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The Directives on Artificial Insemination

In recent years many books on medical ethics have included the text of our Ethical and Religious Directives for Catholic Hospitals. This has given rise to a great deal of criticism as first called to our attention by a bookreview that appeared in an influential clerical publication entitled The Australasian Catholic Record. After the publication of this book review, Father Kelly wrote an explanatory letter to the Editor of The Australasian Catholic Record. This letter, which was published in the Record for April, 1955 (pp. 162-63), is of considerable importance to all who use textbooks such as those by Father Kenny, Father McFadden, etc. The text of the letter is as follows:

"The October, 1954, number of the Record (pp. 360-62) carries a review of Medical Ethics, by John P. Kenny, O.P. The reviewer, while praising Father Kenny for basing his treatment of artificial insemination on the Allocution of Pope Pius XII, criticizes our own publication, Ethical and Religious Directives for Catholic Hospitals, for being 'a little out of date' on this point. The criticism is justified, since it is based on the Directives as published in Father Kenny's book; but it should be noted that this book does not give a complete picture of the Directives as actually and officially published by the Catholic Hospital Association of the United States and Canada. Since this matter concerns an official publication of a very large association of Catholic hospitals, and since this publication represents the fruit of painstaking collaboration of distinguished theologians and physicians, a further clarification seems in order.

"Ethical and Religious Directives for Catholic Hospitals is a code of concise statements concerning the proper moral and religious care of patients. It contains not only the directives themselves but also a number of explanatory reference notes. Had Father Kenny printed the reference note for the directive on artificial insemination, your reviewer's criticism might not have been made.

"The pertinent directive reads as follows: Artificial Insemination of a woman with semen of a man who is not her husband is morally objectionable. Likewise immoral is insemination even with the husband's semen, when the semen is obtained by means of masturbation or unnatural intercourse. Advising or co-operating in these practices is not allowed in this hospital. The pertinent explanatory note in the first printing of our booklet (March, 1949) gave this explanation: The statement in the code includes only the forms of artificial insemination that are certainly immoral. Other methods of insemination between husband and wife are still debated by theologians. For the English version of the text of the code, see Moral Aspects of Sterility Tests and Artificial Insemination, M.M.P. II. 14-22. (The Linacre Quarterly is the official journal of the Federation of Catholic Physicians' Guilds in the U.S.A. MMP is an abbreviation for our booklets entitled Medico-Moral Problems.)"

Yours, etc.

Gerald Kelly, S.J.

Linacre Quarterly

Sickness and the African

Edward M. Baskerville, M.M., M.D.

It has oft been stated that progress in Africa is hindered by three big problems: ignorance, poverty and disease. Unfortunately they are so closely interrelated that they present a formidable obstacle to anyone seeking to solve them. But one thing is certain: sickness in Africa presents an opportunity and a challenge to all who would heed the precept of charity. To approach it one must think not only in terms of sickness in general, but also of the problems peculiar to sickness in the African. And when I refer to the African, I refer particularly to the Luos, Bakuria and Basambiti who live in the vicinity of Kowak Mission.

First of all, the African is born into a relatively hostile environment where less than half of the babies reach their first birthdays. He is raised in the shadow of ignorance and schooled in the pagan practices of magic and witchcraft. He is fed a monotonously starchy diet of cereals supplemented by a few greens and a bit of meat. He has no knowledge of hygiene and is surrounded by poor sanitation. Even the use of the simple outhouse is ignored. Outside of the rainy season he is perennially short of water, and the surface water he must use is usually contaminated. He must work under a fierce tropical sun to wrest a precarious living from a poor, impov-
Finally, the African patient is passive and inclined to be disillusioned in his illness, and he is totally unable to associate his symptoms. As an example, he'll complain of sore glands in his armpit, but will omit any reference to the self-take of an amputated thumb to be transported to a modern dispensary. Lacerations present their own problems as demonstrated recently when an elderly African presented us with an amputated thumb to be replaced. It took a half hour's gentle persuasion on the part of Maryknoll's Sister Mary Agnes Jude, R.N., to convince this trustful and submissive patient, even if not entirely cooperative. Unhappily, in his sense, he has a fanatical faith in a "sandan," a hypodermic injection. One day I drove out into the veldt during the height of a cold epidemic in the African village. Sometimes manacled if he resists, an elderly African presented us with a typical picture of his present illness. In his words: "It is eating me." He still requested a hypodermic injection to ease his suffering.

Contrary to popular opinion the African has his mental problems too. Accurate diagnosis of these afflictions is most difficult while institutional care is woefully inadequate. A United Nations survey indicates that half of the African mental cases are of short or short duration. So today the mental patient is tolerated in his village, sometimes manacled if he resists, or shortly after arrival. But for those who arrive in good time there are no more love for the needle or blood than the white man. But he is always trusting, docile and submissive patient, even if not entirely cooperative. Unhappily, in his sense, he has a fanatical faith in a "sandan," a hypodermic injection. One day I drove out into the veldt during the height of a cold epidemic in the African village. Sometimes manacled if he resists, an elderly African presented us with a typical picture of his present illness. In his words: "It is eating me." He still requested a hypodermic injection to ease his suffering.

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It is apparent that medical care in Africa must be approached from a public health viewpoint. In this connection, Sister James Elizabeth, R.N. has recently opened a maternity unit at Kowak. In addition to providing the usual amenities, she will train young African girls in the basic principles of village mid-wifery. Also, a leprosy clinic has been initiated under Maryknoll's Sister Catharine Maureen, R.N. With limited facilities plus a high incidence of leprosy in this locality there is already a long waiting list. But for these efforts much remains undone. For example, no effort at all is made to cope with the problems of defective vision or impaired hearing. Dental care is unknown, and no one would dare to start doing tonsillectomies—the work would be endless. Practically every African baby presents a pot-belly with an umbilical hernia. But no one thinks of repairing these hernias—the Africans regard them as a thing of beauty and a joy forever!

In spite of all the problems in caring for the sick African the work has its compensations. Andre Paré, the great French surgeon, once observed that we merely tend the sick, that God heals them. In this we concur, but it is soul-satisfying work to be an active partner in the Divine Plan. And deep within the heart of every humanitarian worker in Africa lies the hope and conviction that among our African people will one day arise those dedicated workers to pursue the work and ideals which we are striving to establish. Such is the history of progress—and the missions!

Author's Note: For those seeking an introductory book on the subject of disease in Africa, the author recommends, The Sick African by Doctor Michael Gelfand, published by Stewart Printing Company, Ltd., of Capetown, South Africa, and to which the author acknowledges a debt for both inspiration and information.

THE WHITE MASS is scheduled for October 18 to honor St. Luke, Patron of Catholic Physicians. Plan to assist at Mass with your Guild for this special observance.

Doctors Ask These Questions

During the last decade I have given many talks to and conducted many informal discussions with medical students and doctors. On these occasions questions were usually asked, sometimes orally, sometimes in writing. I have kept a fairly accurate record of these questions, and I believe that other doctors besides those who presented the questions or listened to the discussion of them would be interested in seeing them.

I am giving here the questions that are most typical at doctors' meetings. To these I am adding a few that are rather unusual. Regarding the typical questions, I should like to make this preliminary observation: almost all of them are already answered rather completely in the booklets entitled Medico-Moral Problems. I have found, however, that many Catholic doctors either do not have these booklets or, if they have them, do not have time to read them. As for the unusual questions, these are generally not covered either in my booklets or in other texts on medical ethics. I am including them in my list, not merely because they are unusual and seldom answered in print, but also because they seem to have a special practical value.

1. Is a physician morally bound to tell a patient he is dying so that he may prepare properly for death? This question is answered here. It is answered in Ethical and Religious Directives for Catholic Hospitals, and in the Code of Medical Ethics for Catholic Hospitals. The pertinent text of both Code and Directives reads as follows:

"Everyone has the right and the duty to prepare for the solemn moment of death. Unless it is clear, therefore, that a dying patient is already well-prepared for death, as regards both temporal and spiritual affairs, it is the physician's duty to inform or to have some responsible person inform, him of his critical condition."

Proper understanding of this directive requires the consideration of many factors: hence a few brief observations are in order.

First, it should be noted that the directive concerns a real moral duty, binding in conscience. That duty belongs primarily to the physician because it flows naturally from the physician-patient relationship. But, as the directive clearly indicates, the doctor can fulfill this duty by having someone else communicate the required information, e.g., the chaplain, a special friend of the patient, etc. It seems to me, however, that it is seldom advisable for the doctor to use an intermediary. Doctors often have a special facility for giving this information—call it the "bedside manner" if you wish, or call it the