesterone increase in early pregnancy, in the nulliparous woman only the estrogen will affect the breast. Women having first trimester-induced abortions before their first full term pregnancy were shown to be similarly at risk, with a 2.4-fold increase.16

In the R.C.G.P. study of the Pill, initiated in 1968, the findings in regard to breast cancer were reported in 1981. One hundred thirty-three cases of breast cancer were recorded. There were 19 deaths among ever-users of the Pill and 10 in the controls. Analysis showed a significant increase in the incidence of breast cancer among women aged 30 to 34 at diagnosis if they had ever used the Pill. By 1979, less than 5% of the original 23,611 women — were current, if intermittent users. No figures are given for how many of the 18,735 women, enrolled when they were already using or had used the Pill, had developed breast disease during their previous use of the Pill, thought to amount to 25,570 women years (R.C.G.P. 1974). This previous use was excluded from the final analysis because it had not been observed in use.
In 1981, Pike et al collected records of 293 women with breast cancer under the age of 33 between 1972 and 1978; 48 had died and of the 163 interviewed, 83% had used the Pill. Those who had taken it before their first full-term pregnancy had an increased risk which rose with the duration of Pill use. In 1977, Passenbarger et al found that 15 out of 25 women under the age of 30 with breast cancer had used the Pill. Pike also found a significant increase in breast cancer in women with a history of benign breast disease. Hoover et al, in 1976, found that estrogen use was related to an especially high risk of breast cancer. However, the risk of the benign disease developed after the women had started the drug. The finding of large epidemiological trials that the Pill reduced benign breast disease has always seemed anomalous to some clinicians whose observations seemed just the opposite.

The study of Pike et al gave rise to extensive correspondence in the British Medical Journal, especially challenging their concept of the classification of oral contraceptives according to “progestogen potency,” but of Swayne in particular. However, Swyer said: “My competence in epidemiology does not allow me to criticize the general contention by Pike et al. of long-term use of oral contraceptives by young women may increase the risk of breast cancer.”

Meanwhile, the FDA, having reconsidered its position about oral contraceptives and cancer, made a firm statement that there is no increased risk of breast cancer in oral contraceptive users of any age or in association with any particular formulation or long-term use. However, the FDA felt somewhat uneasy about Professor Vessey’s findings. It was planning to revise the labeling of oral contraceptives to include a warning that their use may be associated with an increased risk of cervical cancer.

More recently, a group of Swedish researchers has added its support to the findings of Professor Pike and his Los Angeles group in a preliminary report of a study about to be published. A case-control study was done on 120 consecutive cases of breast cancer in women born in 1939 or later and diagnosed at the age of 45 or earlier, who were interviewed personally by their physician. These were matched with 225 controls.

When the data were analyzed by conditional logarithmic regression, women who had started to use the Pill at 20-24 years of age had three times the risk of developing breast cancer prior to 46 years of age compared with non-users. The relative risk increased with earlier age of starting the Pill. Women beginning to use the Pill after their first pregnancy had a lower relative risk than others, although the difference was not significant. In this investigation, both a low age at menarche and a high age at first full-term pregnancy were related to increased breast cancer risk.

The authors conclude: “Our results, taken together with earlier reports linking early O.C. use with breast cancer, are a matter of great concern in respect of O.C. use by young women.”

The Pill and Liver Tumors

The association between taking the Pill and the development of non-malignant liver tumor hepatoma was first suggested in 1972 by Horvath. The following year, Baum et al described seven women, all oral contraceptive users, who developed benign hepatic adenomas. Subsequently a number of reports have appeared supporting these findings, although the histopathologic diagnosis has been variously reported as focal nodular hyperplasia, adenoma, hamartoma, benign hepatoma, solitary hyperplastic nodule and focal cirrhosis. Prior to 1970, benign liver tumors in young women were very rare.

The risk of developing these liver conditions increases dramatically with duration of use of the Pill, particularly after 5 years. The majority of affected women had been taking mestranol-containing compounds, mestranol being a synthetic estrogen metabolized in the body to ethinylestradiol. Nevertheless, significant numbers of these lesions have been reported in patients taking ethynylestradiol-containing compounds. A few patients have taken DES, conjugated equine (natural) estrogens and progestogen-only compounds.

Benign hepatoma is a very vascular tumor and subject to spontaneous rupture, death often resulting from massive hemorrhage. A carefully conducted national survey, carried out by the American College of Surgeons’ Commission on Cancer, showed the frequency of benign lesions indicated a peak in the 26- to 30-year age group. This peak corresponds to the increased use of oral contraceptives in this age group. The increase is true only for Pill users and benign lesions. Vana et al in another study showed that 40% of tumors were diagnosed in women exposed for five years or less. Hemorrhage was most frequently associated with adenomas and almost exclusively confined to the oral contraceptive users. A significant number of patients present with signs of intraperitoneal hemorrhage and shock, the lesions seeming most prone to rupture at or about the time of menstruation. A number of the reported deaths have occurred secondary to attempts at resection. For those lesions which are asymptomatic, the best and safest course would appear to be to discontinue the Pill, urge the patient to avoid pregnancy and await spontaneous resolution of the lesion. Pregnancy, with the resultant high levels of sex steroids, may have a particularly stimulating effect and increase the propensity for these lesions to hemorrhage.

Individual case reports have appeared in the literature, particularly in Lancet, linking oral contraceptive use, some compounds containing mestranol and others ethinylestradiol, with malignant liver tumors in young women. For instance, two cases of cholangiocarcinoma in women on the Pill, aged 21 and 29 years respectively, were reported. This malignant tumor has its peak incidence in the sixth decade, being very rare in the third. An added risk factor in the development of primary hepatocellular carcinoma is infection with hepatitis B virus which is endemic in Asia and Africa. Nevertheless this liver malignancy is rare among women of childbearing age (15-40) in Singapore. However Chong-Jin Oon et al from
the Hepatoma and Liver Study Group of Singapore General Hospital reported 
primary hepatocellular carcinoma in a 29-year-old woman who had been 
on two different formulations of the Pill (both containing ethinylestradiol) 
for seven years. They considered the administration of the Pill may well 
have resulted in the earlier development of primary hepatocellular 
carcinoma in this case.30

The Pill and Malignant Melanoma in Australia

Valerie Beral et al have reported a case control study 
of 287 women aged 15-24 years with malignant melanoma and 576 
matched controls conducted in Australia.

Their findings indicated that, after a lag of 10 years, oral contraceptive 
use for a total of five years or longer was associated with a 50% increase 
in risk. This relationship persisted after adjusting for a number of potential 
confounding factors, including complexion, sunbathing activities, occupation 
and education.

In conclusion the authors state: 'If, as our data and that of others 
suggest, a lag period of 10 years or more is involved, it may still be several decades 
between the effects of oral contraceptives on malignant melanoma can be 
properly evaluated.'31

The Pill and Cancer of the Cervix

One of the most fascinating stories of modern medicine is the gradual 
unfolding of the epidemiology of cancer of the cervix. While ultimately 
linked with the intricacies of behavior (perhaps misbehavior would be the 
better word) of human beings in regard to sexual activity and the not 
unexpected influence of sexually transmitted diseases, the Pill has managed 
its way into the labyrinth, together with the ubiquitous cigarette.

While the epidemiological jigsaw is not yet complete, enough pieces have 
been fitted into the picture to provide a good idea of the general landscape.

It is an ill wind that blows no one any good. We have to thank the advent 
of the Pill for the tremendous stimulus it has provided to epidemiological 
research and the crop of outstanding researchers who have risen to the 
occasion in elucidating its many ill effects and its occasional health benefits.

The accompanying rise in sexually transmitted diseases has provided another 
rich field for research with many interesting discoveries. All of which, it 
pays one to reflect, has been an expensive ongoing exercise. Chastity may 
in the eyes of modern liberated humanity, be a very dull virtue, but its cost-
effectiveness is undoubted. It also sets the standard in public health and 
preventive medicine. Its cost to the taxpayer is nil, in sharp distinction to 
the legacy of sexual liberation. While it may be cynically pointed out that 
it is simply a case of virtue bringing its own reward, it should be considered 
worth of a civic award — perhaps even a Nobel prize.

The suggested solutions take no account of the possibility that the 
promotion of chastity may provide the answer. No, man's ingenuity will 
find a way by producing some marvelous new polyvalent vaccine, dealing 
a death blow to gonorrhea and syphilis, as though they were as controllable 
as diphtheria and tetanus. Among the ranks of man's brilliant modern 
researchers is waiting another Salk or Sabin who can produce a vaccine 
to eliminate the villainous Herpes virus II and its partner in crime, the genital 
wart virus. Chastity, like modesty, is a term soon to be dropped from the 
dictionary as obsolete, belonging to the Victorian era of sexual suppression 
and frustration. Sexual liberation is here to stay, a much-venerated sacred 
cow. It is unthinkable that it be open to challenge. Yet all the findings point 
to sexual promiscuity as the culprit in the epidemic of pelvic inflammatory 
disease, of herpes genitalis, of cervical neoplasia and even of acquired 
immune deficiency syndrome — AIDS.

Up till about 30 years ago, mortality figures for endometrial and cervical 
cancers were combined for statistical purposes. Only since that time has 
it been possible to study cervical neoplasia in any detail. There are two 
principal hypotheses considered in the etiology of cancer of the cervix:

(1) the association of cervical cancer with factors related to an early age 
at first intercourse and first pregnancy. It proposes that during adolescence, 
the cervical epithelial cells are especially vulnerable to carcinogens (the 
Coppeleson theory).

(2) the association of cervical cancer with factors related to the multiplicity 
of sexual partners, not only of the woman herself but also of her husband, 
proposing that malignant change is induced by a sexually transmitted 
fission. Herpes virus type II, the cause of genital herpes, has been long 
regarded as the specific agent.32 However, more recently, human papilloma 
virus, responsible for genital warts, has been joined with the herpes virus 
as a cofactor.

Cancer of the uterine cervix is almost unknown in nuns. The list of 
epidemiological factors associated with cancer of the cervix have been known 
for a number of years. They constitute a formidable list indeed: broken 
marrige, multiple marriages, extramarital sexual activity, premarital sexual 
activity, early age of first marriage, early age of first intercourse, multiple 
uninduced abortions, illegitimacy, multiple sexual partners of the woman, 
multiple sexual partners of her husband, history of prostitution, history of 
sexually transmitted disease, low socio-economic status, and urban residence.

On the other hand, common denominators of the low risk groups are: 
restrictive codes of sexual conduct (chastity), and religious endogamy, e.g., 
those who marry within their religious faith, particularly of the Jewish faith. 
A study of 750 Taiwan prostitutes by Sebastian et al provided strong
support for Coppleston’s theory. Their women subjects did not start their trade until they were aged 18. They showed a low yield of 10.7 per 1,000, indicating that it is sexual activity during the phase of active metaplasia which predisposes to cervical dysplasia and neoplasia. Many authors feel that there is a continuum between dysplasia and neoplasia, including invasive carcinoma of the cervix.

A new hypothesis of the etiology of cancer of the cervix has been proposed by Skegg et al, underlining the importance of the male factor. The authors point out that concentration on female sexual behavior fails to explain several epidemiological features of cervical cancer, e.g.:

1. The extremely high incidence in parts of Latin America among female chastity before marriage and fidelity within marriage are highly valued in some of these societies;
2. The large decline in mortality in many western countries after the past half century or more which started long before screening programs began in 1965;
3. The low risk in Jewish women;
4. The association with cigarette smoking, which appears to be independent of sexual risk factors, and
5. The possible association with oral contraceptives.

If cancer of the cervix is caused by an infectious agent transmitted venereally the sexual background of each male partner must be of great importance. In one study of cervical dysplasia and carcinoma-in-situ in women who claimed to have had only one partner, the relative risk increased with the number of sexual partners their husbands reported. The husbands of affected women were also more likely to have had venereal disease, to have visited prostitutes and to have had affairs during marriage.

In some Latin American societies, women are expected to have one partner, whereas their husbands may have many. Such behavior was characteristic of European societies in the Victorian era and favors the flourishing of prostitution. Call in Colombia and Recife in Brazil both have incidence rates of cervical cancer four to six times higher than United Kingdom registries. It has been suggested that this could be due to deficiency of Vitamin A in South American countries. However prostitution has been a prominent feature of life in these countries and visits to brothels by men may account, at least in part, for the high risk of cervical cancer in their wives.

The decline in mortality in cervical cancer, which has characterized the present century, was interrupted by increased rates in women born between 1911 and 1926, who spent part of their early adult lives during the 1939-45 war, when the incidence of gonorrhea was high. This suggested the presence of an infective agent which was increased by the changes in customary sexual partnerships brought about by war and its aftermath.

The general decline in mortality may involve changing patterns of sexual behavior in men from Victorian and Edwardian patterns which resembled those of contemporary Latin America where there is a “double standard” of sexual morality with much resort by men to prostitutes.

In contemporary western society, the so-called permissive society, marked by increasing premarital sexual activity, particularly in women — both men and women tend to have several sexual partners. Cervical cancer mortality rates in young women have begun to rise again, at least in Britain and New Zealand.

Another important etiological factor is related to the husband’s occupation. There is a high mortality in the wives of men in specific occupations which involve travel and absence from home. There is also evidence which suggests that, if cervical cancer develops in a man’s first wife, his subsequent wife may be at an increased risk. This might reflect transmission of a virus from the male, the identity of which virus is as yet unknown.

Malignant disease is the most common cause of death in women aged 25 to 50. While the immediate effect of the Pill on vascular disease was accepted fairly quickly, the increased risks of malignant disease and mental illness have taken longer to be acknowledged and quantified by large scale trials. In the Oxford/F.P.A. contraceptive study of 17,032 women aged between 25 and 39, there were twice as many deaths from neoplasms (25.3) as compared with circulatory disorders (12.3). 18,19

A 1978 report of this same study was entitled “Neoplasia and dysplasia of the cervix uteri and contraception: a possible protective effect of the diaphragm”.

Sixty-five of the women developed cervical neoplasia, the incidence rate in diaphragm users being 0.17 per 1,000 women years of observation as against the much higher rates of 0.95 in Pill users and 0.87 in those fitted with an I.U.D. All six women who developed invasive cancer had been using the Pill at the time of entry to the study. For the first time, cigarette smoking was reported as a major risk factor in cervical neoplasia in this study. Also, as compared to Pill and IUD users, diaphragm users were less likely to have had coitus at an early age and had had materially fewer sexual partners. 20

In 1980, Harris et al showed that the risk of cervical dysplasia or carcinoma-in-situ increased with duration of Pill use, while the risk decreased with prolonged use of barrier methods. They also found that the number of partners exerted effects independently of age at first intercourse. Cigarette smoking once again showed up as a significant risk factor. 21

Meissels et al, in a study of French Canadians in Quebec, found in 2,017 women with mild and moderate dysplasia highly significant correlations between early age at first coitus and oral contraceptive use. When corrected for age at first coitus, there was a significant excess of dysplasias in Pill users. Dysplasia of the uterine cervix behaves epidemiologically like carcinoma-in-situ and invasive squamous carcinoma, they stated — in other words, essentially as a venereal disease. It remained to be seen whether all dysplasias form one continuum or whether there are two morphologically similar but biologically distinct forms of dysplasia — one more frequent, progressing spontaneously; the other relatively rare, progressing to carcinoma-in-situ and invasive carcinoma of the cervix. 22
Stern et al, in a study of 300 women with cervical dysplasia compared to 300 with negative smears, found that those using the Pill had an increase in both severity of dysplasia and in the incidence of conversion to carcinoma-in-situ. The probability of progression from dysplasia to cancer was 0.3 after seven years, compared with 0.05 in non-users.

In the American Walnut Creek study of 16,638 women, 61% had used the Pill while 50% of those aged 50 to 54 had taken estrogen. The major cause of the 170 deaths were malignant neoplasms (45%), compared to only 15% of deaths due to vascular causes. Cancer of the cervix was significantly increased for those under 40 years of age. Malignant melanomas were significantly increased as was lung cancer in Pill users who smoked. All six cases of urinary tract neoplasms and six of the seven thyroid cancers occurred in users.

Registration rates for carcinoma-in-situ have increased from 1.6 to 15.2 per 100,000 between 1965, when registration began, and 1978. The largest increase in new cases is in the 15- to 24-year-olds (ten times) followed by the 35- to 44-year-olds (twice). These figures show considerable increases in the incidence of both breast and cervical cancer since the early 1960s when the Pill was introduced. Estrogen "replacement" therapy became fashionable. The largest increase is in the 15- to 24-year-olds who, although they still have a low risk of cancer, have only recently become the main age group to start using the Pill. This age group has a risk of double exposure to exogenous hormones. Their mothers may have taken them during pregnancy or lactation (e.g., the mini-Pill or Depo-Provera).

A very recent study by Holst and Abyholm looked at a group of 318 women with tubal infertility in Norway. Women with tubal infertility due to pelvic inflammatory disease tend to have many of the risk factors which characterize women who develop cervical neoplasia. Thirty-one of these women (9.7%) had dysplasia of varying degree or carcinoma-in-situ. Fourteen (4.4%) had severe dysplasia or carcinoma-in-situ. This was 44 times the national average for women in the age group (20-39). Among 200 unselected infertile controls, one patient had moderate and one severe dysplasia. Both of these were found to have tubal infertility. The authors conclude, therefore, that women with tubal infertility represent a comparatively high risk group for the development of premalignant lesions of the cervix.

In the U.S.A., the use of the Pill fell by 25% between 1974 and 1977 but increased by 25% in the U.K. The Pill is the contraceptive method of choice for young unmarried girls who are now at much greater risk of becoming promiscuous than they were 20 years ago and having unplanned pregnancies, abortions, sexually transmitted disease and abnormal babies.

The prestigious medical journal, Lancet, is noted for the number of papers it has published which have aroused a furor in the media because of consistently dramatic discoveries concerning the Pill's ill effects. The Lancet on Oct. 22, 1983, published not one, but two such papers, one by Prof. M.C. Pike and his group in Los Angeles on breast cancer and the Pill and the other by Prof. Martin Vessey and his colleagues on the possible adverse effect of the Pill in cervical neoplasia. The reaction of the media and of medical leaders in the field of family planning to this "bombshell" was characteristic — one of startled dismay and, in the case of many of the doctors, disbelief. In fact both studies confirmed evidence which had been mounting for some time.

As these papers were published when mine was well advanced I shall deal with them both at this point as what one might call a Stop Press item.

The Breast Cancer Study

Pike and his colleagues carried out a case-control study of 314 breast cancer patients aged less than 37 years at diagnosis and 314 individually matched controls to assess the influence of the Pill on the risk of the disease. They found that long term use of the Pill, before age 25, of the combination type containing a "high" content of the progestogen component, was associated with an increased risk of breast cancer. The relative risk was approximately four after five years of such use, and nine cases and no controls had used Pills of this type for more than six years before age 25.

Previous studies of this type had few data on long term Pill use before the first full-term pregnancy. Pike et al postulate that, as the combination Pill suppresses ovulation, there is a lack of rupture of the surface of the epithelium of the ovary and, hence, a decrease of mitotic activity in this area where ovarian cancer arises. A similar lack of activity characterizes the effect of the Pill on the endometrium, the peak of mitotic activity taking place in the follicular phase of the normal cycle.

In the breast, the reverse occurs, mitotic activity reaching a peak in the lutal phase due to the effect of progestrogen acting in combination with estrogen. Combination oral contraceptives, with their mixture of estrogen and progestogen, may therefore stimulate breast tissue mitotic activity. The higher the estrogen and progestogen content of the Pill, the greater the mitotic activity and hence the increase of risk of breast cancer. If Pill use begins at an early age, when long and frequently anovular cycles are still common, then the longer the time and the more intense the stimulation before the first pregnancy.

The authors point out that the use of the Pill during similar cycles experienced during the pre-menopausal period is also associated with increased risk of breast cancer.

As an interesting sequel to Professor Pike's study, a letter signed by both Professors Vessey and Pike as well as two other researchers and published in the following issue of Lancet, announced that they were joining forces to conduct a large case control study of breast cancer and the Pill in young women in the U.K.
The Neoplasia of the Cervix Study

The Oxford-based group carried out a 10-year follow-up of women who entered the Oxford-FPA contraceptive study with Pill and 3,154 parous women who entered the study who used other methods to determine the incidence of biopsy-proven cervical neoplasia of invasive cancer, which were of squamous type, occurred in the oral contraceptive group. Both carcinoma-in-situ and cervical cancer also occurred more frequently in this group than in those using other contraceptive methods. The greatest majority of cases of invasive cancer were of squamous type, which were more frequent in those with more than eight years of use. The incidence for all three forms of neoplasia combined, rose from 0.4 per woman-years. The great majority of cases of invasive cancer provided considerable evidence for an association with oral contraceptive use — a disturbing finding.

Vessey and colleagues had already pointed out in a European study published in 1978 that the use of the contraceptive Pill protects against cervical neoplasia and that all six women in whom invasive cancer of the cervix had developed at the time of using the Pill. Therefore, women using a diaphragm are an unsatisfactory comparison group in view of the relatively low incidence of cervical neoplasia among them.

Unfortunately data about age at first intercourse and numbers of sexual partners were not collected for the women under study. Women with long durations of Pill use were slightly more likely to be heavy smokers and to have married and had their full term pregnancy at an earlier age than women with short durations of use. Similar small differences were also apparent in the IUD group.

Cervical neoplasia was not found to be associated with a specific estrogen or progestogen or with any particular dose of estrogen or progestogen in the Pill. A large number of epidemiological studies concerned with oral contraception and the risk of cervical neoplasia have been published, some showing negative results while others showed a positive association between risk and duration of use. The negative studies included very few long-term users of the Pill. In the Oxford group study, no association would have been apparent if the data had been restricted to women of up to 48 or even 72 months of exposure.

The possibility that prolonged oral contraceptive use is making a contribution to the steadily rising death rates from cancer of the cervix and the incidence of invasive cervical cancer and carcinoma-in-situ in England in women under 34 in the last decade, should be borne in mind. These trends have generally been considered to be attributable to changes in sexual behavior.

It is uncertain by what mechanism the Pill might have an unfavorable influence on the risk of cervical neoplasia, but cervical tissues are known to be responsive to the influence of contraceptive steroids. Furthermore, if the Pill does indeed speed up the "transit time" from cervical dysplasia to more serious neoplastic lesions as described by Stern et al.⁹ this might explain why the Oxford group observed a substantial relation between Pill use and invasive cancer. The authors conclude that their data offer considerable support to the view that long-term use of the Pill may increase the risk of cervical neoplasia, while not overlooking the influence of sexual factors. They recommend that women who have accumulated more than four years of Pill use should regularly have cervical smears to enable serious disease to be detected and treated while it is curable.

Now, almost two years later, the significance of the study by Vessey and his colleagues remains, although attempts have been made to discredit it on the grounds that it did not identify age at first intercourse and numbers of sexual partners. Early age at first intercourse is recognized as an important factor in the etiology of neoplasia of the cervix, while the sexual history of male consorts has also come to be accepted as of considerable significance. The possible confounding effect of cigarette smoking, which was unknown as a co-factor in cervical neoplasia at the time the Oxford study began, has also been put forward to weaken the impact of its findings.

Further evidence in support of a Pill-cervical neoplasia hypothesis has come from a WHO study, largely based on women in developing countries whose preliminary findings show an increase in the relative risk for invasive carcinoma of the cervix in women who have ever used the Pill. The relative risk of 1.19 for ever-users increased to 1.53 after five years of Pill use.¹¹

The limited levels of screening procedures for cervical cancer in developing countries was considered important as it overcame the problem of a bias in favor of early diagnosis in Pill-taking women who tend to make frequent use of these procedures in countries where they are more readily available. Only 31% of the cases gave a history of multiple sexual relationships. As in the Oxford study, information on cigarette smoking was not collected. However the research hypothesis is that this is unlikely to be an important contributing factor. Cigarette smoking is uncommon among the older women in developing countries who made up the bulk of those studied in this survey.

The weight of evidence from what are now numerous studies dealing with prolonged use of the Pill and the development of neoplasia of the cervix is considerable. The implication of this for women currently using the Pill, however, is somewhat uncertain because the findings are based in part on exposure to preparations which contained higher doses of estrogens and progestogens than many products now in use.

As with the findings showing the cardiovascular risks associated with taking the Pill, efforts have been made to undermine the findings of this WHO study by emphasizing the importance of cigarette smoking as a co-factor in the causation of cancer of the cervix. It seems that the protagonists of the Pill would have us believe that the Pill is harmless and it is only a matter of persuading women not to smoke. There does not appear to be any doubt.
however, that cigarette smoking and taking the Pill are a pretty lethal combination.53,54

Smoking and Cervical Cancer

An association of cigarette smoking and cervical neoplasia has recently been recognized. A study by Trevathan et al in the U.S.54 has shown cigarette smoking to be significantly associated with carcinoma-in-situ, severe dysplasia and mild to moderate dysplasia with relative risks of 10.2, 10.7, 12.7, 3.3 and 2.4 respectively. Cumulative exposure to cigarette smoking (as measured by pack-years smoked) was strongly related to risk of these conditions. Women with 12 or more pack-years of exposure had relative risks of 12.7, 10.2 and 4.3 respectively for the three conditions, with some evidence that the risk was greatest in women who began smoking in their early teenage years.

Generally the results of this survey support the data from previous studies. It is suggested that cervical cells may be exposed to components of cigarette smoke that are absorbed into the blood and then secreted by the cervical epithelium.

The possibility of a causal association between cigarette smoking and cervical neoplasia does not exclude the possible, or even essential, role of other factors such as herpes simplex type II and multiple sexual partners. Perhaps the cervical epithelium, especially while undergoing the metaplastic changes of puberty, is particularly sensitive to the carcinogenic effects of cigarette smoke. Alternatively a systematic effect of smoking, conceivably related to vitamin A metabolism, could be the mechanism.

By way of conclusion I could do no better than to quote from the JAMA editorial on the subject of smoking and cervical cancer:

"Cervical carcinoma in situ is a disease of young women. The risk imparted by smoking is especially large for young women. Given that the treatment for this disease may result in sterility it is obvious that in addition to jeopardizing their lives, smoking has resulted in an inability to bear children for thousands of women."55

Conclusion

With the news in 1970 that DES in mothers had caused genital cancer in their daughters, the scenario was set for the eventual recognition of an association between the Pill and cancer. By the mid 1970s, the occurrence of new growths of the liver, albeit mostly benign, had already been discovered. These were related, not surprisingly, to length of exposure to the Pill.

About the same time, the news that endometrial cancer had been discovered in women taking sequential oral contraceptives containing high dose estrogens and a weak progestogen, demethisterone, caused the immediate withdrawal of Pills of this type from the market. However it was realized that all estrogens seemed to increase the risk of endometrial cancer, irrespective of their formulation or mode of administration.

By the late 1970s, the etiology of breast and cervical neoplasia had become much clearer. The work of Pike and Passenbarger and their colleagues highlighted the possible effect of the Pill in the cause of breast cancer. Although large epidemiological trials appeared to show that the Pill reduced benign breast disease, many clinicians gained the opposite impression. As time went by, more women entered long-term categories of Pill-taking, or even just aged to the point where carcinogenic agents could exert their effect.

The most recent findings of Professor Pike's research put the spotlight squarely on women who had taken high potency progestogen Pills from an early age, drawing attention to the concentration of the Pill's carcinogenic effects in adolescence and early adulthood. They also showed that progestogens, as well as estrogens, had carcinogenic potential.

The rapidly rising incidence of cervical neoplasia in young women, at a time when mortality from this disease in older women was declining, worried the epidemiologists. The etiology of cervical cancer is complex and multifactorial, involving such factors as early commencement of intercourse, multiplicity of partners who themselves may have been promiscuous, viral infections, with Herpes virus II and the Papilloma virus acting as cofactors; and now the recognition of an association between cigarette smoking and cervical cancer. Meanwhile, the Pill during the late 1970s had entered the list, gradually establishing its claim to be recognized as an important etiological factor.

Finally, Vessey and his colleagues from Oxford confirmed the findings of others. As the Lancet editorial said, in commenting on their recent paper: "The relation reported by them and others of an increasing incidence of cervix cancer with increasing duration of oral contraceptive use is strong and consistent and the progression of dysplasias lesions to in-situ carcinoma seems to be accelerated by the Pill."56

The effect of the Pill in causing thrombo-embolism, stroke and heart attacks, together with its disturbance of lipid metabolism, are well known. Cigarette smoking, although the mechanism of its action is obscure, is clearly recognized for its synergistic action in increasing the incidence of cardiovascular pathology in women on the Pill. It is of more than passing interest that cigarette smoking has now taken its place as a contributing factor in neoplasia of the cervix. It remains to be seen whether there is a similar synergism of action with the Pill in this area.

That the Pill could theoretically be an important cause of immunosuppression offers an interesting area for research in the immediate future. As Ellen Grant has said: "Most women who are allergic to the 20th century are previous Pill users."57 The Pill's disturbance of liver function could interfere with enzyme removal of mutagens and carcinogens.

The responsibility for the harmful effects of prescribing the Pill for adolescents needs to be sheeted home to those in our community who openly and consistently advocate it on the grounds of being "realistic" towards
the reeds of the young. It seems that, to them, the ultimate evil is pregnancy which is to be avoided at all costs, whatever the consequences. Those advocates feel that parental rights should be overridden and the law either flouted, twisted or changed; that the young must have their will and have it now, unrestricted, but always “protected” against pregnancy. Surely it is time, in the interests of the health of the women of our nation, for too long the guinea pigs of the oral contraceptive industry, for an appraisal of this disastrous policy.

The Centres for Disease Control Cancer and Steroid Hormone Study

Oral Contraceptive Use and the Risk of Endometrial Cancer

(JAMA 1983. 249. pp. 1600-1604)

This study showed a protective effect for women who had used combination oral contraceptives (OC) for at least 12 months, their relative risk being 0.5 that of never users. The protective effect was most notable for and largely confined to nulliparous women, whose risk was only 0.4 that of nulliparous never users. This has not been previously reported.

However, users of sequential OCs and all other OCs were at greater risk of endometrial cancer developing than never users, with risk ratios (RR) of 2.1 and 1.8 respectively. It appears that at least six days of progestogen treatment per month are necessary for it to exert its protective effect against the carcinogenic effects of the estrogen of the Pill.

The authors estimated that 39,000 women with endometrial cancer would be diagnosed in the U.S. in 1982 with 3,000 deaths, the disease having the third highest incidence of all cancers. It was considered that more than 40 million women in that country have used OCs. Approximately 2,000 potential new cases of endometrial cancer would be averted by the use of combination OCs in 1982, according to the authors of the report.

The Centres for Disease Control Cancer and Steroid Hormone Study

Long-Term Oral Contraceptive Use and the Risk of Breast Cancer

(JAMA 1983. 249. pp. 1591-1595)

The authors of this report state that OCs have been used by more than 25 million women in the U.S. and 150 million world wide. Breast cancer is the leading cause of cancer mortality among women in the U.S., the disease affecting 7% of American women.

Most published studies of the effects of OC use on breast cancer were conducted in the early 1970s and hence were unable to look at the influence of long-term OC use or the delayed effects of OC use on the risk of breast cancer, said the authors.

This study reports the initial 6 months of a 25 month study based on data for 689 women with newly diagnosed breast cancer and 1,077 controls. The women were aged 20 to 54. Those with breast cancer, when compared with controls, were more likely to be nulliparous, be older when their first child was born, have a history of breast cancer in first degree relatives (mother, sister, daughter) and a history of benign breast disease. They were also more likely to be premenopausal.

Compared with women who never used OCs, the relative risk of breast cancer for women who used the Pill for at least one month sometime in their lives was 0.9. The duration of OC use, up to 11 years or more, did not influence a woman’s risk of breast cancer.

A lack of association between OC use and the risk of breast cancer was noted for women of all ages studied. Even long-term use (11 years or more) which began more than 15 years ago, did not alter the risk. Women who used the Pill before their first full term pregnancy showed a risk ratio of 1.3 when compared to controls. The authors did not consider this to be a materially increased risk, but suggested further analyses of such cases because of their importance. Use of the Pill did not increase the risk of breast cancer among women with benign breast disease or a family history of breast cancer.

The authors make no claims of any cases of breast cancer being averted by use of the Pill.

The Centres for Disease Control Cancer and Steroid Hormone Study

Oral Contraceptive Use and the Risk of Ovarian Cancer

(JAMA 1983. 249. pp. 1596-1599)

Ovarian cancer ranks as the fourth leading cause of cancer mortality among women in the U.S. An estimated 18,000 cases and 11,400 attributable deaths will occur among American women in 1983. Almost one-third of the cases will occur among women aged 20 to 54 years. Pregnancy appears to exert a protective effect, several studies having noted an increased risk of ovarian cancer among women of low parity.

The authors report their analysis of ovarian cancer data collected during the first 10 months of a study of 179 women, aged 20 to 54, with newly diagnosed ovarian cancer, compared to 1,642 women with intact ovaries. Compared with controls, women with ovarian cancer were more likely to be younger than 30 years of age, to have never married or been pregnant and to have a diagnosed infertility problem.

The authors found that the age-adjusted relative risk of ovarian cancer developing for ever-users compared with never-users was 0.6, the risk...
decreasing with increasing duration of OC use to 0.4 in women who had used the Pill for five years or more. This lower risk appeared to persist long after OC use ceased.

The authors consider that whether ovarian cancer is caused by the "incessant ovulation" of the nulliparous woman or by the alternative theory that high levels of circulating pituitary gonadotrophins promote its development, both are consistent with a protective effect of the Pill, which both inhibits ovulation and suppresses gonadotrophin release.

They estimate that the incidence of ovarian cancer in women 20 to 54 might be about 30% higher if women had never used OCs. In other words about 1.700 cases of ovarian cancer in this age group were averted in 1983 by the use of the Pill. Further investigation of the etiology of ovarian cancer and its relationship to OCs is clearly warranted in their opinion.

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In the Matter of Clare Conroy
John R. Connery, S.J.

A noted theologian and long-time member of the Linacre Quarterly editorial advisory board, Father Connery has taught at Loyola University of Chicago, and has served as advisor to the National Conference of Catholic Bishops in Washington.

Claire Conroy was an 84-year old nursing home resident who suffered from serious and irreversible physical and mental impairments. At the most, she had about a year to live, but she would die within a short time if a nasogastric tube, through which she was being fed, were removed. She was able to respond "somehow", although only in a minimal way. But she would not be classified either as comatose or in a persistent vegetative state, much less as brain-dead. The question that was raised had to do with the removal of the nasogastric tube. Would this be permissible?

Legal Solution

The legality of removing the tube was tested in the New Jersey courts. The trial court decided to permit its removal on the grounds that Ms. Conroy's life had become "impossibly and permanently burdensome" and that her "intellectual function had been permanently reduced to a very primitive level." Briefly, it was a quality-of-life judgment. It was not based on the kind of burden or benefit offered, but on the quality of the patient's life apart from the treatment.

The guardian ad litem appealed the case and the Appellate Court ruled that removing the tube would be tantamount to killing the woman. According to the court, the right to terminate life-sustaining treatment was limited to incurable and terminally ill patients who are brain-dead, irreversibly comatose or vegetative, who would get no benefit from treatment. Briefly, the Appellate Court did not depart from the quality-of-life approach but simply decided that the quality-of-life of Ms. Conroy was sufficiently low to warrant withdrawal of tubal feeding. Since she could respond "somehow", her

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quality-of-life was above that of the brain-dead, irreversibly comatose or persistently vegetative, so tubal feeding (life-sustaining treatment) needed to be removed. The court had no doubt that Ms. Conroy, if competent, could be chosen to have the nasogastric tube removed. The present question arises because she was not competent. How does one decide in such cases whether treatment may be terminated? The Supreme Court proposed three tests for making these decisions for the incompetent. The court was dealing with the case from the viewpoint of law. Our concern here is with the moral dimension of the case and the tests in question. Although not unrelated, there are indeed two different dimensions and they should not be confused, so it is important to examine these tests from a moral perspective.

Moral Solution

The court had no doubt that Ms. Conroy, if competent, could be chosen to have the nasogastric tube removed. The present question arises because she was not competent. How does one decide in such cases whether treatment may be terminated? The Supreme Court proposed three tests for making these decisions for the incompetent. The court was dealing with the case from the viewpoint of law. Our concern here is with the moral dimension of the case and the tests in question. Although not unrelated, there are indeed two different dimensions and they should not be confused, so it is important to examine these tests from a moral perspective.

Subjective Test

The first test the court proposed, which it called a subjective test, was that it be clear that the patient would have refused treatment under the circumstances of the case. The court enumerated several acceptable ways in which the patient (when competent) might have made her intention known. If it was clear that she would have refused treatment, no further testing would be necessary.

Consent and Morality

From a moral perspective, there is no doubt that the consent of the patient is a requirement for the withdrawal of treatment (or non-treatment). Of itself, however, such consent would not have been sufficient to justify withdrawal or non-treatment. The patient has an obligation to preserve his or her life. Although this obligation has its limits, it must be respected by the patient and it would be morally wrong for the patient to consent to withdrawing treatment if such an obligation were present. The fact that it was legally permissible would not change this.

So even if there is clear evidence of consent, it will not of itself morally justify the withdrawal of treatment. This is true of the incompetent as well as the competent patient. In the case of the incompetent patient, the proxy must assure himself not only that the patient would have consented, but also that it was morally permissible to do so, before he could cooperate in any decision-making about withdrawing treatment. Without this assurance he would have a moral obligation to remove himself from the case.

The court indeed recognized that the right of self-determination is not absolute but is limited, even legally, by a compelling state interest. It enumerates four such interests: preserving life, preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties. At the same time, however, the Court states that ordinarily these interests will not foreclose a competent person from declining life-sustaining medical treatment for himself. Presumably, the same would be true of an incompetent patient if the conditions of the first test were met. This makes one wonder whether compelling state interests will cover the whole moral obligation. Certainly the fact that there is clear evidence of the patient's refusal of treatment will not of itself justify the cooperation of a proxy in withdrawing treatment. As already mentioned, he would also have to be sure that it was morally permissible to withdraw treatment before he could give his consent. So, whatever the legality of the decision, meeting the requirements of the first test would not be enough for a moral judgment about withdrawing treatment.

Limited-Objective Test

The Conroy decision calls for other testing only when it is not clear that the patient would have refused treatment. In this event it requires what it classifies as a limited-objective test. This test demands that there be some evidence that the patient would have refused treatment, but also requires that the decision-maker be satisfied that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him. It elucidates this norm further, asserting that the patient is suffering, and will continue to suffer throughout the expected duration of his life, unavoidable pain, and that the net burdens of his prolonged life (the pain and suffering of his life with the treatment less the amount and duration of pain the patient would likely experience if the treatment were withdrawn) markedly outweigh any physical pleasure, emotional enjoyment or intellectual satisfaction that the patient may still be able to derive from life.

Burden And Consent

From a moral viewpoint we must also raise a few questions about this test. We have already pointed out that even clear consent on the part of the patient would not of itself justify withdrawing treatment without further testing. Here we have to ask whether such testing can supply uncertainty about consent. In other words, will the fact that a treatment is very burdensome automatically remove doubt about consent to withdrawing it. We do not think so. We say this because even if a particular treatment is very burdensome and, therefore, morally optional, the patient may still want it—and many patients do. All an analysis of the burdens and benefits of
Consent and the Incompetent

Discerning the wishes of the patient is undoubtedly difficult when the patient is incompetent. How does one determine the wishes of the person who is incompetent? If the person anticipated the situation when he was competent, he might have made his wishes sufficiently clear. But if he cannot, what can be done? Perhaps the best approach in this event is to propose the best interests of the patient. If it is in the best interests of a patient to terminate treatment in these circumstances, there is reason to believe that the present patient would do likewise. It may be helpful to discern whether it is in the best interests of the patient by examining the decisions competent people make in analogous cases. If competent people generally refuse treatment in these cases, one can make a legitimate presumption that incompetent patients would also do so. On the other hand, if competent patients usually continue treatment, the presumption would be that incompetent patients would also do so. Such presumptions would reinforce whatever evidence may have been present of the patient’s own intention. Although not as reliable as clear evidence of the patient’s intentions, it will be sufficiently warrant a decision to withdraw treatment in a case where no better evidence is available. The process clearly offers a stronger basis for assuming the consent of the patient than a simple judgment that it would be markedly burdensome and, therefore, could be legitimately withdrawn.

Quality of Life vs. Quality of Treatment

The second question has to do with the objective test itself. Traditionally, moral theologians have admitted that one would not be obliged to take treatment which would be excessively burdensome or offer no hope of benefit. The test speaks of the burdens of the continued life of the patient with treatment. The difference is that traditionally theologians were assessing the burdens of treatment as such. The present decision seems to include the burdens of the patient’s life. If these burdens are the effect of the treatment as such, the two approaches will coincide. But if they are antecedent to the treatment and, therefore, independent of it, the court test includes a quality-of-life claim. Consequently, the burden resulting from the treatment might be minimal, e.g., taking an antibiotic, or artificial feeding over a short period of time, the major burdens antecedent the treatment.

For all practical purposes, what the decision is saying is that the burden of the person’s life itself may be such that there is no obligation to preserve it even by means which are only minimally burdensome in themselves or their effects. Traditionally, everyone, even the most handicapped, had no obligation to preserve life by treatment which would be effective without being too burdensome. The test departs from the traditional moral norm in this respect.

The decision disclaims any intention of allowing withdrawal of treatment based on personal worth or the social utility of another’s life, or the value of that life to others. Insofar as the decision rules out the social utility of another’s life or the value of that life to others, it is being consistent with the norm it has set down. But it seems contradictory to rule out personal worth as a criterion and, at the same time, include the patient’s quality-of-life with treatment. It is not easy to see the difference between the two. If the court saw a difference, it should have pointed it out.

Burden, Benefit and Proportion

The traditional moral approach did not call for the kind of comparative assessment the present test calls for. The duty to prolong life was determined by the burdens or the benefits of a particular treatment, not by a balancing of the two. Obviously, no normal person would choose pain or any other burden unless some good was to be derived from doing so, but there was no moral requirement to measure the burdens against the benefits. In the traditional approach, if the pain or other burdens were excessive, whatever the benefits of the treatment, it became optional. To demand such a balancing would be to expect too much of most patients.

Besides making the process itself very difficult, the requirement of balancing burdens against benefits could lead to much more rigid conclusions than anyone would wish. Such conclusions did not surface in the Conroy case or in other court cases, since the concern was whether and to what extent the burdens of the patient’s life with treatment outweighed the benefits. But in the Herrtage case (Calif.) the judge in the Court of Appeals pointed out the possibility that if a treatment offered “significant benefit”, it would be proportionate (and presumably obligatory) even if it were extremely painful. In the traditional approach, while the fact that a treatment would be very beneficial might have been considered a factor in interpreting the wishes of an incompetent patient, it would not have made it obligatory. If a treatment caused excessive pain, it would not be obligatory even if it was effective. As we shall see, in the third test, the New Jersey Court itself seemed to depart from the balancing requirement in dealing with treatment which would prolong a life of pain that would be inhumane.

A final question must be raised about a tendency in the decision to define the burdens of life in terms of pain. The traditional moral approach was much broader. Besides pain, it would include other hardships — cost, or anything else the patient would consider burdensome. It may be that the
court was not limiting itself to physical pain but intended to include mental pain, anxiety, privation, etc. But if the intention was to limit legal withdrawal to cases of severe physical pain, it was more restrictive than a moral norm would require.

Pure-Objective Test

If there is no evidence that the patient would have declined treatment, a third, pure-objective test must be passed. Under this test, the burdens of the patient's life with treatment should clearly and markedly outweigh the benefits that the patient derives from life. Further, the recurring, unavoidable and severe pain of the patient's life with treatment should be such that the effect of administering life-sustaining treatment would be inhumane.

The first part of the objective requirement of this test does not differ perceptibly from the objective requirement of the second test. What distinguishes this test is the requirement that the pain of life without treatment be such that the effect of further treatment would be inhumane. The decision is saying that if the pain of further treatment would be inhumane, it would be legally permissible to forego it even without any evidence of consent on the part of the patient.

When Does Pain Become Inhumane?

This third test has the advantage over the second test of making it look reasonable (if its conditions could be fulfilled) to conclude the consent to withdraw treatment. One can legitimately presume that no reasonable patient would want treatment that would be inhumane. We said that such a conclusion could not safely be drawn from the fact that the burdens were great, or that they even outweighed the benefits. The key question in this test then is the following: When does the severity of pain make the effects of further treatment inhumane? The test includes pain which antedated (but continued through) treatment, not simply the pain related to treatment as such. Since we have already dealt with the problems related to a quality-of-life criterion, we will not discuss that aspect of the third test. We will assess the test solely in regard to the inhumaneness of treatment stemming from the severity of the pain. When do the effects of treatment become inhumane by reason of the severity of the pain?

No normal human being desires or consents to pain for its own sake. Ordinarily the reason that makes pain tolerable for the individual is some good to be achieved. He or she is willing to put up with the pain necessary to achieve that good. The person is not willing to tolerate pain apart from achieving some desired good; he or she is not willing to tolerate any more pain than is necessary to achieve this good. It would be inhumane to inflict such pain on an individual. So it could be inhumane to inflict pain on an individual even apart from its severity.

Even if pain is associated with some good, the human being does not automatically accept it. He or she will accept the pain only if he or she wishes the good. If the good is something which is obligatory, e.g., preserving life, and to the extent that it is, he or she must accept the pain associated with it. However, the duty to preserve life is itself limited by the degree of pain associated with the means to do so. If the pain of treatment is excessive, the person's obligation of life ceases in regard to that treatment. But the desire to preserve one's life may go beyond his or her duty. The person may therefore be willing to accept whatever pain is associated with achieving his or her desire. And if the desire is there, any pain associated with achieving it would not be considered inhumane. It would be inhumane to inflict pain relating to preserving life only if it went beyond the person's wishes. So, basically, it would be inhumane to inflict pain without some benefit. It would also be inhumane to inflict pain beyond the wishes of the patient even if some optional good was to be achieved. But the question at issue is whether inflicting pain can be considered inhumane by reason of its severity, etc. In other words, given some good to be achieved and the wishes of the patient to obtain that good, would it be inhumane to do so by reason of the severity of the pain involved?

The assumption underlying the third test seems to be that this could happen. What is not clear is whether it is saying that it can be inhumane by reason of severity, no matter what the good to be achieved, or whether it is saying that it can be inhumane because it is unreasonable in reference to the actual good to be achieved (in this case, the quality-of-life to be achieved). Theologians would have discussed this in terms of the morality of life-preserving treatment rather than its humanness. They did admit that there were limits to what one might do to preserve life. It would be immoral, for instance, to take the life of another person to save one's life. But to my knowledge they never set a limit to the amount of pain that would be morally acceptable to preserve life. The degree of pain involved in treatment might release one from any obligation to preserve life, but it would not impose an obligation on a patient to forego treatment. It was up to the wishes of the patient. So it was on the wishes of the patient that the traditional moral approach put the emphasis, rather than the degree of pain. Theologians never argued that it would be immoral to accept treatment because of the degree of pain involved. And the same would be true of giving treatment, as long as the patient wished it. A legal obligation in this regard would have no underlying moral basis.

Conclusion

The court ultimately overturned the decision of the court of appeals that removing the tube from Ms. Conroy would be tantamount to taking her life. On the other hand, it did not feel that the evidence at trial was adequate to satisfy the subjective, the limited-objective, or the pure-objective tests it set up. But since Ms. Conroy had already died with the tube in situ, there
was no need for further exploration of the case. Looking at the case from a moral perspective, we have presented several reasons to show that some of the tests would have satisfied moral requirements. Even if the Conroy case had passed one or the other of the tests, one would not have been able to make a moral judgment about withdrawing the tube on that basis. In making this statement we do not wish to imply that legal norms should always coincide with moral norms. In the Conroy case, we have seen that the law was in some respects less demanding than morality would require from others; it was more demanding. But the relation between law and morality is a much larger question which we cannot enter here. Nor do we wish to imply that it was immoral to withdraw the tube. Rather, from a moral perspective, we would judge that long-term use of a nasogastric tube may be very burdensome for a patient, and therefore morally optional. If that was called for (and it seemed to be the case), it would be morally permissible for Ms. Conroy (or her proxy following her wishes) to have the treatment withdrawn. Our purpose was simply to show that even though passing one or the other of the proposed tests would have made withdrawing the tube legal, it would not have guaranteed its morality.

A Theologian’s Perspective
Upon Illness and the Human Spirit

Rev. William Rankin, Ph.D.

Rector of St. Stephen’s Episcopal Church, Belvedere, CA, the author has held the Rockefeller Foundation Fellowship in the Humanities (1970) and the Andrew Mellon Post-Doctoral Fellowship (1977). He received his bachelor’s, master’s and doctoral degrees from Duke University, and his master of divinity degree from the Episcopal Divinity School, Cambridge, Massachusetts. The following paper is a modification of a talk which he gave at the Meyer Friedman Institute at Mount Zion Hospital in San Francisco.

A theologian is or ought to be concerned with the “spirit” aspect of human life as it is implied in the notion that human life is at least conceivable as both body and spirit. It is easier, of course, to specify what the body is, for one can literally take the measure of that. To speak of the human spirit, however, requires the use of the language of inference and poetry, more than of quantity and measurement. A person’s spirit is appropriately described with the help of such terms as aspiration, duty, gratitude, dependence, commitment, hope — qualities which are rather affective more than quantitative. The poet James Dickey speaks from and to the spiritual sensibilities when he describes “the moon lying on the brain as on the excited sea as on the strength of fields.” He goes on immediately, “Lord, let me shake with purpose.” ("The strength of fields", 1977). To “shake with purpose” refers to human spirit and its ability to mobilize one’s life toward...
some desired end — the purposes which each of us claims as our own cause to us to fashion our lives, sculpt ourselves, to be a certain kind of person. That certain kind of person who is recognizable as the self in outward expression of spirit — all those things that comprise the feeling, the willing thing that each of us is.

Some people form themselves, or express and nourish the spirit, by reference to a transcendent reality or power whose existence they hold on faith or, perhaps, only on hope. Thus, the brilliant poet, novelist, and translator, Robert Fitzgerald, expressed his spirit in this statement in the dedication of his Harvard class. He said: "So hard at best is the lot of man, and so great the beauty he can apprehend, that only a religious conception of things can take in the extremes and meet the case. Our lifetimes have seen the opening of abysses before which the mind quails. But it seems to me there are a few things everyone can humbly try to hold on to: Love and mercy and humor in every day living; the quest for exact truth in language and affairs of the intellect; self-recollection or prayer; and the peace, the composed energy, of art."

Such a sentiment expresses the spirit of Mr. Fitzgerald: that the "things one humbly tries to hold on to" symbolize the "ultimate concerns" of a person’s life. These concerns and this spirit, of course, may never more sorely be tested or shaken than during the trauma occasioned by serious illness. What one really believes or hopes about the self and the world can suddenly or gradually undergo a distressing assault. In consequence, a person’s spirit may end up turning in the direction of being for ugliness-graciousness or meanness.

I am a theologian. That means that I have chosen to hope for a number of things for which I have no scientifically adduced evidence. It happens that I do not care much if anyone shares the particular hopes I possess. I have never admired the missionary imperialism of any true believer, even one with whom I might otherwise agree as to substance. I do for myself, however, hope (in the absence of evidence) that there is some power out there which works for good. I hope that goodness will one day be shown to be sovereign; that there is some meaning to life; that forgiveness is worth practicing and receiving; that kindness, mercy, wisdom, gentleness, courage, and the like, are valid sensibilities to possess and cultivate. Even in this world. I might share with many others the hope that human beings are somehow more "true" and desirable and sustainable in the cosmic perspective than is its opposite, illness. I assume, further, that most people accept most of these kinds of statements as either more or less true or useful, or both.

To possess lively hopes of the sort I have described is not always credible or convenient in today’s world. I believe that the human spirit is enhanced by holding hopes such as these, however, and I believe, therefore, that the erosion under the conditions of illness constitutes a grave challenge to the spiritual and physical well-being of women and men. If this be so, then a thoughtful and caring religious response to the spiritual threats of illness seems desirable. I should like to offer a few instances of spiritual threat and a few examples of possible responses to these threats.

1. Exactly due to illness, an ill person may suffer a powerful "identity crisis." Dr. Irving Cooper, for example, a neurosurgeon at St. Barnabas Hospital in New York City, has written of illness and the seriously ill who must manage a crisis of this sort: "The disease lives in that person; but there is no longer a person with a disease, but a diseased person. The two have become one. . . . The disease embraces the person, clings him, they fuse to become the diseased-person. The new person may become more sensitive than before, but he is never, never the same." (Irving Cooper, Living with Chronic Neurologic Disease, p. 35, New York: Norton, 1976.) To move from a self-understanding as "well" to that of a "diseased-person" is, of course, to undergo a profound crisis in identity. The emotional components accompanying such a transition can be devastating. For example, the loathing which the healthy feel toward the ill, perhaps at some partly conscious level, is particularly damaging when the ill take upon themselves such a feeling as self-loatheing.

In a moment of this sort, the soul itself experiences "malheur," in the words of Simone Weil. In her terms, "malheur stamps the soul to its very depths with . . . scorn and disgust." (S. Weil, "The Love of God and Affliction. Waiting for God, translated by Emma Crawford, New York: Harper and Row, 1973.) She uses the metaphor of a butterfly, pinned forever into an album, to describe the feeling of helplessness before an illness which attacks both body and soul, and seemingly, due to self-loatheing, fixes the soul firmly in time and space, trapped with no possibility of movement. The destruction of body, in other words, may proceed directly to the destruction of the spirit.

Another example: Susan Sontag wrote in Illness as Metaphor (New York: Farrar, Straus and Giroux, 1977) of the destructive self-contempt to which cancer patients are subject, due simply to the converse connotations of the term "cancer" in the imagination of ordinary people.

Still another example of crisis of identity: James Jones describes in his book, World War II, how the honorable wounded seemed, in an uncanny way, to be subjected, even in their own eyes, to a soul-destroying shame over having been wounded, at "being a drag and weight on their outfit." He adds, tellingly, "nor do the wounded seem to be less isolated from each other. Being in the same fix does not make them closer, but even further apart than they are from the wall." James Jones, World War II, (New York: Ballantine Books, 1975) p. 88.

The point, therefore, is that ill persons may well have fundamental problems of basic identity due to their physical depletions and to the extent that their essential self-contempt is compromised, the stakes of such a predicament may be very high indeed for them. The mutual causality between bodily and (what I am calling) spiritual, well-being or illness, are too obvious to be detailed.

Here religious kinds of responses might be a help. They could occur
along a few lines such as the following:

From a religious point of view, a person’s essential dignity does not need to inhere in one’s self-concept, or health status, or even one’s emotional state. Rather, from a religious perspective, one’s dignity is conferred, imparted, assigned from the deity.

Gandhi, for instance, spoke to the untouchables and he called them “Children of God,” for he knew that on their own terms they were worth nothing, but from God’s vantage point, they were infinitely precious as His own children.

The prophets of Israel said the same thing repeatedly concerning the impoverished people of the land in their own time and place. The carpenter from Nazareth said that the poor, the “little ones,” were the ones exactly who were blessed by God.

When the afflicted have little reason to think or feel themselves dignified in their own eyes, they can at least hope to find themselves dignified and valued in the eyes of God.

Someone trained and inclined to help religiously conflicted people see and feel a valuation of this sort can boost the self-confidence and, thus, the self-esteem of ill persons. To do this would be factual, indeed, but more, from a religious faith, to do so would be an expression of the truth.

Theology, in distinction from various kinds of counseling technologies, is concerned with testing the truth claims which arise from religious faith. At risk of overstatement and caricature, I am attempting to say that some non-religious counselor may endeavor to help an ill person live with some modicum of acceptance of the ambiguities and sometimes the terrors of life. But a theologian is concerned with the possibility that such qualities as, for example, love, hope, trust, goodness, mercy, and the like, are in some sense “true” because standing behind them, so to say, just might be a cosmic lover, a cosmic force for good, or some such, which can really be trusted unrestrainedly, because it is sovereign. truly.

Theology, as I conceive it at least, does not aim at obscuring the realities of illness or of suffering. Instead theology points as to a depth and breadth of ultimate reality beyond suffering and death which is more real, more sustaining, more perduring than the suffering one perhaps must now endure. My preferred example of this is the graffiti scribbled on the wall of a sanctuary by someone doomed and then executed by the Nazis: “I believe in the sun when it is shining; I believe in love when it is absent; I believe in God even when He is silent.”

To be able to say that from within the extremities of life, suffering, illness, or at the point of death is not childish, nor is it necessarily only wishful thinking. To believe in those things in this world, with one’s eyes wide open, might be wishful thinking indeed. But more, to believe those things might well be to believe what is real and true.

I think a religious person is prepared to offer the hope and encouragement that that kind of attitude is not only practical — as the placebo effect, for example, is practical — but that hope is valid because, according to religious faith, it is warranted by something or someone real and true.

3. The theologian can, in some instances, be a help not only to the ill, but to health care professionals. This can be accomplished indirectly by helping the ill, and perhaps their families, to make a mature differentiation between magic and grace.

I believe that many people are respectful of the efficacy of hope. Yet we are equally respectful to the requirement to honor the self, and others, with a truthfulness based upon valid inferences from hard statistical data. How to keep the door open to realistic hope, and not engender reckless optimism, or presumptuous despair, must surely be a terrible and persisting burden to people in the health care professions. I myself have thought there was a correlation between wild optimism and the belief in magical cures. The figure of Don Quixote comes to mind. One recalls his charming confidence in the magical powers of the mythical “balm of Fierabras.” a wonderful panacea. He says to his dear friend, Sancho, “It not only heals all wounds, but even defies death itself. If thou shouldst see my body cut in two, friend Sancho, by some unlucky backstroke, you must carefully pick up that half of me which falls on the ground, and clap it upon the other half before the bodd congeals, then give me a draft of the balsam of Fierabras and you will presently see me as sound as an orange” (I.i.2).

There are opportunists enough in my profession, and perhaps also in the health care profession, who pretend, at least slightly, to magical healing powers. With or without them, however, we tend not to be respectful of the innocence of a Quixote these days and so are compelled to pursue understandings of tragic things which offer hope on a more realistic and deeply human basis. I believe that the kind of hope to which thoughtful people might be drawn has to do more with grace than with magic. This was displayed to me unforgettably in that spiritual classic, The Diary of a Country Priest, by George Bernanos, (translated by Pamela Morris, New York: MacMillan, 1966). In this book, the author manages to bring out the presence and power of grace as a miracle, against the foil provided by an embittered woman whose soul is poisoned by resentment. The woman’s life has been wrecked not so much by illness or accident as by the tenacity with which she holds to herself the injustice she perceives has been done to her. Here her soul becomes completely poisoned, closed entirely to the operations of God’s grace upon her.

In that great story, however, is another figure. He is dying slowly of cancer, with its ever-present pain. What fills this man’s life is not the pain, or perhaps a justifiable despair, but rather his commitment to live out “the everydayness” of what remains to him. He does what he feels obliged and able to do, consistent with his own history, his
commitments, his appointments. At the moment of his death, friend 
leans close to him, straining to catch the man's last words. They are: 
"Does it matter? Grace is everywhere." (p. 255) 
A theologian might say that though that man's body was destroyed, 
yet he saw God. His soul was tried in the crucible of human suffering 
and by some miracle it emerged purified with the clarity, the integrity, 
of a gemstone. There is no magic in that story, but there is a miracle 
in it, and it is the miracle of God's grace and the consequent manifestation 
of the human spirit. The physical adversity which was this man's lot 
became the occasion for the emergence of a spirituality which seems 
to have triumphed over and through his extremity. A story of this sort 
is not altogether unusual, for we know many who have shared the 
dark night of the soul and have come through with some precious 
simulacrum of greater, more complete humanity. An event of this sort 
does bear witness to the truth of the enhancement of the human spirit 
under adversity. A person religiously convicted might precisely in this 
sense be inclined to speak of a miracle of grace as a manifestation of truth. 

A religious person might skillfully point to the reality of grace that 
can fill any life with surprising refreshment, and perhaps transformation. 
One, of course, does not want to speak too glibly of these things, nor 
does one want to appear to dispense grace as if it were merchandise. 
for the two are quite different. One does, however, want to be acutely aware 
of the faith claim that grace is present and operative in life, and that 
its presence and efficacy somehow in certain contexts, at least, seem 
self-authenticating and therefore, essentially "true".

I conclude. At its best, religion and some of its various practitioners have 
sought sincerely to assist people in the wonderful and terrifying business of 
living and dying. Somewhere between these limits of living and dying 
are the moments of a person's illness which a religious man or woman 
may point — kindly, unobtrusively, with humility — to the hope which 
sustains and assists people in different circumstances, in various extremities, 
and which has been done so through countless generations. Surely in the absence 
of the scientifically measurable, one may yet fortify another (who is already 
religiously convicted) in this hope: that trusting in the power of love, 
generosity, goodness, and the like, and possessing at least a conferred dignity 
and value, one may still live and so one may still die in the presence of 
peace, i.e., gratuitously. To trust in these things and live in this fashion, from 
a theological standpoint, is more than simply practical. It is warranted 
ultimately because, to the eyes of faith, it is essentially true.

The Consistent Ethic of Life 
and Health Care Systems

Joseph Cardinal Bernardin

Cardinal Bernardin, archbishop of Chicago, gave the following address at the Foster McGaw Triennial Conference which was 
sponsored by the Loyola University Stritch School of Medicine in May, 1985. The Cardinal has served as 
President of the National Council of 
Catholic Bishops and the United States Catholic Conference, has 
been a delegate to recent world 
synods of bishops in Rome, and is 
active in a variety of other religious 
and secular organizations.

We meet on an auspicious day to explore more effective ways of 
preserving, protecting and fostering human life — the 40th anniversary of 
the end of the war in Europe, which claimed millions of lives, both European 
and American. It was also a war in which, tragically, the word Holocaust 
will be forever emblazoned in history. We must never forget.

This anniversary is not only for remembering victory over the forces of 
persecution, which led to this savage destruction of life, but also for 
commemorating ourselves to preserving and nurturing all human life.

Daily we encounter news headlines which reflect the growing complexity of 
contemporary life, the rapid development of science and technology, the 
global competition for limited natural resources, and the violence which 
is so rampant in parts of our nation and world. The problems of contemporary 
humanity are enormously complex, increasingly global, and ominously 
threatening to human life and human society. Each of them has moral and 
religious dimensions because they all impact human life.

At times, we may feel helpless and powerless as we confront these issues. 
It is crucial that we develop a method of moral analysis which will be 
comprehensive enough to recognize the linkages among the issues, while 
respecting the individual nature and uniqueness of each. During the past
year and a half, I have addressed this task through the development of a "consistent ethic of life" — popularly referred to as the "seamless garment" approach to the broad spectrum of life issues.

I come before you today as a pastor, not a health care professional or theoretician, not a politician or a legal expert, but a pastor. I wish to share with you the teaching of the Catholic Church that pertains to human life issues.

I am very grateful to Father Baumhart for the invitation to address you on "The Consistent Ethic of Life and Health Care Systems," but first briefly describe the concept of a consistent ethic. Then I will explore the challenge it poses to health care systems, both in terms of "classical" medical ethics questions and in regard to "contemporary" social justice issues.

1. The Consistent Ethic of Life

Although the consistent ethic of life needs to be finely tuned and carefully structured on the basis of values, principles, rules and application to specific cases, this is not my task here. I will simply highlight some of its basic components so that I can devote adequate attention to its application to health care systems and the issues they face today.

Catholic social teaching is based on two truths about the human person: human life is both sacred and social. Because we esteem human life as sacred, we have a duty to protect and foster it at all stages of development, from conception to death, and in all circumstances. Because we acknowledge that human life is also social, we must develop the kind of societal environment that protects and fosters its development.

Precisely because life is sacred, the taking of even one human life is a momentous event. While the presumption of traditional Catholic teaching has always been against taking human life, it has allowed the taking of human life in particular situations by way of exception — for example, in self-defense and capital punishment. In recent decades, however, the presumptions against taking human life have been strengthened and the exceptions made ever more restrictive.

Fundamental to this shift in emphasis is a more acute perception of the multiple ways in which life is threatened today. Obviously, such questions as war, aggression and capital punishment have been with us for centuries; they are not new. What is new is the context in which these ancient questions arise, and the way in which a new context shapes the content of our ethic of life.

One of the major cultural factors affecting human life today is technology. Because of nuclear weapons, we now threaten life on a scale previously unimaginable — even after the horrible experience of World War II. Likewise, modern medical technology opens new opportunities for care, but it also poses potential new threats to the sanctity of life. Living, as we do, in an age of careening technological development, means we face a qualitatively new range of moral problems.
2. The Consistent Ethic and "Classical" Medical Ethics Questions

As I noted at the outset, the consistent ethic of life poses a challenge to two kinds of problems. The first are "classical" medical ethics questions which today include revolutionary techniques from genetics to the technologies of prolonging life. How do we define the term and what does it mean to address them from a Catholic perspective?

The essential question in the technological challenge is this: when we can do almost anything, how do we decide what we should do? The even more demanding question is: In a time when we can do anything technologically, how do we decide morally what we should do? My basic thesis is this: Technology must not be allowed to hold the health of human beings as a hostage.

In an address in Toronto in September, 1984, Pope John Paul outlined three temptations of pursuing technological development:

1) pursuing development for its own sake, as if it were an autonomous force with built-in imperatives for expansion, instead of seeing it as a resource to be placed at the service of the human family;

2) tying technological development to the logic of profit in the constant economic expansion without due regard for the rights of workers or the needs of the poor and helpless;

3) linking technological development to the pursuit of maintenance of power instead of using it as an instrument of freedom.

The response to these temptations, as the Holy Father pointed out, is not to renounce the technological application of scientific discovery. We need science and technology to help solve the problems of humanity. We also need to subject technological application to moral analysis.

One of the most recent and most critical ethical questions which impacts the quality of human life is that of genetics, genetic counseling and engineering. Perhaps no other discovery in medicine has the potential to change so radically the lives of individuals and, indeed, the human race itself.

As with most scientific achievements in medicine, there are advantages and disadvantages to the utilization of this theoretical knowledge and technological know-how. Many genetic diseases can now be diagnosed early, even in utero, and technology is also moving toward treatment in utero.

Proper use of such information can serve to prepare parents for the arrival of a special infant or can allay the fears of the expectant parents if the delivery of a healthy infant can be anticipated. The accumulation of scientific data can lead to a better understanding of the marvels of creation and to the possible manipulation of genes to prevent disease or to effect a cure before the infant sustains a permanent disability.

On the other hand, people also use available diagnostic procedures to secure information for the sex selection of their children. Some may wish to use it to eliminate "undesirables" from society. Many believe that the provision of genetic information contributes to an increase in the number of abortions.

At the other end of life’s spectrum is care of the elderly. Our marvelous progress in medical knowledge and technology has made it possible to preserve the lives of newborns who would have died of natural causes not too many years ago; to save the lives of children and adults who would formerly have succumbed to contagious diseases and traumatic injuries; to prolong the lives of the elderly as they experience the debilitating effects of chronic illness and old age. At the same time, some openly advocate euthanasia, implying that we have absolute dominion over life rather than stewardship. This directly attacks the sacredness of each human life.

Other new moral problems have been created by the extension of lives in intensive care units and neonatal intensive units as well as by surgical transplants and implants, artificial insemination and some forms of experimentation. Computers provide rapid, usually accurate, testing and treatment, but they also create problems of experimentation, confidentiality and dehumanization. Intense debate is being waged about the extension of lives solely through extraordinary — mechanical or technological — means.

The consistent ethic of life, by taking into consideration the impact of technology on the full spectrum of life issues, provides additional insight to the new challenges which "classical" medical ethics questions face today. It enables us to define the problems in terms of their impact on human life and to clarify what it means to address them from a Catholic perspective.

3. The Consistent Ethic of Life and "Contemporary" Social Justice Issues

The second challenge which the consistent ethic poses concerns "contemporary" social justice issues related to health care systems. The primary question is: How does the evangelical option for the poor shape health care today?

Some regard the problem as basically financial: How do we effectively allocate limited resources? A serious problem today is the fact that many persons are left without basic health care while large sums of money are invested in the treatment of a few by means of exceptional, expensive measures. While technology has provided the industry with many diagnostic and therapeutic tools, their inaccessibility, cost and sophistication often prevent their wide distribution and use.

Government regulations and restrictions, cut-backs in health programs, the maldistribution of personnel to provide adequate services, are but a few of the factors which contribute to the reality that many persons do not and probably will not receive the kind of basic care that nurtures life — unless we change attitudes, policies and programs.

Public health endeavors such as home care, immunization programs, health education and other preventive measures to improve the environment and prevent disease, have all served as alternate means of providing care and improving the health of the poor and isolated populations. In the past, if patients from this sector of society needed hospitalization, institutions built with Hill-Burton funds were required to provide a designated amount
of "charity care" to those in need.

In some instances, hospitals continue to follow this procedure. However, access to these alternate, less expensive types of health care is becoming more difficult. Cuts in government support for health programs make it increasingly more difficult for people who need health care to receive it.

Today we seem to have three tiers of care: standard care for persons receiving Medicare or Medicaid benefits; partial care for Medicaid patients, and emergency care only for the poor. Cuts in government support for health programs for persons receiving Medicare or Medicaid benefits, appears to be an unjust distribution of the goods. How can Catholic hospitals continue both to survive and to provide substantially more free care for uncompensated hospital care. Much of this is for deliveries to women born with severe problems because of the lack of care given their mothers during pregnancy.

Our national resources are limited, but they are not limited. As a nation we spend more per capita and a higher share of our Gross Domestic Product (GDP) on health than any other country in the world — nearly twice as much as Great Britain, for example. Yet our system still excludes at least half the poor. In 1982, the U.S. share of GDP devoted to health care was 10.6% against 5.9% within the United Kingdom, which has universal access to health care and a lower infant mortality rate than the U.S.

The basic problem of health care in the U.S. is managerial: the effective allocation and control of resources. The key is the underlying philosophy and sense of mission which motivates and informs managerial decisions. As a nation, we spend enormous amounts of money to prolong the lives of newborns and the dying while millions of people don’t see a doctor until they are too ill to benefit from medical care. We allow the poor to die in our hospitals, but we don’t provide for their treatment in the early stages of illness, much less make preventive care available to them.

These facts are disturbing to anyone who espouses the sacredness and value of human life. The fundamental human right is to life — from the moment of conception until death. It is the source of all other rights, including the right to health care. The consistent ethic of life poses a series of questions to Catholic health care facilities. Let me enumerate just a few.

Should a Catholic hospital transfer an indigent patient to another institution unless superior care is available there?

Should a Catholic nursing home require large cash deposits from applicants?

Should a Catholic nursing home transfer a patient from a state institution when his or her insurance runs out?

Should a Catholic hospital give staff privileges to a physician who won't accept Medicaid or uninsured patients?

If Catholic hospitals and other institutions take the consistent ethic seriously, then a number of responses follow. All Catholic hospitals will have outpatient programs to serve the needs of the poor. Catholic hospitals and other Church institutions will document the need for comprehensive pre-natal programs and lead legislative efforts to get them enacted by state and national government. Catholic medical schools will teach students that medical ethics includes care for the poor — not merely an occasional charity case, but a commitment to see that adequate care is available. If they take the consistent ethic seriously, Catholic institutions will develop efforts for adequate Medicaid coverage and reimbursement policies. They will lobby for preventive health programs for the poor. They will pay their staffs a just wage. Their staffs will receive training and formation to see God “hiding in the poor” and treat them with dignity.

I trust that each of you has an opinion about the importance of viability of responses to these challenges. My point in raising them is not to suggest simplistic answers to complex and difficult questions. I am a realist. and I know the difficulties faced by our Catholic institutions. Nonetheless, I do suggest that these questions arise out of a consistent ethic of life and present serious challenges to health care in this nation — and specifically to Catholic health care systems.

Medical ethics must include not only the "classical" questions but also contemporary social justice issues which affect health care. In a 1983 address to the World Medical Association, Pope John Paul II pointed out that developing an effective medical ethics — including the social justice dimension —
fundamentally depends on the concept one forms of medicine. It is a matter of defining definitely whether medicine truly is in service of the human person, his dignity, what he has of the unique and transcendent in him, or whether medicine is considered first of all as the agent of the collectivity, at the service of the interests of the healthy and well-off, to whom care for the sick is subordinated.

He went on to remind his listeners that the Hippocratic oath defines medical morality in terms of respect and protection of the human person. The consistent ethic of life is primarily a theological concept derived from biblical and ecclesial tradition about the sacredness of human life, about our responsibilities to protect, defend, nurture and enhance this gift of life. It provides a framework for moral analysis of the diverse impacts of cultural factors — such as technology and contemporary distribution of resources — upon human life, both individual and collective.

The context in which we face new health care agendas generated both by technology and by poverty is that the Catholic health care system today confronts issues both of survival and of purpose. How shall we survive? For what purpose? The consistent ethic of life enables us to answer these questions by its comprehensiveness and the credibility which derives from its consistent application to the full spectrum of life issues.

On Playing God: The Theological Center of Daniel Maguire’s Death by Choice

Michael E. Allsopp

Father Allsopp, who has lectured widely both in Australia and the United States, is the author of numerous publications. He holds college degrees from St. Patrick’s College, Sydney, Australia, and a doctorate in theology, summa cum laude, from the Gregorian University in Rome. From Gonzaga University, he was awarded master’s degrees both in religious studies and in administration and curriculum, and he joined the Creighton University department of theology, as associate professor, in 1984.

Daniel Maguire is a moral theologian. Death by Choice, in its newly released and expanded edition, while informative on current law and medicine is, at its heart, a work of moral theology. And rightly so. As Maguire would agree. I am sure, ultimately when all is said and done, the decision to end one’s life, to die with dignity, to take steps to insure that the dark stranger will come quickly when we have reached that corner, is inherently theological, involving issues such as the role, place, autonomy and authority of the person in the cosmos. The acceptability of Death by Choice as a contribution to moral theology, especially to Catholic moral theology, whether it meets the tests of soundness and validity, depends largely upon Maguire’s stand on these issues. Here, however, I believe, the work is flawed, unacceptable as Catholic moral theology, and principally for one reason: the “homo agens” (the achieving person), as Maguire calls the new person he sees in our Post-Modern World — the person Maguire encourages us to be wears, in my mind, the mask of Prometheus, not Christ, the mantle of Nietzsche not Adam.

In dealing with objections to his thesis, Maguire considers such matters as “The Domino Theory,” “Suppose a Cure Is Found,” “They Shoot Horses, Don’t They?” and “The Hippocratic Oath.” Being a theologian, “Playing God,” posed special danger, obviously, and the rebuttal is written with poise and flair.
arguments. Who can deny the curious examination of Maguire’s defense contains not of the American experiment options for Western men and women, a shift in self-consciousness.”

God as a fact of their Christian faith, do possess the his point is important, since it is crucial to his case:

Notice, however, that we are not entirely parting company with the ancients on the issue of whether direct termination of life could be moral, but only on how we know that it can be moral. Moral authority is now seen as discoverable. Applied to the question of death by choice, we need not await a miraculous divine revelation of the sort that Abraham is said to have had to assume this freedom. Rather we must probe and see whether there are proportionate and good reasons to recognize this moral dominion over our dying. To do this is not to play God but to be human. It is to do what is proper to persons as persons, beings with powers to deliberate and to act on their deliberations when that action appears to achieve what is good.8

Now, if Maguire destroyed a “straw man” he had set up for his own convenience in the opening section of this case, it is no less obvious this last statement embodies not one but actually two central beams in his defense of death by election. Surely, while the initial remarks deal with knowing right and wrong by the exercise of our own minds, the closing words move to applying our knowledge; to the right of the person to act upon the judgments of his mind. For Maguire, to conclude that some course is good inherently implies it is moral; to judge that an action is within the limits of God-given human freedom carries with it the right of action. According to this point of view, as I interpret it, each moral person in today’s world, as in ages past, must face the pain, must wrestle with the issues. Should he discern after prayer, thought and consultation that, assisting somebody to kill himself by providing the means, lies within the divine mandate, “Increase, multiply, fill the earth, make it yours.” Then this action may be done.

Even those only casually acquainted with Catholic moral theology would be aware of the movement toward greater self-determination in decision-making, as well as the replacing of many moral boundary markers during the last hundred years. From Augustine’s defense of the right of the Christian soldier to kill in battle, to Richard McCormick’s stand on letting infants die, there is remarkable change, as Maguire’s book frequently reminds us. When one reads Suarez and Molina on rules for a just war, on the proper treatment of conquered peoples, it seems hard to justify today’s weapons, the legitimacy of conventional warfare; yet Catholic moral theologians do. The question remains, however, whether the tendency, the drift of theology has a limit?

Few of us, I believe, consider it morally wrong to provide simply supportive care in the case of a spina bifida infant born with severe intracranial hemorrhage or some other major life-threatening anomaly.7 At the other end of life, with Pope Pius XII’s observations in mind about those being preserved “alive” by extraordinary means, most physicians, I am sure, do not scruple now when acting in accord with the Harvard Medical School’s “brain death” guidelines. But are there no limits? Are abortion, euthanasia, voluntary suicide simply the next steps along the moral path?

Here, I believe, lies the theological flaw in Death by Choice. Although the movement toward moral self-determination cannot be denied, nor the fact that the Christian belief in personal dignity has been extended to death, it seems to me that Maguire’s analysis gives insufficient place to the limits set upon the role and authority of the human species embodied in those monumental theological sources: the Genesis creation and fall narratives. Second, his case gives too little weight to Christian history and moral teaching. Since Vatican II, all things are possible, and it is dangerous to

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“The primal legend of Paradise, of original sin and of the punishment of subjection to the powers of death and pain, and of enslavement by the anguish of living may be cloaked partly in mythical elements, writes von Balthasar in his *Theological Anthropology.*” “But it is the excess of that existential difference between the heights of the demands of God and the impossibility of satisfying them which man carries round within him always as a dark mystery.” The legend also expresses a realistic vision of other boundaries within life, that the human species may be, with good reason, the summit or center of the cosmos, the supreme work of the power of God, and a microcosm of the universe, but “God is God, and we are simply humans.” A feature of the Biblical world, and the Christian worldview of the universe, according to Emil Brunner, is this awareness and acceptance of roles and borders, relationships and limitations.

The Genesis creation narratives take us into a world not our own, where Heraclitus’s “All is change,” rules. While these narratives are patently anthropocentric, and we are nowhere depicted as simply a “bit of the world” like the other works of God’s hands; while we are “special,” not alone, to have been fashioned in “the image and likeness of God”; nevertheless, Brunner reminds us, we are the ones who receive, not the ones who give. We are “images,” not self-sufficient “lights.” Created out of and in and before never eternal nor omniscient. Adam is master of Eden because, and only insofar as, God makes him His steward, and gives him the task of, with its innumerable which outweigh its rights. “Man is not unconditioned but conditioned.” Brunner writes, “not autonomous and self-sufficient, but wholly dependent upon the positing of God.”

For Christians facing the close of this 20th century, Christ not Adam, the New Testament not the Old, should be our guides and models, many will retort. “The cosmology, the social stratifications of the ancient Hebrews, are not obligatory for us. They are not part of Revelation,” others no doubt will aver. “Jesus Christ is the Word. He is the word and language of the immortal God.” But in Christ Himself, in the New Testament faith, the awareness of roles, borders, limits and relationships remains.

“As child, youth, and man, as a mortal, dying, and resurrecting man, the eternal Word underwent limitation in order to be still the whole within the fragment,” writes von Balthasar states. We, however, His disciples (by definition a relational word) are inescapably also male or female, Jew or Gentile—people separated by nationality, borders, ideologies, frontiers of blood, thought and time. Furthermore, human freedom and obligation, our autonomy and our responsibility, are inseparably tied to such realities as the cosmos itself, Truth, Beauty, Virtue, Conscience. The authentic Christian is not an existentialist fixed upon self-realization in the future, but a person, an essential part of whose being springs continually from the past.

Now, it is my opinion that Maguire’s interpretation of the divine mandate, “to think and feel and listen and do all of the things that make moral beings fully alive in all of their sensitivities,” as well as his *Weltblink*, are not authentically Christian in their acceptance of the realms of relationships and limitations. In his chapter, “Ethics: How To Do It.” as in this chapter, the model of the “achieving person” fits neither the Old nor New Testament anthropologies. For Maguire’s moral person, “all is possible,” whereas, for Adam and Christ, the divine command “But of the tree . . . .” always remains a feature of the human condition. Maguire’s “achieving person” is a Post-Modern, not a Christian person.

This study is not the place to record the history of the Church’s teaching on killing in war, abortion, suicide, the exposure of infants or mercy-killing. Some illustrations of that tradition alone are in order.

Who can deny the truth of Richard McCormick’s closing remark on the subject of letting infants die?” “Any discussion of this problem would be incomplete if it did not repeatedly stress that it is the pride of the Judeo-Christian tradition that the weak and defenseless, the powerless and unwanted, those whose grasp on the goods of life is most fragile — that is, those whose potential is real but reduced — are cherished and protected as our neighbor in greatest need. Any application of the guideline that forgets this is but a reason of the adult world profoundly at odds with the gospel.”

While the Hippocratic Oath has set a standard for Christian health care professionals, McCormick’s allusion to the gospel’s teaching should immediately bring to mind that for Christians, Luke’s parable of the “Good Samaritan” provides the model *par excellence* of compassion, giving that second mile, and caring for the dying.

The monastic tradition of hospitality is inextricably tied to a tradition of medical attention that predates the Christian era. The fact that England, for instance, had so few community hospitals was due to the role of the monastery. St. Bartholomew’s Hospital in London being a classic example. Even in the fever of the crusades, the establishment of the Knights of St. John of Jerusalem, the Hospitallers, reflects the deep Christian “difficulty” with war, plague and death, that they were at best “unfortunate evils.”

Life’s journeys are often like that tale of Ulysses: cyclic, and Germaine Greer’s seems to be in this pattern. In her latest book, *Sex & Destiny*, one of her strongest themes is, “No human society exists in which human beings may copulate at will; no human community has ever been organized around the principle of free love, or could be, as long as reproduction and sexual activity were inextricably connected.” And at the close of this chapter, “Chastity as a Form of Birth Control,” she touches a nerve which Daniel Maguire in his elementary analysis (what is closer to death than sex in the psyche and bonding of any society?) has missed. Greer writes, “Instead of teaching reverence for the body, we chose to teach callousness; instead of exploring concern for children (read the dying) and the passionate desire for them to survive, we assumed that too many were living already. The chance to develop the human propensity for sexual restraint in the interests of the congested world has been missed.” How well, and with what little alteration, do these comments speak to our times and our changing reverence for life?”

Fifty years ago, Romano Guardini in his monumental book, *The End of the Modern World*, showed incredible foresight, seeing with remarkable...
clarity the society ahead of him. “He saw a “new” man, and I, a “new” faith. Death by Choice, had Guardini possessed even greater wisdom, would have been cited, I am sure, as proof of his thesis, namely, that the Modern World had ceased to exist, a new person was being born, and the distinctive character of the quickly shaping Post-Modern world.

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3. Ibid. pp. 119-120.
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6. Ibid.
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9. With von Balthasar, Brunner represents the best voice in recent years on this subject, an authority in the field whose opinion does not need the bolstering of a cluster of supportive writers. For his remarks, Emil Brunner, Man in Revolt: A Christian Anthropology, (Westminster: Herder & Herder, 1947), pp. 400ff.
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The Church and Human Sexuality

Wanda Poltawska, M.D.

(Wanda Poltawska, M.D., is a psychiatrist who is presently — as she was under Cardinal Wojtyla — in charge of the Institute for the Theology of the Family, Pontifical Faculty of Theology of Krakow, Poland. She is now also on the faculty of the Institute for Studies on Marriage and Family at the Pontifical Lateran University in Rome, and a member of the Pontifical Council for the Family in the Vatican.

Sex education as such does not exist, in fact. It is a conventional term, because the subject cannot be isolated from education of the entire person who in his very substance is sexual, is a man or a woman and education of man is a complex process. Its result depends on many factors; and this process, in fact, lasts for the whole life of man. In the light of the current discussion rooted in the proposal of introducing sex education into school programmes, one might conclude that the sex education issue is a very new idea, thus indicating that the previous education of man missed, or shunned, problems related to the sexual life of man. As a matter of fact, sexual problems were always considered in the total context of education, though more implicitly, and more modestly presented than is now the fashion.

Isolation of Sex is Degrading

Nowadays, some try to isolate the sexual problems of man and set them up as a subject independent from the whole of education, which I consider to be impossible as well as destructive. Although man is a complex being, yet he is a complex unity, and sex in isolation does not exist; while sexual man and his fate does. Education of man depends on the culture of the society in which a human person lives, and on the accepted anthropology, for there is always some purpose or other to education; man is always educated for sanctity. Nowadays, it is a question not only of a school program in sex education, but primarily it is a question of the whole notion of man; and as a matter of fact, an ideological struggle is taking place in this field. The
sex education programs that ensue are symptomatic of a certain view of man, the view according to which one is permitted to manipulate and treat other human persons as things, that is, below their objective viewpoint. Isolation of sex from the bulk of man's fate and from moral norms in fact a degradation of humanity. And therefore, people believing in God cannot remain indifferent to the ideological fight waged in this field. Christianity contributed unique values to the world's culture. These values include the whole substance of man, thus including also human sexuality. Catholic ethics do not reject what is sexual; just the opposite. They integrate and give human sexuality the proper, that is, the personal, dimension. The personal dimension of human sexuality is a spiritualization of the human body — man is not a body; rather man is in himself, human love, etc. — and obviously the Church is never indifferent to the ideological struggle for true values.

Church defends true values

Sexuality is fully human and relates to the highest values such as life itself, human love, etc., and obviously the Church is never different to these values. By the Church I mean the hierarchy with the Holy Father at the top as well as the community of those believing in God and being conscious of their responsibility arising from this. The Church makes statements on the human sexuality issue. Particularly in recent years, the Holy See has issued several documents related to this. The Church also defends all the values which are threatened. Our century is not an age of cultural progress in human education, but in a way, more a time of anti-culture, given the extent of savagery and violence. The rights of the human person are violated in many ways, particularly in the field of sexuality. A struggle takes place, a struggle for the holiest values, and we cannot afford to give in. We have to achieve such an education — sex education in particular — such that man in his activity never destroys himself.

While using the term 'man,' I wish to express what the Greeks call 'anthropos,' the Germans, 'Mensch,' the Poles, 'czlowiek.' I know that often this concept is rendered by 'person.' But from the philosophical point of view there is a certain difference between the Greek 'anthropos' and 'hypostasis,' between the German 'mensch' and 'person.' On the other hand, these languages have a clear differentiation between 'man' and 'woman'; the Greek 'aner' and 'gyne,' the German 'mann' and 'weib,' the Polish 'meszczyzna' and 'kobietta.' Hence, there is no difficulty in these languages. When it is necessary to express a truth extending to the whole human species, we speak of 'anthropos,' 'mensch,' 'czlowiek.' In English, this is difficult.

So I am going to use 'man' when speaking generally of humankind, 'a man' or 'a woman' when treating of the different sexes. No slight on women is intended.

I. DANGERS OF SEX EDUCATION PROGRAMS IN SCHOOL.

The Danger of Confusion of Ideas — Loss of Authority

Although all these matters imply transmitting information, and it is clear that parents, often not sufficiently prepared, do not feel able to pass it on — it is necessary to be very cautious and prudent with any school program. It is evident that the school must teach, but since sex education is truly education only when no information is abstracted from the ethical context, there exists a danger that information thus abstracted may bring more harm than good.

The information in this field depends also on ideology. There is a real danger that children baptized and belonging to the Catholic Church might receive in school teaching that is not compatible with the doctrine of the Church; they would therefore become not only uneducated, but demoralized. Contradictory tenets give rise to doubts as to the information itself, also the Catholic principles, if not the authority of teachers and parents themselves.

A negative influence on the child's psyche

When such delicate themes are treated collectively, without taking into consideration the different milieux, preparation, degree of development of the children, it may prove that such an impersonal demonstration of the technique of sexual activity is a shock for the child's psyche. It is well known that children develop differently and it is not true that all children of the same age have, or are ready for, the same amount of information.

The danger of spoiling 'A thing of beauty'

Of course, if one demonstrates sexual behaviour in a technical way and, what is more, in a vulgar way — as so many textbooks do; if one likens human sexuality to animal sexuality, then human sexuality is shown in a way that is incompatible with the whole dimension of human destiny and the role of human sexuality. The result is vulgarization, a stripping of the depth of its meaning from a certain sacred mystery.

Sexual matters easily become then an object of ambiguous jokes, and the whole way of speaking of such matters is far from respectful.

Danger of misinformation

Teaching in a popular way, simplifying matters without penetrating into their deeper meaning, sometimes causes unintentional falsification; what is worse, it is often the expression of an unintentional distortion tending to change the outlook of pupils and to smuggle in permissive ethics. This happens in the most important and responsible fields; purity, love, parenthood, responsibility for life, etc. For instance, when one speaks in an official handbook of ways of preventing pregnancy, and proposes contraceptive methods, without mentioning marriage, it is evident that the pupil will become convinced that he is permitted to act sexually outside the boundaries of marriage.
of marriage, on condition that conceiving a child will be excluded. In this way the contraceptive mentality is propagated; it treats the child as a harmful factor which has to be avoided at all costs. Even when abortion is not mentioned, one arrives at the conclusion that the child is an unwanted intruder.

The greatest falsification of moral laws and denial of values is caused by information about legalizing abortion.

Quoting only statistics of how many countries accept this practice legally, doing so without any comment from an ethical point of view, must lead to the conclusion that what is legal is right. In this way human conscience becomes depraved.

**Danger of immediate demoralization**

Mass information about the manner of sexual intercourse is also about the way of provoking orgasm by different perverse methods. Again, without any mention of ethics or any prohibition, may easily encourage applying these practices, the more so since these lessons are also often televised.

Whatever the original intention, such an approach to sexual matters deprives this type of sex education of all value, and instead of educating the young, it demoralizes them. It is therefore not surprising if Christians protest and demand a different program for their children. And what is more to the point, not only a different program, but a totally different approach to the whole problem.

It would seem that the best way out of this dilemma would be to teach these matters during Religious Instruction, while transmitting the doctrine of the Church. The basis of this teaching should be the relevant documents released recently by the Church, such as *Humanae Vitae*, *Pers ad Humanae* Gaudium et Spes, *Familialis Consortio*, and *The Charter of the Rights of the Family*.

Lay people are right in demanding from the Church a pastoral program in this special field. It surely is the first task of every pastor, as Paul VI stressed.

II. THE CHURCH AND SEX EDUCATION

**Christianity and Human Sexuality**

The Catholic Church, which for ages has led humanity towards development and progress, is now accused of obscurocratism. The reason is its opposition to trends which experiment in and manipulate the sphere of human sexuality. The Church is accused of incomprehension. The norms of Catholic ethics are said to endanger the development of the human personality. What is more, the Church is accused of rejecting sexual problems, of severely deprecating everything that is sexual. Where is the truth?

The truth is that the whole of Revelation, the whole doctrine which the Church transmits, reveals, among other things, the immense perspective of human existence; and human existence implies sexuality. For a person is determined by his or her sexuality. "Don't you know that your body is a temple of the Holy Spirit within you which you have from God? You are not your own. You were bought with a price. So glorify God in your body" (I Cor. 6:19-20). What more could be said about the human body? All of the doctrine of the Church since Christ, through the documents of the Holy See, is faithful to the great truth revealed by the Book of Genesis. It gives a clear answer to the question of who man is in his sexuality: "God made them, man and woman, in His image and likeness."

In a certain sense, the teaching of the Church is sex education, for it leads man, with his sexual body, to sanctity, to God. The whole sexual reality of man finds expression in the doctrine of the Church. This begins already in the biblical scene in paradise, when man and woman lived in harmony and happiness while they were naked. Their nakedness became a source of shame only because of the sin of disobedience. It is not nakedness which is sinful and evil — the nakedness of the human body reveals the person.

Man is born naked and is always uncovered before God. The beauty of the human body is the gift of God. The body in itself is innocent; only human deeds may be sinful, not the constitution of the human body.

Precisely the analysis of human sexuality demonstrates the beauty of God's thought and plan with regard to man. It also shows how tragically man ruins this beauty with his deeds.

The Church, through its teaching, embraces all human matters, showing the way for all human activity. God Himself reveals the right direction for humanity by means of the Decalogue.

The norms of Catholic ethics, which rule and correct man's attitudes and behaviour, accept the constitution of man as God's creature.

**Church and Love**

The Church is accused of forgetting the 'rights of love' and of giving priority to parenthood as the aim of sexual activity. But at the same time one forgets that there exist no more beautiful texts on human love than the Canticle of Canticles.

It is not therefore true that the Church in her teaching has avoided these themes; she has always embraced them and continues to do so.

Paul VI in *Humanae Vitae* reminds us that the Church did not invent the norms of human behaviour, but faithfully transmits them according to the Maker's eternal plan. She transmits them faithfully and without change — and it is precisely this which causes opposition. Modern man wishes to change moral norms, sometimes even justifying his actions by appealing to God's command: "Have dominion over all the earth" (Gen. 1:26).

Man cannot create by himself, but tries to transform the world and feels that this is his vocation. With the universally propagated intervention into human fertility, every manipulation of the process of fecundation is being allegedly justified by precisely this divine command: "Have dominion over all the earth". Man, who received from God the right to rule the world,
tries also to subordinate man.

But there are two levels of human activity: the world of things and the world of persons. In the world of things man, endowed by God with reason, may discover the laws that rule nature and direct them. He may thus improve this world. But 'improving' man is possible only in one way: by making him holier; and this is only possible with the help of grace. You must be perfect just as your Father in heaven is perfect” (Mt. 5:48).

This task of ‘being perfect’ embraces the whole life of man, which is only a way to eternity. John Paul II once said: “Remember that human life on earth is only a way and nothing else. . . .” This task is therefore the aim of human life and embraces the whole man and therefore also his sexuality. The fact of having sex and a personal vocation does not change the universal vocation to holiness.

The bodily, sexual existence of man is essentially nothing else but an irreversible progress towards inevitable death, and with it toward eternity, whether man is conscious of it or not, whether he accepts it or not. Every human life is a way leading to God. To understand the meaning of one’s own destiny and aim of life is at the same time to understand one’s vocation, which is always related to one’s gender since man is a sexual being.

**Man’s sexuality and vocation**

Since man is a sexual being, his vocation bears the impress of his sex and only within its orbit may he realize his vocation and thus truly fulfill himself. A vocation which has the impress of his gender in a special way is the vocation to one of two great sacraments: the priesthood and marriage. Both these sacraments demand a total self-giving, a total commitment and a liberation from human egotism.

The priestly vocation demands total commitment, a full sacrifice; it is actualized in a bodily way, and demands from a man supreme dominion over his body and its mechanisms.

The vocation to marriage is fulfilled also in a bodily way, through an activity to which God Himself invites man by allowing him to cooperate in divine creativity. Both these vocations embrace human sexuality and demand man’s dominion over himself.

Since the original harmony and balance has been lost, together with ‘original innocence’, this self-dominion must be worked upon. It is not given to man ready-made, it is presented as a task to be accomplished. In this task, which often proves difficult, God Himself comes to man’s aid by giving him a special ability to realize his vocation, a special grace—the sacramental grace.

Whatever his vocation, each man and woman is created by God in His image and possesses the potential ability of dominating his body, although there always exists a certain tension as a result of the lost balance. “For the desires of the flesh are against the Spirit, and the desires of the Spirit are against the flesh, for these are opposed to each other, to prevent you from doing what you would” (Gal. 5:17).

The church is an educator in the sexual field through its teaching which reminds everyone of the Sixth Commandment. This commandment is binding for everyone and does not exceed human possibilities. Christ even gives as ‘methodical directions’, teaching us how to handle our own body, with which we often have to struggle: “But now I tell you: anyone who looks at a woman and wants to possess her is guilty of committing adultery with her in his heart. So if your right eye causes you to sin, take it out and throw it away! It is much better for you to lose a part of your body than to have your whole body thrown into hell. If your right hand causes you to sin, cut it off and throw it away!” (Mt. 5:28, 29). While accepting the body is itself, St. Paul clearly defines what purity is, and with what it is necessary to struggle. The human body becomes obedient to its owner if it is educated. Subordinating the body to the spirit—the spiritualization of the body—is true sexual education.

**Human sexuality and Holiness**

The Church clearly defines what is good in sexual activity and what is not; she shows the divine dimension of humanity, the way to holiness. However, from observing human life, it often seems that the whole sphere of human sexuality is stigmatized by sin, that sexual activity and sexual reactivity lead man to sin. It would seem that the fact of being sexual is an obstacle for man’s potential holiness and makes cooperation with God impossible. The casuistical approach may lead to the conclusion that sex is an obstacle to reaching God. This happens because in this field, man departs from God’s plan, rejects it, and introduces his own plan, burdened by human frailty. And thus sexual activity, born in the divine thought, may become a source of sin, degradation, wrongdoing and even crime. It is precisely in this sphere that man’s deeds are such today that we may rightly call them ‘inhuman’, below the dignity of the human person. Such a degradation is the result of a lack of proper sexual education and formation.

Proper sexual education is correct only when all the sexual activity of the person is subordinated to his progress towards holiness. Human sexuality, thus realized according to God’s plan of love, becomes for the subject—a human person—a source of happiness and holiness. The analysis of human sexuality and directing it towards fertility should awaken human admiration, admiration for God’s work. This domain reveals in a special way God’s thoughtfulness towards man and his body, which should worship God with its very existence.

The sexual act of the married couple can and should be a hymn of the thanksgiving to God the Creator. Then, this love is total; that is to say, it is a very special form of personal friendship, in which husband and wife generously share everything, without undue reservation or selfish calculations. Whoever truly loves his marriage partner loves not only for what he receives, but for the partner’s self, rejoicing that he can enrich his partner with the gift of himself.

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Information and formation

Quite independently from the existence or non-existence of other programs of education, a human being, endowed with reason and the ability to perceive and think, acquires wisdom thanks to his own experience and history. Sexual experiences, which essentially concern the deepest structures, enter into his consciousness and subconsciousness in a deep and indelible way. And that is why it is singularly important to defer from experiences which would cause wrong attitudes and convictions. Man must acquire wisdom and understand the meaning of sexual actions more and more deeply. But this wisdom must be in harmony with faith and proper reason to be able to discover the whole truth.

The sexuality of man must serve his holiness and his love. Information must reveal this dimension to the pupil.

In the sphere of sexual activity, whose object and subject is the human person, there are no morally indifferent acts. Either man takes in this action God’s plan, while complying with the whole divine reality, which gives rise to happiness and is holy, or in this action man is isolated as an object, as a thing, which degrades him — and then the deed is morally evil.

The proper information must take into consideration the individual vision of the human person, who possesses a body permeated by the spirit. We could also say that the human being is an incarnate soul, and that body and soul is the image of God.

Some proposals of proper information

Information should be given in such a way that it does not interfere with the proper development of the human being directed toward holiness. It should be real and true, but at the same time given in a comprehensible way, corresponding to age and degree of development. It is of course evident that human attitudes depend not only on teaching, not only even on verbal transmission of ethical norms, but to a high degree, on an observed and accepted model of behaviour. Observation of the attitudes of adults and of adult behaviour is for the child a source of information and at the same time a way to educate and to form attitudes.

The basic information concerning sexual matters, the fascinating question of the beginning of human life, may be transmitted to a very small child in the most natural way by observing family life. When the whole family awaits the coming of the next child with joy, when the father draws attention to the pregnancy of the mother, demanding from the children a special attitude of care towards mummy, who “is now carrying a growing baby”, when he shows that attitude himself, then the children accept the fact of a new baby without surprise, and also the special part the mother plays in its arrival. If children were born only to married couples, it would be evident to children that “one has to marry to have a child”. Sometimes the child comes to such a conclusion by himself, without any exterior information.

If the family stresses the special elements which accent and underline the role of the mother, for instance, when children on their birthdays prepare little gifts for her at the suggestion of the father, who tells them that when they were born it was the mother who suffered — this instills into the child respect for maternity and gratitude to the mother for giving him life.

If the whole family prays while awaiting the arrival of the child; when it thanks God for his birth, when it celebrates religiously the day of his Baptism, it is easy to transmit to the child the deepest truth of the divine origin of man, and also the fact that God transmits life through the child’s parents, which is why he is bound by the Fourth Commandment.

The first information about human sexual activity should be given in the context of these two great divine commandments, the First and the Fourth: I adore God who has created me and I thank my parents who cooperated with Him. In such a context the details of the anatomy of the woman are not important or necessary. However, since the false opinions widely propagated today assert that the child before birth is not yet a human being, it would be advisable to add the biological information in the form of a beautiful film about the prenatal development of the baby: it shows how wonderfully human life develops from one cell. The real photographs generally arouse the children’s enthusiasm.

If in a family where children of different sexes are born, the older brothers and sisters assist at the baby’s bath, they notice the differences of sex and accept them in a natural way, without surprise; they find their own similarity to mummy or daddy, and thus accept their own sex. If the parents love their children equally, while taking into consideration their psychological differences and demanding from them according to their possibilities, the acceptance of sexual differences is accomplished without traumatic experiences, and the children grow within a correct inter-personal relationship built on a strong foundation of brotherly and sisterly love.

While growing, the children comprehend more and more deeply their masculinity and femininity, not wishing to change their sexuality, and fully accepting their vocation.

The correct model of a father, responsible for the destiny of his family, causes admiration and high regard: the model of the mother, tenderly loving and caring for all the needs of the child, gives a sense of security. No programs of sexual education will provide what the strong arms of the father and the tender hands of the mother embracing the family transmit to the children. The child learns love at home, and only then is born that deepest reality — the correct interpersonal relationship of the ‘communion of persons’.

Information and non-transmissible matters

In the family’s dialogue of love, the parents should transmit the ethical norms of behaviour: it is their privilege, right and duty.

Sexuality characterizes man and woman not only on the physical level, but also on the psychological and spiritual levels, making it mark on each of their expressions. Such diversity, linked to the complementarity of the two sexes, allows thorough response to the design of God according to the

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vocation to which each one is called.

"Sexual intercourse, ordained towards procreation, is the maximum expression on the physical level of the communion of love of a married Christian couple. Divorced from this context of reciprocal gift—a reality which is a special aspect of the Christian marriage—love loses its significance, exposes the selfishness of the moral disorder."

(Educational Guidance in Human Love, 5).

They educate the child through their example and they should give him information on human sexuality. It is clear, however, that sometimes during childhood, and especially in intimate sexual experiences, there are experiences which are not transmissible. All attempts to describe the sexual act fail to transmit its essential content: all descriptions, drawings, photographs, become pornography, since they cannot render the great interior dimension but show only one dimension, thereby degrading this sublime act.

Parents who try to give their children a good sexual education do not always know how to manage this difficulty, how to describe the event. However, nobody, while even observing the sexual act closely, will ever be able to learn what is really happening. It is the secret of the two participants, who are living their union before God Himself. It is a mystery, and that is precisely what the children must be told: these matters are so great that they are indescribable.

This is the sphere in which it is necessary to leave space for mystery, for the depth of silence, in which the young person guesses and awaits marvelous fulfillment. Young people in love look into each other's eyes and this look transmits depths known only to themselves. A body which does not yet understand much knows well if he is loved; he recognizes love without any 'education', he experiences love. Man possesses a sensitive heart, an intuition which allows him to learn and feel what is indescribable.

Teaching children the true meaning of love

And so silence in sexual matters need not, after all, be such a great educational mistake, since it may give more real wisdom than irresponsible talking. If a child grows up in an atmosphere of love, he sees that love searches for expression by means of different bodily gestures. As the interpersonal relationship changes, passing through friendship and then love, so do the gestures change. The child understands very well such signs as the expression of feelings. From the gestures of amiable welcome to a stranger through the cordial gestures in the family, it understands the need of engaging the body in all expressions of love and of making the body obedient to love. A young man must learn the gestures of altruistic tenderness, not gestures of desire, since desire with its tendency to appropriate, is against love.

It becomes clear to the young that if all interpersonal relationships search

for some sign of expression, the married love to which God calls people must find its expression in a special bodily sign. Scripture says simply: "They become one flesh" — and that is enough. It is not true that man is able to accomplish the sexual act only if he sees a diagram or even photographs in a pornographic magazine or a manual, showing the number of possible positions. It is not true that "technique" deepens the strength of the experience of the partners. True human love is a strength that embraces the whole man, and then the body, obedient to love, finds an expression comprehensible to the beloved. People in love conduct their own individual dialogue. "The profile of your love depends on you alone." (Card. Karol Wojtyla)

Although human love makes use of the body, it takes place in the soul. The body has no power to love. The popular formulae, 'bodily love', 'sexual love' in fact do not reflect any reality, since the body alone cannot love, it can only be an instrument of love. Educated, it can become an obedient instrument. The body can be taught purity or, to the contrary, impurity. True experience of love is not through the senses, it is above the senses. Man is convinced of love not by descriptions, not by words and gestures, but by the depth of mutual trust: "I know you love me, although you are not always able to express it; I know I love you, although I show it so awkwardly..." What is greatest, deepest, most holy and dearest to man must remain his secret. Uncovered, reduced to dimensions that are expressed, it loses its mysterious value.

Sexual education and fertility

While it is not possible to transmit by mere teaching the true significance of human sexual activity — and this sphere should remain to some degree the personal secret of the concerned — the field of human fertility demands both information and teaching. It is not however, teaching about the activity of the human person, but the action of his organism. Human fertility depends on the functioning of healthy genital organs, and these organs, like all others, function in harmony with the whole organism. Fertility is the proof of biological maturity and health. The functioning of the genital organs is controlled by the brain and especially by the pituitary gland (hypophysis).

Information on fertility should be given to young people during their course of biology or physiology, with all respect for the human being and his body, and especially for those parts about which St. Paul writes: "No, much rather, those that seem the more feeble members of the body are more necessary; and those that we think less honourable members of the body, we clothe with more abundant honour, and our uncomely parts receive a more abundant comeliness, whereas our comely parts have no need of it. But God has so tempered the body together in due portion as to give more abundant honour where it was lacking; that there may be no dissimilarity in the body, but that the members may have care for one another."

The correct information about the functioning of the organism allows the married couple to direct their fertility according to their conscience and
responsibility. The Church stresses responsibility in this sphere, and in several documents speaks of it in detail. Married couples can be entirely familiar with the Church’s teaching in this realm.

Conclusions.
1. Sexual education, rightly understood, is a formative process which is the result of many different factors.
2. The most important seems to be maintaining a just proportion between information and formation. There exists a real flood of information. It should not be given without a proper moral formation. Much of it need never be given at all.
3. The persons to whom the duty of sexual education belongs in a special way are parents themselves. It is their inalienable right and duty.
4. The Church should help parents in their duties both by pastoral work and by providing approved programs for parents who feel the need of them, and most of all by administering sacraments and thus becoming a channel of grace necessary for sanctification.
5. Parents should be vigilant with regard to the mass media and their programs, and openly protest when they offend the religious feelings of the spectators or degrade their human dignity.
6. All education requires a parallel self-education. Cooperating with his educators, and with the help of grace, a young person can manage his sexual body perfectly. He will always find his model in Christ and His Mother; he will also find help with those who were able to attain holiness and have been canonized.

Infant Care Review Committees: Their Moral Responsibilities

Robert L. Barry, O.P., Ph.D.

Father Barry, a theology department faculty member at St. Thomas College, St. Paul, Minnesota, is book review editor for Linacre Quarterly.

The moral duties of infant care review committees has become a widely discussed issue in the past few months among physicians, ethicists and legal scholars. It now appears as if these committees will come to have a great deal of responsibility over the care and treatment of handicapped newborns, and it is necessary to outline their moral duties in this role. Recently, very broad, formal, procedural guidelines for their proceedings have been suggested by other authors. In this paper, I wish to present a fuller account of what is morally required of these committees.

Ethics committees had their beginning in the decision rendered by the court in the Matter of Karen Quinlan.1 In this decision, the court urged health care professionals, physicians and families to consult with ethics committees in difficult cases so that there could be full, free and open discussion of treatment issues. This proposal was not generally heeded by medical professionals or parents, largely because most seemed to want to preserve the traditional prerogatives reserved to them. As a result, few institutions established ethics committees after the Quinlan decision. In the years that followed this decision, only Catholic hospitals established ethics committees in large numbers.

Infant care review committees received their major impetus from the infamous Bloomington Baby Doe case for, in response to the death of that baby, the Department of Health and Human Services issued regulations to prevent the denial of care and medical treatments to handicapped children for the sole reason that they were handicapped. These regulations were based on section 504 of the Rehabilitation Act of 1973 and these regulations implied that:

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The best minds in medicine, law and additional measures to intervene if they could newborns and to promote quality medical The Department of Health and Human acceptance of these committees, spurred the present interest in m tra tions of this regulation, and many medical accepting the care of handicapped infants. Infant care review committees hold out a Federal hotlines were initiated for the protection of handicapped newborns and to promote quality medical decision-making.

Infant care review committees hold out a promise of significant benefits. They could make it less necessary for law enforcement agencies to intervene if they could guarantee that the rights of handicapped infants to normal care and ordinary medical treatments would not be violated. These committees could bring together some of the best minds in medicine, law and ethics to examine and resolve some critical problems in contemporary infant care.

To study the moral responsibilities of infant care review committees, I shall begin by briefly surveying the views of various authorities on the roles and functions of these committees. Then, I will examine some of the concerns and problems that have been addressed about ICRC's. Finally, the general and specific moral obligations of these committees to handicapped infants, parents, physicians and society will be studied.

Infant Care Review Committees: Their Role and Functions

The three general functions of infant care review committees will be examined here. Virtually all authorities and commentators agree that ICRCs can serve a general educational function for both health care facility staff members and the public at large. They also agree that these committees can review treatment proposals both prospectively and retrospectively. And ICRCs are also seen as agencies which could assist in the formation of guidelines, standards and norms for the care of handicapped infants.

The Educational Function of Infant Care Review Committees

While there is general agreement that ICRCs should educate health care facility staff members and the public at large concerning the care and treatment of handicapped infants, there is no unity on what should be taught by these committees. The American Academy of Pediatrics asserted that these committees should educate parents about the means of treatment available in health care facilities and in a community for these children. However, these tasks seem to be better suited to other bodies, and most authorities agree that ICRCs should limit themselves to instruction in ethical matters. The most common view held is that infant care ethics committees should inform parents, physicians and health care staff members of their ethical responsibilities.

There is some debate as to whether ethics committees should merely provide a forum for the discussion of ethical issues, or whether they should assume an explicitly pedagogical role in which they would teach determinate ethical principles and rules.

Infant Care Review Committees and Case Review

Almost all authorities agree that ICRCs have a role in reviewing the treatment given to or proposed for handicapped infants. A number of writers have asserted that infant care review committees should not make decisions about the cases they review, but they are not clear on what they mean in saying this. If this assertion means that ICRCs should only decide who should treat, it does imply that these traditional forms of medical decision-making should be subjected to strict ethical scrutiny and that all decision-makers should be held accountable for any irresponsible decisions about actions or treatment proposals.

It would seem that ICRCs, by their very nature, are to aim at promoting judgments about actions or treatment proposals, but to deny them the freedom to do this would be to defeat their primary purpose. That ICRCs should make ethical judgments does not mean that they should replace the traditional loci of medical decision-making, but it does imply that these traditional forms of medical decision-making should be subjected to strict ethical scrutiny and that most authorities do not object to infant care review committees making ethical judgments about treatments and proposals for treatment. But at the far end of the spectrum, some authors suggest that ICRCs should only decide who should decide about the provision of treatment. It is difficult to take this suggestion seriously, however, for shortly after making it, the author asserted that parents should make decisions about the treatment of children unless they are judged incompetent by a court. This view would unduly restrict the freedom of action of ICRCs and it is one that has not been shared by...
many authors.

Case review can either be prospective or retrospective. A prospective review of cases, it has been argued that committees should obtain all of the relevant facts of the case, identify the relevant issues, resolve differences between parents and physicians, and recommend intervention or enforcement agencies if necessary.16 A serious problem writers mention is that of determining when ICRCs should intervene whenever life-sustaining treatments are requested to do so by physicians, parents or staff. Another difficult problem mentioned by authors is the determining the authority of judgments or recommendations made by infant care review committees. Some claim that ICRC recommendations be binding upon those who treat handicapped infants, while others would hold that they should be binding on them in varying degrees according to the circumstances.19

When committees do intervene prospectively, there is little agreement among authorities as to how they should evaluate proposals. Some assert that ICRCs should only require "reasonable" or "appropriate" actions be taken in behalf of handicapped infants or the "best interests" of the child be promoted by ICRCs.20 Others have asserted that the dignity of the parents and physicians should be affirmed and promoted by ICRCs.21 But to say so knowledge, few notable authors recommend that infant care review committees intervene when the rights of the infant are in jeopardy. The presence of an affirmation of this should be a cause of concern, for it is in such a situation that the Baby Doe regulations were specifically promulgated. In their prospective review of cases, some writers have suggested that ICRCs should not aim at reaching a consensus in their judgments, but should merely settle for a wide-ranging discussion of the issues.21 And virtually all authorities agree that courts and law enforcement agencies should only be allowed to intervene and investigate cases as a measure of last resort. 22

Policy and Guideline Formation

Most authorities hold that infant care review committees should have a role in the formation of policies and guidelines for the treatment of handicapped infants, but there is not much agreement on the nature of these guidelines.23 No writers have suggested that guidelines contrary to institutional bylaws be adopted or endorsed by infant care committees. Being predominantly procedural and formal, the review committees have been thus far proposed have not demonstrated that they could effectively protect the rights of handicapped infants in critical situations.24 As there is little or no mention of these guidelines in Section 504 of the Rehabilitation Act, one can readily draw the conclusion that the primary objective of these guidelines is the protection of parents and physicians. Most authors claim that their wish to promote high quality medical decision-making, but they are not specific concerning the nature of this improved decision-making.

II

Infant Care Review Committees: Concerns and Problems

There are five general areas of concern with infant care review committees:

1) Probably the most significant concern with ICRCs is that they could really become dominated by the interests of one or a small number of groups or individuals to the detriment of physicians, patients and handicapped infants.25 Reports have shown that it is relatively easy for physicians to dominate these groups and use them to promote their own private interests.26 This problem has been less acute in some committees in Catholic health care facilities, as they have generally had greater diversity in their membership.27 Virtually all authorities assert that infant care review committees should strive to attain diverse membership and thereby limit the harmful effects of domination by a single group or individual.

2) Holding infant care review committees accountable for their actions is another major area of concern.28 ICRCs appear to have a problem similar to that which Institutional Review Boards (IRBs) had when they first began. IRBs often failed to adequately protect the rights of research subjects against immoral research, and it is thus feared by some that ICRCs could jeopardize the rights of handicapped infants by being negligent of their duties to argue in behalf of their rights.29 ICRCs appear vulnerable to this possibility, and most authors call for measures to make ICRCs accountable for their judgments and actions. Without such measures, it is quite possible that ICRCs could become culpable cooperators in unjust actions against infants.

3) A further problem with these committees is that their roles and functions appear to be so vaguely defined that they could readily align themselves to the roles of parents, physicians, surrogate decision-makers, health care institutions, law enforcement agencies or the courts. This is a serious issue because it is not certain that ICRCs have the competence or authority to assume any of these roles completely. Related to this concern is that of the possible violations by
ICRCs of rights of privacy and confidentiality of involved parties because of inadequate procedural standards and regulations. To counter this possibility, many authors have strongly urged for measures to protect the privacy and confidentiality of involved parties.

4) There have been few reported instances of infant care review committees requiring excessive treatment, and it is quite possible that these committees might become biased in favor of unjustifiable non-treatment or nonintervention. A number of authors have charged that the activities of ICRCs be severely limited, and if these proposals are accepted, the power of these committees to require treatment could become severely restricted. This problem could be minimized if there were more specific and concrete guidelines for ICRCs, for the guidelines being proposed currently have little capability for compelling committees to require justified treatment.

5) Up to the present time, practically all of the procedures and guidelines suggested for ICRCs have been purely procedural and formal. This raises the possibility that ICRCs could intervene without justification or fail to intervene in review cases where they would be justified or morally required. Enactment of sound, precise and substantive norms and standards has thus been recommended frequently.

In light of these problems and concerns about the nature and functions of infant care review committees, it is now possible to discuss their general and specific moral responsibilities. While this discussion of their responsibilities will focus primarily on their moral obligations, some attention will be given to their legal obligations to the extent that these bear upon their moral duties and responsibilities.

III
The Moral Responsibilities of Infant Care Review Committees

Before discussing the general moral responsibilities of these committees, it is necessary to state that those who establish ICRCs have a strict moral duty and obligation to structure them so that they can fulfill their moral duties in full freedom. If ICRCs are so restricted in their actions that they cannot execute what is morally required of them, then any attempt to impose moral responsibilities on them would be futile.

Infant care review committees have four moral responsibilities in all of their functions and roles.

1) All ICRCs are bound via the duties imposed by what has come to be known as the Kew Gardens Principle. This principle asserts that all moral agents are required to take actions which do not entail grave risk for them if those actions would prevent another from losing a fundamental human good or from experiencing grave sufferings. For infant care review committees, this principle means that they must take whatever actions are reasonably within their means to prevent handicapped infants from suffering grave harm or injury by either commissions or omissions performed by other moral agents.

2) All infant care review committees are under a common and ordinary moral duty to protect innocent human life from direct and deliberate lethal commissions or omissions. This principle is correlative to the Kew Gardens Principle, but it states the nature of this obligation in more technical and precise terms.

3) In all of their actions concerning innocent human life, infant care review committees are morally required to adopt the morally safer course of action. This does not mean that ICRCs must adopt the safest course of action in all circumstances, but only that they must act to guarantee that handicapped infants not be denied any reasonable chance for life and improved health. This principle does not endorse moral rigorism, for it promotes and encourages moral responsibility, prudence and respect for fragile and innocent human life.

4) All infant care review committees are morally obliged to promote, endorse and support laws and efforts of law enforcement agencies which seek to responsibly protect the moral rights of handicapped infants to ordinary medical treatments and care. ICRCs are not meddlesome "do-gooders," exceeding their authority when they do this, but are only fulfilling a common and ordinary jurisprudential duty incumbent on all moral agents. Because the law is more precise and specific than are moral principles, norms and rules, it is better able to protect the rights of all parties, and there is a moral duty to support it when it is administered responsibly. By doing this, infant care review committees are better able to fulfill their moral responsibilities toward handicapped infants.

These are the general moral duties of infant care review committees, but there are also some specific moral responsibilities of these committees which must be examined.

The Moral Duties of Infant Care Review Committees in Education and Case Review

In all of their case review activities, infant care review committees are to gather all possible relevant factual data concerning the cases. They are to studiously preserve privacy and confidentiality in doing this. All aspects of their reviews and investigations are to be properly and accurately documented and recorded.

When infant care review committees function in their educational role, they are to recall that their primary function is to instruct physicians, staff members and parents of their moral duties. ICRCs are not simply to provide forums for discussion, or aim at replacing legitimate regulatory functions of the government. ICRCs are to take a pedagogical role in their educational activities because this is required by the principle that the safer course of action is to be followed.
care review committees are to train health care professionals in their moral duties toward handicapped infants. They are to give precise ethical guidance which, above all else, positively promotes the rights of handicapped infants, especially in difficult and complex cases. In this role, they are to instruct in the requirements of obligatory moral duties and in what is demanded by the safer course of action in various circumstances. And it is also a moral obligation of these committees to instruct parents and physicians in their moral obligations toward the law.

In their roles of retrospective and prospective case review, infant care review committees might not be required to make medical decisions, but that does not prohibit them from making ethical judgments about treatments or treatment proposals. To prohibit them from making ethical judgments is morally equivalent to prohibiting physicians from making ethical judgments concerning clinical cases brought to their attention.

In both prospective and retrospective case review, ICRCs are to take the safer course of moral action and intervene to review three separate kinds of cases. First, they are to intervene as a matter of moral obligation and make ethical judgments in cases were life-sustaining treatments are being proposed for withdrawal to handicapped infants, or where they are actually withdrawn. This is required because there is imminent danger that the withdrawal of such treatments or care could be directly lethal or would be a violation of the rights of the infant to care and obligatory medical treatment. Second, infant care review committees are morally required to intervene in cases in which possible medically beneficial care or treatments are being proposed for withdrawal or have actually been denied to a handicapped infant. This is morally required because it is quite possible that grave harm could come to a child if such proposals or actions were carried out, and therefore, taking the safer course of action requires review. Third, infant care review committees are required to review cases where nutrition and/or fluids are being proposed for withdrawal or have actually been withdrawn. Taking the safer course of action requires this because there are few, if any, situations in which denial of nutrition and/or fluids would not be direct killing. Whenever nutrition and/or fluids are of nutritional or hydrational value, whenever they can be successfully ingested by a human being, they are of benefit and should be provided unless it is physically impossible to do so. Nutrition and fluids are not medical treatments, but are basic resources of the body whose provision sustains life and whose withdrawal certainly causes death. Their provision directly supports the natural functions of the body and its natural defenses against diseases. Because they are not specifically medical treatments, their provision should be regulated by principles other than those which govern the administration of medical treatments. Nutrition and fluids are aspects of normal care, and they should be given whenever they can meet the nutritional and hydrational needs of the patient, as they are of benefit when they do so. There is nothing immoral whatsoever in feeding a patient if this will not impair his ability to recover, and there very well might be something seriously immoral in denying nutrition and fluids to a patient so that death is brought about. Taking the safer course of action requires that one avoid the risk of unjust killing by providing life-sustaining food and fluids when they can preserve life. Food and fluids are different from medical treatments because they are not directly therapeutic as they do not directly and proximately correct or ameliorate clinically diagnosable conditions. If anything constitutes medical abandonment, it is the refusal to provide food and fluids to persons whose lives can be sustained by them. The Vatican recognized this in its Declaration on Euthanasia when it asserted that normal care was always to be given to patients, even to those who were terminally ill.

In both prospective and retrospective case review, infant care review committees are to uphold the requirements of the law. Specifically, this requirement implies that infant care review committees are not to be used in any fashion to impede the enforcement of the law seeking to protect the rights of handicapped infants. They are to instruct individuals in their duty to report suspected cases of child abuse and neglect, and they are to reprimand individuals or organizations which fail to do this. ICRCs are not only to report cases of child abuse when they judge that there is sufficient evidence for a conviction, but even when there is only a suspicion that neglect or abuse is occurring. And in both retrospective and prospective case review, infant care review committees are to take steps to assure that their actions are carried out.

Infant care review committees also have specific moral duties in their role of assisting in the development of policies and guidelines, and these will be examined in the next part.

**Moral Duties in Policy and Guidelines Formation**

The fundamental duty of ICRCs in the development of policies, guidelines, norms and standards is to assure that these are not merely procedural, formal and subjective, but substantive, binding and specific. This is required by the principle of the safer course of action, as failure to demand this places handicapped infants in imminent danger. Guidelines cannot be merely "feasible," for these would not guarantee the rights of infants to obligatory medical treatments in complex and difficult situations. Guidelines cannot aim at being merely "reasonable," "appropriate" or in the "best interests" of the child, for these will not assure protection of the rights of the child to normal care and ordinary medical treatments. All of these criteria being proposed currently are purely procedural and formal, and by themselves they can-
not impose any specific concrete and practical moral duties on any one. All norms and standards regulating the activities of review committees must aim at concretely protecting the rights of handicapped infants above all else, as they are far more vulnerable than any other parties.

All norms and standards endorsed or promoted by ICRCs must be in full compliance with civil and criminal laws protecting the rights of handicapped infants against discriminatory acts. There is a specific requirement in this demand which forbids ICRCs from endorsing policies and guidelines which violate the moral rights of physicians, health care institutions and parents. And it is particularly important that ICRCs endorse policies which protect the privacy and confidentiality of all individuals and parties involved in the treatment of handicapped newborns.

Recently it has been suggested that some handicapped infants be included in a treatment category called “supportive only,” in which no life sustaining measures or treatments would be provided. Policies such as these, when suggested for handicapped newborns who are not imminently and unavoidably dying and for whom nutrition and fluids would be life-sustaining, should never be endorsed by infant care review committees. There are instances in which palliative care could be provided morally because nutrition and fluids would not be ingested, but a policy permitting this for infants who are not imminently and unavoidably dying is immoral.

It has also been suggested by some authorities that “no treatment” as a medical policy is morally legitimate when various kinds of other treatments would be of clear benefit to a child and when “nontreatment” would do nothing to improve the child's clinical picture. Adopting “nontreatment” as an option is not morally tolerable when positive measures would improve a child's condition or when the child is not imminently and unavoidably dying. Adopting a policy of “nontreatment” when positive treatments would promote the health of the child is nothing but a violation of the rights of the child by omission rather than commission.

There are quite a number of specific kinds and conditions from which infants can suffer, and in the next section, we will consider the moral responsibilities of ICRCs in respect to some of the more important afflictions of newborns.

Moral Responsibilities of ICRCs in Special Cases

It has been suggested by some authors that compassionate and humane treatment of infants with various conditions such as Lesch-Nyhan, Tay-Sachs disease, hydroencephaly, trisomy and other ailments be withdrawn or withheld. The justification for this position is that the suffering experienced by children with these conditions is so severe that death is preferable to life. This position is highly objectionable, however, because it is implied that nutrition and fluids would also be removed so that the children would be starved or dehydrated to death. As a result, these children are not killed by being allowed to die, but are rather killed by culpable omission. Denying the food and fluids would do nothing to improve their condition and it would introduce a certain lethal cause which did not previously exist. Removal of nutrition and fluids does not cause the child to die due to a condition from which he or she is suffering, but rather it introduces a new culpable and immoral cause of death.

It has also been suggested that it would be morally permissible to bring certain handicapped newborns to death by directly killing them. If it was judged that continued life was not in the best interests of a child, if the child suffered in the absence of treatment, and if death could be brought about intentionally, then it would not be immoral to directly kill a child, probably by lethal injection. This is also quite objectionable because direct killing is never morally permissible, even when its motives are compassion and concern. Life is a basic and fundamental good and it can never become a burden to one in and of itself. The conditions from which one can suffer can become burdensome, but life itself cannot become burdensome. Giving lethal injections to infants makes physicians killers and it violates the medical canon of “do no harm.”

When considering treatments to be given to children with spina bifida, any and all treatments which improve the clinical picture of these children should be given. Any treatment which palliates, alleviates or corrects their clinical conditions and which can be given without undue burden to the parents or health care providers should be given as a matter of moral duty. Aggressive treatment of children with spina bifida should never be regarded as imposing harm on them when there is a prognosis that such treatment will improve the condition of the child. But where a child with spina bifida will die imminently and unavoidably, aggressive treatment which cannot ward off death can become morally extraordinary. Even in this circumstance, palliative care and provision of nutrition and fluids are morally required, as the life of the child is a basic good which should never be deliberately...
destroyed or turned against by anyone.

"Do not resuscitate" orders should only be given for capped infants who suffer from terminal illnesses and men- tality and unavoidably dying. These orders should not be based on the "quality of life" judgments, or on other standards such fit" or "burden of resuscitation, but rather they should be issued for handicapped infants when it is clear that death could be staved off by further treatment.

Tay-Sachs disease is often difficult to detect at birth, becomes markedly worse as the child grows older. Infants in this condition and with similar conditions should not be being imminently and unavoidably dying, and therefore which includes palliative and supportive care should always be pro- vided. Only when medical treatments cannot forestall death can they be held elective, even though nutrition and fluids should be provided.

Conclusion

For all of the discussion of infant care review committees in recent months, it appears that such committees have been overly under-utilized in the recent past. One study showed that hospital ethics committees were only used once a year on the average in those hospitals which had instituted them. At the present time, there is a con- cerned effort to create a network of infant care review committees, and this effort should be regarded with caution. Many authorities admit that there are not experienced ethicists to be found on most committees, and this could lead to highly objectionable practices and judgments by those committees. It is quite possible that ICRCs could be used in the future as shields against legitimate intervention by law enforcement authorities, and this would be quite unfortunate if it were to happen. Thus, it is imperative that ICRCs adopt strict moral standards and that they be closely monitored during this phase of their growth and development. The existence and development of these committees are only tolerable if they enhance protection of the rights of handicapped newborns and if they facilitate enforcement of laws designed to protect their moral and civil rights. They cannot be allowed to become impediments to strict law enforcement, and for that reason it is imperative that a close watch be kept on them in coming months as they grow and develop.

REFERENCES

6. See Department of Health and Human Services, Infant Care Review Committee Interim Model Guidelines, 45 CFR 1340 Section IV A, "Basic Functions.
13. It would be as hard to consider ethics committees to be truly such if they were either explicitly or implicitly forbidden to make ethical judgments as it would be impossible to consider prognosis committees medical committees if they were forbidden to make medical judgments.
15. Ibid.
16. Ibid.
31. Fleischman and Murray, op. cit., p. 9. They would wish to remove all serious ethical debate about the morality of acts and treatment proposals and only discuss who should decide. The net effect of this would be to radically limit the activities of these committees.
Withdrawing Nourishment, pp. 22-25.

34. Ibid., Vol. I, p. 258.

35. Department of Health and Human Services, Child Abuse Treatment, p.


39. This is required for the reason that there are so few, if any, situations in which nutrition and fluids could be legitimately withdrawn from infants that the strong probability is that any denial of nutrition and fluids would be an instance of culpably direct killing.


41. Sacred Congregation for the Doctrine of the Faith, Declaration on Euthanasia, sec. IV.

42. Department of Health and Human Services, Child Abuse Treatment, p.


44. Weir, Robert, Selective Nontreatment of Handicapped Infants, (New York: Oxford University Press, 1984), p. 216. Weir claims that there are many meanings of “nontreatment” but in only one of them will an infant not die imminently from the denial of treatment. His views of the nature of “nontreatment” are so elastic, however, that he considers the administrative use of potassium injections to infants who will not die when all other treatments are removed to be a form of “nontreatment.”

45. Ibid., p. 235. It also seems as if he considers these children to be candidates for direct killing, for many of them will not die imminently when all other treatments are withdrawn, and therefore they can be directly killed by swift and painless lethal injection.

46. Ibid., p. 216. Weir argues that direct killing is morally tolerable when nothing can be done to prevent the suffering of an infant. It might even be mandatory to give lethal injections, according to him, to abide by the principle of nonmaleficeance.

47. Ibid., p. 249.

48. President’s Commission, op. cit., p. 446.

BOOK REVIEWS

Sex And Sensibility by Dr. H.P. Dunn

Published by E.J. Dwyer, PTY, LTD. Sydney and Wellington: distributed by Costello Publishing Co., Box 9, Northport, N.Y. 11768 $8.95.

In this masterful undertaking, New Zealand’s Dr. Pat Dunn asks and answers 133 questions in nine chapters and 134 pages in the tradition of our dear departed colleagues, Drs. Bill Lynch and Sean O’Reilly.

What is most remarkable is that Dr. Dunn is not a theologian, but a conservative, busy OB-GYN. His advice is always practical. His nine chapters cover Love, Sex Gone Wrong, Marriage and Normal Sexuality, Contraception, Sterilization, Abortion, Investigation of Sterility, Artificial Insemination, and Something About Everything. There are no surprises. While Pat Dunn opposes modern marriage manuals, he proceeds to write what may be the best marriage manual yet. Who should read it? Surely doctors, nurses, and married couples, those about to marry, high school students, and, above all, the religious—priests and nuns.

One of the most unfortunate changes of our times is that sexual morality is seldom if ever, taught from the pulpit. Many young couples, even those who have attended Catholic high schools, are not aware that there is such a thing as sexual morality. Many Catholic hospitals appear to be no different from public hospitals. There is enough material in this book for all of next year’s sermons in your parish and mine.

Homosexuality, masturbation, abortion, contraception and sterilization are all vehemently condemned. Homosexuality and masturbation are wrong because it is only our reproductive organs which are made to share permanently with a person of the opposite sex.

Pat Dunn uses a postcoital uterine sample for sperm study of the husband in infertility problems. Everything he says is consistent with what has been taught by the Popes of the 20th century, In Casti Connubii, it is said, “it is indeed of utmost importance that the faithful should be well instructed concerning maternity both by word of mouth and written word.” Many of our Catholic colleagues provide for each patient’s needs. Dunn says, “The doctor is the servant of the patient, not the slave. . . . He must have freedom to make decisions according to his experience and principles to protect her interests. . . . “She cannot obligate him to act against his better judgement.”

We should read question #123. Q. “Should a young Catholic doctor take up obstetrics and gynecology?”

A. “He will safeguard the natural rights of both mother and child and will make an important contribution to the nobility and dignity of the profession. There is no doubt that the latter choice is the only one if he wants to do the proper thing in life. Unless a large number of decent young men enter the specialty it will be doomed and mothers of the future will have only abortions to serve them during pregnancy.”

So Dr. Pat Dunn, it is a doctor’s first responsibility to a patient to be her teacher, not her technician.
Caring for the Special Child
by John Glaser
ed. Leven Press, Kansas City, 97 pp.

With the publication of regulations to guarantee lifesaving therapy for handicapped newborns under the Child Protection Act, we have seen the emergence of a new conflict. It is now possible in retrospect to view the input into the public debate from a variety of perspectives. We can now evaluate how persuasive different groups were in making their perception of the problem prevail. The medical profession, in general, denied that there was a problem and viewed all federal involvement as “unwarranted intrusion.” A continuing handicap in sustaining such a position was the reality that the medical literature contained many reports of unacceptable denial of therapy in which centers or individuals accused themselves (e.g., Johns Hopkins, Yale-New Haven Medical Center, U of Oklahoma, Surgeon Section of the American Academy of Pediatrics, etc.). In spite of the fact that the press and media, in general, supported the physician’s interpretation, the public reaction was overwhelmingly to the contrary. After the initial anger at the martyrdom of Baby Doe of Bloomington, the public continued to respond with emphatic support during the commentary period allowed for the Interim Final Rule and for the Child Protection Act. The Academy of Pediatrics sheepishly retreated from its original position taken in litigation before Judge Gesell. It joined with the various parents and advocate groups to oppose the enforcement of Section 504 of the Handicapped Child Act. The AMA, with its usual ethical confusion, still continues to threaten litigation on the bizarre basis of parental sovereignty over all therapeutic decision-making (even when not in the best interests of the handicapped child).

For anyone seeking an accurate chronology of events leading to the belated public condemnation of the secret crime of infanticide in the United States, Death in the Nursery will be an invaluable addition to a library on bioethics. The book has been painstakingly researched to portray a pattern of denial of care beginning with Johns Hopkins in 1972 and evolving through Yale-New Haven Hospital, Sonoma Conference, Infant Doe of Bloomington, Baby Jane Doe and the Neurosurgical Service at the University of Oklahoma. It is not a pleasant story but it needed to be accurately recorded before it was distorted further by the historical revisionists. The book should be read as investigative reporting and not as an in-depth evaluation of competing philosophies.

Caring for the Special Child is a brief compendium of papers related to the same issues raised by Manney and Blattner in Death in the Nursery. The selection of the papers is useful in helping us to understand why it took so long to achieve protection for handicapped newborns at the federal level. The book is apparently intended as a study guide. It is difficult to imagine a more undesirable way to introduce an uninstructed student to the topics covered in this book. The following germs of disinformation can be gleaned from the carefully selected materials:

1. Parents should always decide whether to exert maximal effort to sustain life. Doctors should be available to advise but parents will “act unselfishly” where life is at stake (AMA Judicial Council). In the city where the AMA headquarters are located, there were 250,000 reports of child abuse last year.

2. The “morally relevant” issue is not whether the retarded have rights but rather whether they impose unacceptable burdens on the family (Carson Strong).

3. The investigation of the Spina Bifida case in Robinson, Illinois was a “politically responsive prosecutorial threat” to a non-treatment decision (Paris and McCormick). The baby who was being neglected in Crawford Memorial Hospital was, as a result of the investigation, surgically treated, adopted, and now walks with braces in a loving home.

4. Intravenous or oral “forced feeding” should not be given to a child with meningencephalocoele, necrotizing enterocolitis, or a child with perinatal asphyxia who is not brain dead (Paris and Fletcher).

5. The number of babies born with handicaps has “doubled” in the last 25 years according to some unidentified “pediatricians and statisticians” (source unknown).

6. The real problem in the care of handicapped infants is that “ill-advised ‘right to life’” (quotes in the original) groups intervene inappropriately to reduce difficult moral choices to a “crusade of slogans” (Paris and McCormick).

7. In Great Britain, the problem of trying to save very small infants could be better addressed by “abortion reform.” The Swedes are wiser than the Americans because they do not try to save any baby under 750 grams (Young).

8. We should not try to save lives in which “the potential for human relationships is simply non-existent or would be utterly submerged and undeveloped in the struggle to survive” (McCormick). (Try to translate that statement into a useful guide for bedside decision-making.)

9. The federal government’s role was “well intentioned but heavy handed and has promoted only controversy and further confusion.” (Glaser).

If your view of the handicapped newborn controversy is that noble physicians were allowing hopelessly deformed infants to die until the federal government needlessly stepped in to demand inappropriate extra-ordinary care, then this is the book for you. Despite some useful chapters by John Robertson, the Bioethics Committee of the American Academy of Pediatrics, and the Sacred Congregation for the Doctrine of the Faith, the book is fatally flawed. It should be kept out of the hands of the young and impressionable at all costs. Companion video cassettes were not reviewed.

—E.F. Diamond, M.D.,
Professor of Pediatrics,
Loyola University

November, 1985
Current Literature

Imhof AE: From the old mortality pattern to the new: implications of a radical change from the sixteenth to the twentieth century. Bull Hist Med 59:1-29 1985

There has been a radical increase in life-expectancy in the 20th century compared with that in the preceding four centuries. This has not been an unalloyed benefit, however. In the past, death in the course of an epidemic was quick and merciful; in contrast, death "caused by today's chronic illnesses in old age... often means waiting for death for years." This has not been a good exchange. In addition and as a corollary, modern man has lost a sense of the eternal. Earthly life has become the only accepted aspect of human existence, whereas in the past "life was composed of a more or less important earthly phase and a much more important and longer other worldly, eternal phase."

"Along with the transition into the new mortality pattern we lost this vision... Life and death have become completely separated at the moment, they are two totally different things for us, hard to combine. As long as we are willing to accept only the first one and to reject the other, we will remain in an unsolvable dilemma...." Colbach EM: Ethical issues in combat psychiatry. Military Med 150:226-265 May 1985

The author, an American Catholic, has always believed in just war theory as articulated by Augustine and Aquinas. Specifically, he considered that the Vietnam conflict qualified as a just war. "And once having acquiesced to my role as a military psychiatrist, I then had to accept that my obligation to my individual patient was far superseded by my obligation to the military and, eventually, to my country. This is the main ethic of military psychiatry." Linacre Quarterly

Materials appearing below is through the kind interest of Linacre Quarterly of its moral, religious, or philosophical content. The medical literature constitutes the primary, but not the sole source of such material. In particular, abstracts are intended to reflect the substance of the original article. Contributions and comments from readers are invited. (E. G. Laforet, M.D., 2 St., Newton Lower Falls, MA 02117)


Among the problems associated with the AIDS epidemic are those of an ethical nature. These include difficulties of allocation of financial and other resources to AIDS research and treatment. Concentrating treatment and support of AIDS patients in specifically designated hospital wards is very efficient, but dehumanizing. Furthermore, the advent of the HTLV-III/LAV antibody test poses issues of confidentiality and of consent, and provokes the tension that exists between the rights of an individual patient and legitimate public health concerns.


There has been a long tradition in medicine that physicians and surgeons should be willing to hazard their own health if necessary in the care of the sick. The epidemic of the 1980s was the last significant occasion where this situation arose. However, the present AIDS epidemic raises similar problems. "Taking risks requires courage, and facing a danger that is direct and threatening is the highest test of courage." Assessing the moral obligation of a surgeon to operate on an AIDS patient and thus to risk his own health requires that the answer always be "conditioned by the particular set of circumstances involved."


An AIDS research project will involve some 200,000 healthy volunteer blood donors and will consist of screening for AIDS antibody. There are two major ethical problems associated with the program. First, should the results of the screening be conveyed to the donors? It would seem that both legally and ethically, full disclosure should be made. Second, should recipients of blood later found to be positive for AIDS antibody be told of this result? Legally, this must be done, and it would seem again that full disclosure to both donors and recipients is an ethical imperative.


Although collaboration between physician and philosopher in the hospital setting is no longer novel, certain objections of this liaison persist. These include (1) the redundancy and (2) disputativeness. As for the first, philosophers bring "a wider range of principles and categories" to clinical problems than do clinicians. With respect to disputativeness, it is conceded that moral discourse may impede the smooth course of decision-making in the hospital milieu, but nevertheless this may "enhance solidarity and patient welfare."


The traditional concept of informed consent, as articulated by bioethical and legal sources, has been that of a patient's right and a physician's duty. However, it is argued that the full concept also involves a right of the physician and a duty of the patient. In this view, the patient is not only entitled to decline information proffered by the physician in order to facilitate the informed consent process; rather, the patient has a right toward his physician to be knowledgeable about the planned treatment.


In the past, many patients hospitalized for psychiatric indications were treated without their consent or that of their surrogates. However, treatment decisions are now no longer validated on a paternalistic basis but are expected to be more egalitarian. Electroconvulsive therapy (ECT) is a case in point. Since liberty and freedom are now considered legal issues of the highest priority, the use of ECT will require inter alia the assessment of competency by interested parties, the obtaining of informed consent, and greater accountability by the medical profession to the public.


The above-cited article by Perloff raises at least three ethical issues. First, was the (Catholic) medical school acting unethically in withdrawing its acceptance of the physician who had performed AID in a lesbian? (No) Second, did the physician who discussed the patient's sexual orientation and his colleague's involvement in AID violate ethical norms? (Yes, he betrayed both the confidentiality due the patient and his professional relationship with her physician.) Third, did the patient's physician have a positive duty to initiate AIDS on her request? (No, because there was no clear medical indication for AID in this case.)
The psychiatric patient is already impaired by his disease in matters such as decision-making. In cases of severe mental illness, the psychiatrist must try to resolve ethical dilemmas of justice, autonomy, and beneficence. The Kantian ethical ideal involving a physician/patient contract may never be achieved in this situation. Paternalistic intervention may therefore be required since most mentally ill patients are not truly autonomous.

A historical overview of the phenomenon of the stigmata is presented. Attempts to explain the stigmas as symptoms of ill success. Psychological mechanisms may play a prominent role in their genesis. Whatever your beliefs, the study of the stigmata does typify the fascinating nature of physical, psychological, and spiritual phenomena.

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