The Linacre Quarterly

Volume 29 | Number 1 Article 8

2-1-1962

Current Literature: Titles and Abstracts

Catholic Physicians' Guilds

Current Literature: *Titles and Abs cts*

Material appearing in this column is thought to be of parti interest to the Catholic physician because of its moral, religious philosophic content. The medical literature constitutes the primary not the sole source of such material. In general, abstracts are inte to reflect the substance of the original article. Parenthetical edit comment may follow the abstract if considered desirable. Books reviewed rather than summarized. Contributions and comments readers are invited.

Blacker, C. P.: World population trends, *Royal Society of Health Journal*, 80: 236-237, July-August 1960.

The area or subcontinent in which population numbers are increasing fastest is South America. According to the medium assumptions, the population of South America will (if current trends continue) increase during the twentieth century by more than ninefold. By contrast, Europe's population will increase during the century by a little more than twofold. But pressure is not yet felt in South America as a whole.

Today, with the exception of Java, population pressures are somewhat a monopoly of the northern hemisphere. Java contains the bulk of the population of Indonesia (89 milion). Australia and New Zealand together hold some 13 milion people.

These matters have moral implications since such procedures as abortion and sterilization are held by many to be ethically unpermissible. Nevertheless they are now being widely practiced in the world and have to be mentioned in any account which aspires to realism.

— W.K.S.

CALLED BY WHATEVER name, human experimentation continues as the final arbiter of the therapeutic worth of drugs and surgical procedures. Since this is so, every physician must be aware of the moral responsibilities incurred in the care of the individual patient as well as in the advancement of medical knowledge. The sad recital at Nuremberg was the inevitable outcome of human experimentation unfettered by moral considerations. A recent paper **(Starr, I.: The testing of new drugs and other therapeutic agents, *J.A.M.A.*, 177:14-22, July 8, 1961)** indicates the impossibility of screening all new drugs in an ideal fashion before using them clinically. A certain minimum of studies, however, is necessary; these include determination of toxicity in animals and human as well as practical evaluation by experienced clinicians. In a related article **Beecher, H. K.: Surgery as placebo; a quantitative study of bias, J.A.M.A., 176 02-1107, July 1, 1961)** ethical aspects are dealt with more specifically. Far from questioning the morality of regulated human experimentation, this writer indicates that in certain circumstances the use of such experimentation may be unethical. "One may question the moral or ethical right to continue with casual or untrained new surgical procedures — procedures which may encompass no more than a placebo effect — when these procedures are costly of time and money, and dangerous to health or life."

Exton-Smith, A. N.: Terminal illness in the aged, *Lancet*, pp. 305-308, Aug. 5, 1961.

This study was undertaken to assess the pain and distress experienced by elderly patients during terminal illness. Two hundred and twenty geriatric in-patients were followed. Of the 220 patients, 30 (13.6%) complained of moderate to severe pain (i.e., pain not responding satisfactorily to aspirin or related analgesics) during their terminal illness. An additional 17 patients (7.7%) complained of other distressing symptoms such as nausea and dysphagia. Less than a quarter of patients dying of malignant disease had moderate or severe pain, and this was usually of short duration: patients with locomotor disorders, such as rheumatoid arthritis, experienced severe pain for long periods. The deterioration accompanying organic brain disease ameliorated the distress of many elderly patients. Awareness of the approach of death was present in at least one quarter of the patients. In most instances it was associated with calmness and lack of fear.

Goodykoontz, H. G.: Christianity and mental health, *Pastoral Psychology*, 11: 27-30, May 1960.

The goal of Christian education is more profound and more comprehensive than "peace of mind," or "release of tensions." Yet "subjective peace of mind" and emotional tranquility may and often do result from objective peace, i.e., the right relationship between God and man in and through Jesus Christ, in dependence upon the power of the Holy Spirit.

Christian education depends primarily on the family unit, and secondarily on the work of the Sunday School. The committed Christian is never free of all tension, because he is motivated by a "divine discontent" to struggle for a better and more brotherly world.

— T.J.T.

THAT THE fetus may show greater tolerance of maternal radiation than usually believed is suggested by two recent articles. In the first, a 40-year-old woman, 6½ months pregnant, received external radiation and radium implantation for histologically proven carcinoma of the cervix. The fetus was normal at the time of delivery and no evidence of radiation effect was noted during an 11-year follow-up period. After birth of the child, the mother received additional radiotherapy and was free of disease 11 years later. **(Ronderos, A.: Fetal tolerance to radiation; case report, *Radiol.*, 76:454, March 1961.)** The second case was that of a 22-year old woman with inoperable ovarian carcinomatosis who received intra-abdominal radioactive isotope therapy during an early unsuspected pregnancy. The child was delivered by cesarean section and at 6 months of age was normal in every respect. No tumor was identifiable in the mother at the time of abdominal delivery and she remains well. **(Ariel, I. M.: Radioactive isotope therapy for ovarian carcinoma; subsequent pregnancy and intra-abdominal radioactive isotope therapy during pregnancy, *J.A.M.A.*, 176:1117-1119, July 1, 1961).**

O'Donnell, T. J. (S.J.): Moral principles of anesthesia: A re-evaluation, *Theological Studies*, 21:626-633, December 1960.

Anesthesia, in its most generic concept, is described merely as the loss of feeling or sensation, especially loss of tactile sensibility. This includes many types, whether general, introduced by inhalation, ingestion, rectally, or by intravenous injection, or whether it be regional or local.

A valuable orientation in regards to anesthesia is found in the following quotations from Pope Pius XII's address to a Symposium of the Italian Society of Anesthesiology (February 24, 1957):

"The fundamental principles of anesthesiology, as a science and an art, and the end it pursues, gives rise to difficulties . . ."

"Within the limits laid down, and provided one observes the required conditions, narcosis involving a lessening or suppression of consciousness is permitted by natural morality and is in keeping with the spirit of the Gospel."

Moral theologians often study anesthesia under the same heading as inebriation, but when the idea of "for mere pleasure and without serious reason" is replaced by "not for the sake of mere pleasure but to avoid the serious evil," the moralists have no hesitancy in defending the liceity of general anesthesia.

In view of the advances in the art and science of anesthesia, perhaps it is time that the moral concepts of general anesthesia be taken out from under the principles of inebriation and evaluated on its own merits.

The voluntary deprivation of the use of reason, induced artificially and with the concomitant inability to regain it immediately, is still part of the picture. However, the morality of a specific clinical use of anesthesia should not be evaluated so much in the light of the reduction of consciousness but rather in view of a proper proportion between the clinical advantage of the anesthesia and the risk involved. Thus the moral issue of any particular case is left where it should be, namely to the competent clinical evaluation of the anesthetist.

— J.A.M.

Sidel, V. W.: Confidential information and the physician, *New Eng. J. Med.*, 264:1133-1137, June 1, 1961.

There is a long tradition that information obtained by a physician within the doctor-patient relation should be held inviolate. In certain circumstances this may conflict with a physician's duty to society, as when he must report a dangerous communicable disease despite his patient's request to the contrary. Difficulties of this nature are fairly easily resolved. However, there is a wide area in which

the physician may be faced with indecision. The problem is particularly apt to arise with confidential information obtained by a psychiatrist. A case is presented in which the revelation of information is considered to have been contrary to the ethical traditions of medicine. "I believe . . . that except under very special circumstances . . . the physician may best serve his patient by the strictest protection of his confidences . . ."

(Subject discussed editorially as "New Rules," *Med. Tribune,* p. 15, July 10, 1961.)

Cf. also: "MD dilemma: to tell, or not to tell," *Med. World News,* 2:30, 31, 34, Sept. 1, 1961.)

Calderone, Mary: Illegal abortion as a public health problem, *American Journal of Public Health,* 50:948-954, July 1960.

Since disease is defined as "any departure from the state of health," and is applicable equally to the individual or to the group, illegal abortion is a disease, for it is a departure from the state of health of the total society. Five facts should be taken into consideration regarding this problem.

1. In 46 states legal abortion is permitted to preserve the life of the mother; 3 states allow preservation of the health of the mother.
2. Interpretation of the law varies between hospitals within a city and between services in the same hospital.
3. Abortion is no longer a dangerous procedure.
4. Other countries such as France, Japan, and Scandinavia are having significant experiences with illegal abortion, which shows that unwilling pregnant women will obtain an abortion whether legally or illegally.
5. The figure for induced abortions in the United States is usually at one million yearly—one to every four births.

Solution to the problem is to be found in these areas: (1) make contraceptive advice, both natural and medical, freely available to all who desire it; (2) encourage, through early, continued, and realistic sex education, higher standards of sexual conduct and a greater sense of responsibility toward pregnancy; and (3) require doctors to report abortions and perhaps in time allow them to freely exercise their medical judgment in granting them. — W. K. S.

THE "QUESTIONS AND AN ERS" section of *J.A.M.A.* continues esent material of medico-moral inter Subjects recently discussed include Artificial Insemination" (177:663). hrosis and Pregnancy" (178:783), "I ations for Sterilization" (177:464), ontraceptive Diaphragm" (177:169 Fertility-Testor Kit" (177:171), an Vasectomy" (177:224).

Evers, H. H.: Indications for st lization in women, *Practitioner,* 18 68-174, August 1960.

Many women are being ab ed and sterilized for economic and soc reasons which would hardly be accep e under legal and moral scrutiny. Ev doctor should strive to keep this tructive operation to a minimum. In ovement in health and advance in me ne may well reduce the incidence of erity of some diseases at present rega d as adversely affected by childbear Widespread teaching of contracep should reduce the necessity for more ical procedures. It must be emphasi that in the psychiatric field, interfe ce with procreative faculty demands e utmost caution, for its ultimate reper sions on the mental state of the wom are difficult to predict and may be se s.

—R. J. T.

Legality of sterilization: A n outlook. *British Medical Journal,* pp 516-1518, November 1960.

The practical position in b English and Scottish law is that a su al operation is generally not a crime performed with the consent of the pati t. (Sometimes. as in cases of emerge consent may be implied.) However, the performance of some operations is harmful to the public interest; and the State, through the criminal law, deprives any purported consent to such operation of any validity in public law (though such consent would generally bar an action for damages at civil law). The effect of such a provision on its own, would be to make the operation in question totally illegal. The State, however, mitigates this effect by saying that, although the surgeon cannot rely on the patient's consent for immunity from criminal penalties, yet if he has that consent and there are also circumstances in which the individual interest (in life or health) may legitimately override the public interest, the operation is lawful.

— P.J.K.

Criminal law — manslaughter conviction for failure to provide medical aid to child because of religious belief reversed, *De Paul Law Review,* Spring-Summer, 271-275, 1960. Editorial comment on recent decision.

Under law parents have the duty to furnish necessaries to their children. This includes medical attention. But when failure to provide medical attention is due to religious conviction, it seems to be in a special category, at least in American courts. English courts, on the other hand, have treated neglect cases involving religious overtones in the same manner as those without these overtones.

In a recent case (Craig v. Maryland, 1959), a conviction of manslaughter was attained for parents who neglected to give medical assistance for their child who died. The defense contended they were conscientious believers in the Church of God and based their belief in divine healing. When their child became sick they cared for it in accordance with the teachings of the Bible.

The Court of Appeals reversed and remanded the case for a new trial, holding that the state's evidence was not sufficient to show that the gross negligence of the parents was the proximate cause of the child's death.

It would appear that though religion is held not to be a defense, it is nevertheless the best defense.

— N. L. C.

THE INTER-RELATIONSHIP between carcinoma of the breast and pregnancy is far from settled, but the effect of the latter has long been thought to be deleterious. However, in 1954 a paper appeared indicating that the lower gross survival rate of patients treated for mammary carcinoma during pregnancy or lactation may be due to delay in treatment rather than to the pregnancy itself. In addition, the gross survival rate in patients becoming pregnant after treatment of carcinoma was comparable to that in patients who did not become pregnant. Abortion was not shown to have any clear effect on the survival rate. **(White, T. T.: Carcinoma of the breast and pregnancy; analysis of 900 cases collected from the literature and 22 new cases, *Ann. Surg.,* 139:9-18, Jan. 1954).** A subsequent report contained substantially similar findings. **White, T. T. and White, W. C.: Breast cancer and pregnancy; report of 49 cases followed 5 years, *Ann. Surg.,* 144:384-391, Sept. 1956.)** More recently a paper has appeared based on 20 patients who became pregnant following treatment of breast cancer. the author stating that neither interruption of pregnancy nor permitting it to go to term affected the ultimate outcome. However, in some instances he would recommend therapeutic abortion. **(Brown, R. N.: Carcinoma of the breast followed by pregnancy, *Surg.,* 48:862-868, Nov. 1960).** When carcinoma of the breast is diagnosed during pregnancy, Montgomery believes that the pregnancy should be terminated promptly because of the rapid growth and metastasis that may occur. **(Montgomery, T. L.: Detection and disposal of breast cancer in pregnancy. *Am. J. Obstet. & Gynec.,* 81:926-933, May** 1961).

Tarumianz, M. A.: Professional ethics for the psychiatrist in the present day, *The American Journal of Psychiatry,* 116, No. 12:1115-1117, **June 1960.**

Although psychiatrists have not lacked definitely stated principles of professional ethics to guide them, it appears that the conduct of some members of the profession has led to questions and accusations suggesting possible violations of ethics. Special note should be taken of the following:

1. The costly training of a psychiatrist warrants higher fees, but unreasonably large fees or unwarranted claims for cures are certainly not ethical. Abuses along this line would be to guarantee, in return for an exorbitant fee, to cure a patient of a mental condition for which there is as yet no known cure or to promise to treat exclusively one mentally ill patient and receive a large fee on a regular basis. The dedication of a physician must be to render service to ill people rather than to make money.
2. Care should be exercised in the involvement of non-medical personnel in the treatment process, e.g., psychologists and other non-medical personnel dealing with persons suffering from mental and nervous disease and disorder should do so only under supervision by psychiatrists.
3. Violations of privileged communications must be avoided. Confidential information should not be given out, even for the good of the patient, without the patient's consent or that of a responsible relation or

guardian if the patient is incompetent. Sometimes, however, the good of society may demand the contrary. The physician must determine.

4. Since a psychiatrist treats mentally ill and emotionally disturbed persons who may misinterpret and misunderstand the physician's relationship with regard to them, the physician must constantly be on guard against any emotional involvement of a patient with himself.

— P. B. O'L.

THE FOLLOWING are additional items of interest:

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