Medico-Moral Notes

John J. Lynch
ly were to be found in the nature of man and in man's outlook at that time, rather than in his beliefs. Ethnology shows us traces of magical thinking which impeded treatment and was the cause of the difficulties. This was more or less due to the spirit of the times rather than the belief of the individuals.

In early Christian times there were several notable establishments for the humane treatment of the mentally ill. One was the Monastery at Monte Casino where the Order of St. John of Jerusalem bestowed benign care upon the mentally afflicted. The earliest hospitals of which we know were founded by Innocent III and the leaders were instructed to provide humane care for the mentally sick in special sections of the city hospitals. This practice of establishing psychiatric wards in general hospitals is just now returning to vogue in these enlightened days.

The mental colony at Geel. Belgium which has its roots in the tenth century is still well known to us today. This colony which was under the protection of church authorities was founded upon the dedication of the towns people to the care of the mentally ill who came originally to pray at the Shrine of St. defenseman, herself the patron of the mentally ill.

The problem of mental disease is with us today as it was when Geel was founded. The hospitals are full to overflowing and the numbers of patients grow as the population increases in age and in size. The problem calls for a multidisciplinary approach. It's everyone's concern. The law, religion, medicine, science — all must join hands to help these patients for their suffering transcends physical illnesses, beliefs and other difficulties. It is not helped by the lack of understanding.

Following the example of Thomas Aquinas, we must take truth where we find it. Though truth is eternal, it may be approached from many directions and also it may be approached by means of various vocabularies. Pope Pius XII in giving direction to thinking regarding the relationship between psychiatry and religion at the close of a dissertation to the Fifth Congress of Psychotherapy and Clinical Psychology in April, 1953, said: "Be sure that We follow your research, your medical practice with warm interest and with best wishes. You labor on a terrain that is very difficult but your activity is capable of achieving precious results for medicine, for the knowledge of the soul in general, for the religious disposition of man and for his development. May Providence and Divine Grace enlighten your path." Just as this was said and the efforts were blessed on that occasion, so should we today assist in every possible way to help those who suffer from mental and emotional diseases.

(footnote: The above is included in Linacre Quarterly with permission of The Sacred Heart Program, the Voice of the Apostleship of Prayer, as Dr. Braceland's contribution to a series of radio programs commemorating the 40th anniversary of The Catholic Hospital Association, 1955-56.)
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 logically to occur.

It has long since become hackneyed to say that any book is "a must." But any doctor who begins the unabridged version of The Miracale 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—it occurs to me that 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. 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 imperious 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." 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 tabula-

The 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" x 6" 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. Pp. 3

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**February, 1956**
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. It concerns the rightness of conducting the treatment of cancer when 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, physicians use greater care in recognizing the patients who have already faced and accepted the reality of their disease.

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.

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.

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. 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.

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