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THE MIRACLE OF LOURDES

The Miracle of Lourdes by Ruth Cranston (New York: McGraw-Hill, 1955) has already received more than an ordinary amount of publicity. A brief pre-publication synopsis appeared in the November issue of *McCall's* and *Reader's Digest* for December featured a more detailed condensation. But this is a book whose full impact cannot be realized from any compressed version. To do justice to the author's most competent treatment of this difficult subject, every page of her remarkable publication should be read — especially by doctors, who are perhaps best capable of appreciating its significance.

Mrs. Cranston is not a Catholic nor is she a doctor. But in her months of research through the records of the Medical Bureau of Lourdes, she had the blessing and cooperation of both religious and medical authorities at the shrine, and has produced a volume which truly merits the commendation it received from Pietro Maria Théas, Bishop of Tarbes and Lourdes, and Dr. S. Oberlin, Surgeon of the Paris Hospitals and member of the International Medical Commission of Lourdes. Prospective readers can be assured that the book is the product of neither mawkish sentimentality nor airy skepticism. Not only is it impeccably reverent in tone and exquisitely courteous to Catholicism, but it is also an achievement of high professional competence.

The author has one predominant purpose, to present accurately and impartially the *medical facts* at Lourdes, "the greatest polyclinic in the world" according to one eminent physician. Of prime interest to doctors as scientists would be the structure of the two medical organizations, technically and financially independent of all ecclesiastical control, which record, evaluate, and interpret the thousands of case histories compiled at the shrine. The first is the Medical Bureau of Lourdes, staffed to a large extent by visiting doctors from all parts of the world. Catholics, Protestants, Jews, agnostics, infidels, schismatics, apostates — provided only that they are medically qualified, all are welcome. And all *de facto* come (to the number of over fifteen hundred in 1953) to take active part in the scientific on-the-spot verification or disproof of alleged cures. (It was the medical testimony of an agnostic doctor, notoriously hostile to religion of any kind, which finally convinced a Canonical Com-

mission of the genuineness of one more recent cure.) The higher echelon is represented by the International Medical Commission of Lourdes (AMIL) with headquarters in Paris and an active membership of five thousand doctors from some thirty countries. Its object is to guarantee further the scientific calibre of the work done by the Bureau by providing additional specialists, technicians, laboratory reports, and any other scientific paraphernalia necessary or useful for medically exact case histories. Not until medical science at its best has satisfied itself that a cure has certainly taken place, and that in the present state of science no natural explanation for the cure can be reasonably alleged, does the Church consider even the possibility that a miracle may have occurred.

The book is filled with astounding actual case histories selected by Mrs. Cranston from the medical files of the Bureau. But with remarkable and commendable restraint she contents herself only with fact, the type of fact which is a doctor's daily pabulum, and never theologizes beyond her capabilities. She does state her own personal convictions: "God is true, the miracles are true." But all that she asks of her readers is that logic be allowed to guide their own conclusions.

It has long since become hackneyed to say that any book is "a must." But any doctor who begins the unabridged version of *The Miracle of Lourdes* will find that professional curiosity alone will demand that he finish it.

MORALITY IS BROADER THAN THE CODE

Every now and then—just often enough to be somewhat disturbing — one encounters in a Catholic doctor the mistaken impression that our *Code of Medical Ethics for Catholic Hospitals* states explicitly the absolute totality of his moral responsibilities as a physician, and that any specific practice or procedure not expressly prohibited in the Code must therefore be permissible.[1] That perhaps is one of the inevitable disadvantages of an ethical code of any kind: of its nature it is liable to misinterpretation. As Fr. Gerald Kelly pointed out some years ago when his first booklet-volume of *Medico-Moral Problems* was published: "A code must be brief. . . . But this imperative need of brevity poses what seems to me one of the most important of our problems: namely, that a succinct statement of an ethical principle or a summary indication of its practical applications can lead to serious misunderstandings."[2] One such misunderstanding is the assumption just mentioned—that within the limits of a chart or a vest-pocket booklet one can expect to find an exhaustive and self-explanatory tabulation of a doctor's every moral right and duty. This is simply not so, and for several reasons.

First of all, as its title indicates, the Code is primarily a moral guide for Catholic *hospitals*, and consequently treats principally of that one phase of a doctor's life and practice. It is true that a physician will encounter elsewhere other problems of a medico-moral nature. But if these do not properly pertain to the care of hospitalized patients, it is not within the scope of the Code to deal with them specifically. That is one reason why certain abuses, recognized by the profession as unethical, receive no mention. Silence on such points as those by no means implies approval of patent abuses, but merely testifies to the restricted nature of our Code as a *hospital* directive.

Furthermore, any ethical guide for doctors should be for the most part a directive for morally *problematical situations*. In other words, it should be able to presuppose certain rudimentary and universally familiar moral principles, together with their more obvious applications, and restrict itself to that area where genuine doubts of conscience are more likely to occur. Is there any real need, for example, to remind Catholic doctors that it would not be right for them to charge exorbitant fees, perform surgery which is patently unnecessary, or to engage in other practices which any person with normal instincts and training would immediately recognize as unethical? To state such basic truths as these in our Code would be in most cases superfluous. Omitting them does not imply that we do not recognize the obligations they entail, but merely that their repetition is considered unnecessary.

And that leads to another reason for restricting the content of our Code: ours is a professedly *Catholic* directive. While we definitely do not maintain that Catholic doctors are subject to a more rigid moral standard than are their non-Catholic confreres, we do recognize the fact that Catholics *acknowledge* a higher standard than do many others. In that sense, therefore, there is such a thing as a distinctively Catholic code of medical ethics, one which begins where others leave off. Ours is predominantly that. Most of the points which it emphasizes are those on which our *acknowledgment* of universal natural-law principles distinguishes us from those who do not share the totality of our convictions. The fact that we do not include some items which are found in the profession's codes of medical ethics does not mean that we disagree with those canons or disparage them. Rather we presume that a Catholic doctor's professional integrity will be no less than that of others, and that his own conscience will dictate fidelity to the legitimate pledges which his profession has exacted of him.

There is one further point that should be kept in mind when one consults either the Code or the Directives. It is the one which Fr. Kelly no doubt had chiefly in mind when he wrote the passage cited above. Moral principles must be

[1] *Code of Medical Ethics for Catholic Hospitals* is a comparatively recent publication and is produced by Catholic Hospital Association in two forms: in an 11-page 4"x6" pamphlet and in a chart suitable for framing. It contains in highly compressed form the substance of the more familiar *Ethical and Religious Directives for Catholic Hospitals*. This latter booklet is now available in a second edition, revised and enlarged, and is indispensable as an aid to a full appreciation of the condensed Code.

[2] p. 3.

concise and impeccably precise, and the language of moral theology is often as technical as is that of medicine. The implications of a single word will many times represent the difference between theological truth and error, and those implications are not always immediately apparent to one who is not trained in theology. Even when moral principles are perfectly understood, their subsequent application to cases is an art in itself. Hence our Code is by no means self-explanatory or all-sufficient. It must be supplemented by more detailed explanation both of general principles themselves and of their application to concrete circumstances. That is the purpose of *Medico-Moral Problems* and of many of the articles which appear in LINACRE QUARTERLY. And when one realizes that even theologians, familiar as they are with the principles of their science, have welcomed much of that writing as a real contribution to moral theology, it should not be humiliating to any doctor to be reminded that there is much more to medico-morality than is self-evident in the Code.

RADICAL SURGERY

Of the questions which have come to me from doctors in recent months, a noticeable number have concerned the physician's moral responsibility in the matter of employing or advising radical procedures when, in terms of risk and ultimate lasting benefit, prognosis is less than optimistic. Perhaps for the benefit of those who may have missed or forgotten the original publications, it might be helpful to give two convenient references to information on this admittedly difficult moral problem.

The first is to an article written in collaboration by J. E. Drew, M.D. and John C. Ford, S.J., and published in *The Journal of the American Medical Association* under the title, "Advising Radical Surgery: A Problem in Medical Morality" (Feb. 28, 1953, Vol. 151, pp. 711-16). This discussion was occasioned by the case of a 7-month-old girl with sarcoma of the bladder. Because in previous cases simple cystectomy had been followed by local recurrence in the pelvis, pelvic exenteration (though not employed before on an infant with this disease) was considered to be the procedure most likely to succeed in this instance. The concomitant ethical question was twofold: would one be morally justified in undertaking pelvic exenteration on a child of that age; and if so, how should the case be presented fairly to the parents? The moralist's answer as contained in the article is perhaps as specific as could possibly be given; and I am sure that theologians in general would agree with Fr. Ford as to the circumstances under which procedures of this nature would be justified.

The second reference is to the fifth volume of *Medico-Moral Problems* by Gerald Kelly, S.J. On pages 6-15 Fr. Kelly explains in even greater detail the theological distinction between ordinary and extraordinary means of preserving life, a doctrine which is basic to the solution of the case proposed by Dr. Drew and Fr. Ford. Each of these two articles supplements the other, and in combination provide as complete an answer as the moralist can presently give to the question of radical procedures.

THE CANCER PATIENT AGAIN

Since publication in the last issue of LINACRE QUARTERLY of "What Must the Cancer Patient Be Told?," my attention has been called to still another article on the same subject, this one by a doctor.[3] Its thesis is that even for purely medical reasons many physicians should re-examine their policy of concealing the truth about cancer when patients ask for it. At least one point upon which that conclusion is based would seem to merit serious consideration.

As this article implies, medical education of the public has made tremendous strides in recent years. The intelligent layman is now much more likely to identify correctly certain specific symptoms and therapies with their respective pathologies. Certainly the "complete physical" and the periodic check-up, even in the absence of any palpable symptoms, have become rather commonplace, and people are no longer so prone to wait for unmistakable signs of cancer before consulting a doctor. Consequently the negative biopsy report in its turn is far less rare a commodity.

[3] Bernard P. Harpole, M.D., "To Tell or Not to Tell" in *Current Medical Digest*, 22 (April 1955), 61-63.

In view of these facts, the author asks two pointed questions: ". . . how can the patient distinguish between the sincerity of a negative biopsy report and the fraud of the well-intentioned dissembling of a physician who presumes to deceive his patient after diagnosis of cancer is established? In the same vein, how can a patient, intelligent enough to know he's been treated for cancer, by a doctor who prefers to tell him that his lesion is not malignant, ever have confidence in that doctor again?" His own answer assumes the form of a recommendation that "in view of the public's increased knowledge of medicine, physicians use greater care in recognizing the patients who have already faced and accepted the reality of their disease." He does not, of course, advise a policy of telling every cancer patient the entire truth.

Though the word *fraud* admits of a harsher meaning than perhaps the doctor intended, the basic point behind his observation is an entirely valid one. The confidence of patients in their physicians and in the medical profession is an item of no small significance. Destroy or weaken it, and the essential function of medicine is to that extent impeded. And since it is the doctor's right and responsibility to decide whether to share with the patient his specific diagnosis of cancer, this consideration should not be overlooked in reaching that decision.