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John J. Lynch

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It has been suggested that the Question Box be resumed in the pages of THE LINACRE QUARTERLY. *To include this feature regularly, we will need contributions from our readers. Rare is the physician who has not on occasion been confronted with a specific problem of medical ethics in which the application of general principles may seem uncertain. Although a correct answer may be secured promptly by appropriate consultation, physicians who have encountered such problems are invited to submit them to the Editor here. Answers will be provided from authoritative sources. It is hoped in this fashion to afford wider circulation for specific medico-moral problems and solutions, and to stimulate interest in this aspect of medical practice. Apart from queries regarding ethical problems, questions and comments of general interest to Catholic physicians are also welcome. Although identification of the writer is preferred, anonymity will be respected if requested.*

We are grateful to Father John J. Lynch, S.J., Professor of Moral Theology at Weston College, Weston, Mass. and medico-moral consultant to the Federation, who prepared material for this issue. He answers questions that have been submitted to him at meetings with doctors.

Q. In the relatively recent medical literature, Tes-Tape has received some little publicity as a simple means of determining concurrently the time of ovulation in the human female, and consequently as an aid to the more effective use of rhythm for avoiding or spacing pregnancies. Is there any moral objection against prescribing or using this device?

[Editor's note. — For abstracts of several medical reports on the subject, cf. THE LINACRE QUARTERLY 26 (November, 1959) 152.]

A. Judging from available information, Tes-Tape[1] is currently being recommended by some doctors for the immediate purpose stated above, viz., to detect with greater accuracy the occurrence of ovulation in a given individual. The knowledge thus acquired may then be used in either of two ways. On the one hand, the couple who are especially desirous of achieving pregnancy are better informed as to the optimal time for exercising their conjugal rights. On the other hand, a couple with good reason

[1] By private communication I am informed that an improved variation of Tes-Tape, viz., Fertility Tape, has recently been developed and is already available upon a doctor's prescription. A detailed report on this new product will perhaps already have appeared in the medical literature before these comments are published.

for avoiding or postponing pregnancy may simply refrain from marital relations during this known fertile period, and with greater confidence engage in them only during the ensuing sterile part of the cycle.

It need scarcely be said that Tes-Tape, when used by married women as a fertility aid, would be subject to no moral criticism. And when intended as a means for determining more accurately the so-called safe period, its use is as legitimate as is the practice of rhythm itself. In other words, those who are justified in employing rhythm for the purpose of avoiding or postponing pregnancy are by the same token justified in making use of this device calcualted only to make the practice of rhythm more certain of success.[2]

Pius XII can be quoted as having expressed the hope that medical science would one day perfect the rhythm theory to the point where it could be practiced with total confidence by those married couples who have valid reasons for avoiding conception even while periodically exercising their conjugal rights.[3] It would appear that Tes-Tape, and subsequent improvements thereon, show promise as a step in that direction, although it is not for the theologian to judge whether or not they represent the ultimate in accuracy to be achieved. However, it can be said without hesitation that in itself and as a helpful adjunct to the legitimate avoidance of pregnancy by means of periodic continence, the use of Tes-Tape and/or its variants is morally unobjectionable.

Q. A recent editorial in one of the medical journals discusses cardiac arrest and advises against the use of cardiac massage in such cases unless circulation can be restored within 3-5 minutes after the cessation of heart beat. The author argues — quite correctly, it would appear, from a medical viewpoint — that resuscitation after a longer interval will leave the patient permanently disoriented, comatose, even decerebrated, and with a relatively short life expectancy; and he concludes that no physician should want to restore a patient to life in such circumstances. Would such a thesis be morally acceptable?

A. It is usually very difficult to state universally and absolutely that a given medical or surgical procedure represents ordinary or extraordinary means of preserving life. Varying circumstances of individual cases cannot be ignored when attempting to reach this theological decision. Even with reference to cardiac massage, moralists would probably be reluctant to commit themselves *a priori* to a proposition which would designate this form of resuscitation as being always and without exception extraordinary means. But in at least the large majority of cases they would doubtlessly agree in classifying as extraordinary, in the theological sense of the term,[4] this attempt to prolong human life.

Certainly in the circumstances of the situation as described in the inquiry above, this conclusion would appear to be beyond question. If memory serves correctly, the editorial which is cited treated of cardiac arrest as it might be encountered in emergency admittances rather than of cases which might occur in the course of surgery. Hence the time element becomes especially significant, since it is most unlikely that thoracotomy and massage could be successfully accomplished within the time limit of 3-5 minutes after the inception of cardiac arrest. Hence prognosis in these cases would presumably be extremely poor and would not verify the element of "reasonable hope of substantial benefit to the patient" which is an essential part of the theological definition of ordinary means of preserving life.

It should be noted, however, that while patients are generally not obliged to employ extraordinary measures to prolong life, they nonetheless have a right to employ them if they choose and if such are reasonably available. Consequently, the decision to use or to forego extraordinary procedures is *per se* the patient's prerogative, though it is not one which in the circumstances he will be capable of exercising personally. If and when it devolves upon the physician — as it so often will — to decide for or against cardiac massage, he must make his decision, as best he can, in the light of what the patient himself would most likely want if he were able to express his rational choice. And it seems most likely that, if patients generally were aware of the common prognosis in these circumstances, few would choose to submit to cardiac massage after the 3-5 minute interval had elapsed.

Father John Connery, S.J., in a recent survey of the periodical literature in moral theology, discusses briefly the question presented here and reaches substantially the same conclusion: "From a moral viewpoint, cardiac massage after such an interval (and even before) would undoubtedly be considered an extraordinary means. While a doctor should certainly comply with the wishes of relatives if they request it immediately after the apparent death, I think he should advise against any such measures after the 3-5 minute interval has elapsed."[5] Such an opinion would appear to be eminently consistent with Pius XII's manner of speaking in his allocution of November 24, 1957, on artificial respiration of the incurable.[6]

Q. Who should make the decision regarding the administration of the "last sacraments"? Is this the attending physician's responsibility or that of the chaplain?

[2] Since the use of Tes-Tape and allied devices is so closely related to the practice of rhythm, the conditions required for the lawful use of rhythm should not be overlooked in a total discussion of the present question. Cf. Gerald Kelly, S.J., *Medico-Moral Problems* (1958 ed.) pp. 168-82.

[3] Address to the Family Front: On ethical aspects of marriage and childbirth. — *Acta Apostolicae Sedis* 43 (1951) 855-60. For an English version of the allocution, cf. *Catholic Mind* 50 (1952) 307-11.

[4] Cf. G. Kelly, S.J., *op. cit.*, pp. 128-41.

[5] *Theological Studies* 20 (December, 1959) 607.

[6] *Acta Apostolicae Sedis* 49 (1957) 1027-33.

A. Decisions concerning the administration of the sacraments are the responsibility and the right of the hospital chaplain or of some other priest in attendance. Because the proper administration of extreme unction requires that the patient's condition threaten some degree of danger of death, prudence will often suggest that the attending physician or a nurse be consulted on this point, or that one or the other spontaneously inform the chaplain or his *locum tenens* of the patient's medical status. But ultimately the decision to anoint is a priestly prerogative which others should recognize. Perhaps certain mutual misunderstandings in this regard could be avoided if one or two theological points were more generally understood.

First, the minimum danger of death which entitles a sick or injured Catholic to reception of the last sacraments is a relatively mild sort of thing, admission of which on the part of a doctor is in no sense of the word tantamount to his despairing of the case and signing the patient's death warrant. Provided only that there is solidly probable medical reason to believe that a patient may perhaps die as the result of his present condition — whether death be envisioned as an imminent or remote probability, and even though there are stronger reasons for believing that death will not ensue from the present malady — the minimum requirements for theological danger of death are verified and the patient is a physically apt subject for extreme unction.

Seminarians are commonly taught that a danger-list or critical-list designation is a fairly accurate rule-of-thumb when determining a patient's eligibility for the last sacraments. Doctors doubtlessly would agree that if a considerable number of patients so listed did not eventually recover, one of two alternatives would have to be conceded: either medicine as practiced in our hospitals would be exposed as inferior, or else the requirements for the danger list would have been proven unrealistically stringent. By much the same token, if approximately the same ratio does not recover after having been anointed, one can only conclude that too much by way of danger is being demanded before extreme unction is administered, and that some patients who are entitled to the benefits of this sacrament are being deprived of them.

If everyone concerned could be brought to understand that this minimum theological danger of death is something far short of certainly imminent death, doctors and patients as well would be much more ready to acknowledge the danger which theologians recognize as requisite and sufficient for valid and licit anointing.

And this leads to a second point on which misconception is all too common even among Catholics. Extreme unction (perhaps because of our unfortunate English transliteration from the Latin "extrema unctio"[7]) is too often considered as being exclusively a preparation for eternity, a sort of spiritual embalming process whereby the soul is prepared only for immediate transmission out of this world and into the next. Relatively few advert to the fact that this sacrament was designedly instituted by Christ Himself for still another purpose, viz., for the physical good of the recipient, even to the point of cure, if such be God's will. This is no magical effect, nor is it even miraculous in the technical sense of the term. But it is literally one of the purposes for which the sacrament was designed. Extreme unction is not exclusively (perhaps not even primarily) a preparation for death, judgment, and eternity; it is likewise intended and instituted by God as a spiritual and physical renovation in order that those who are presently seriously ill may, God willing, be restored to vigorous spiritual and physical life.

If one reads the ritual according to which this sacrament is administered, he should be struck by the significance of the fact that there occurs throughout the entire text only one reference to possible death — and that expressed in a conditional clause at the very end of the ceremony. All other prayers used in the administration of the sacrament request a restoration to health, both spiritual and physical. For anyone with faith who would read this part of the ritual thoughtfully, it would be most difficult to understand why some doctors and patients alike are so reluctant to take advantage as soon as possible of a sacramental therapy designed by Christ Himself for the very purpose to which a physician is professionally dedicated — the total healing of the sick.

[7] English usage gives to the word "extreme" an erroneous connotation of urgency bordering on the desperate. The more likely implication of the Latin "extrema" is merely that this anointing, in terms of normal chronological order, is the last of several which the Catholic would customarily receive in the course of a lifetime. We are first anointed with consecrated oil at baptism and again later upon reception of confirmation; for the priest, a third anointing awaits him at his ordination; and in the normal course of events there comes finally the unction of those who are seriously enough ill to be in some danger of death. It is "unctio *extrema*" only in the sense of being the last of several and not in the sense of being reserved until the very end of one's earthly existence.