MEDICINE

Abortion Notification Law

The March 9, 2006, issue of the *New England Journal of Medicine* featured a special article titled "Changes in Abortions and Births and the Texas Parental Notification Law." Texas began enforcement of a parental notification law on January 1, 2000, requiring physicians to notify a parent of a minor at least forty-eight hours prior to an abortion procedure. After the law was instituted, an 11 percent decline in abortion rates among 15-year-olds, a 20 percent drop among 16-year-olds, and a 16 percent drop among 17-year-olds were observed. There was a small increase in the odds for having an abortion after twelve weeks of gestation among those between 17.5 and 17.74 years of age compared to 18-year-olds. The overall birth rate was increased for this subset of minors, except for a small increase in second-trimester abortions for those between 17.5 and 17.74 years of age at the time of conception. Of interest, the rates of abortion among the older group of minors fell only for non-Hispanic whites and Hispanics. The rates for black minors in a similar group were unchanged. The authors suggest a greater awareness of abortion availability and communication styles among different racial groups as an explanation for these differences. The authors further state that the notification law induced a rise in unintended childbearing among the group of studied minors. Such a judgment seems value laden, since the authors did not investigate the reason for the decline in abortions, such as the potential for increased family or parental support once notification occurred. One can only speculate on the future opinions concerning parental notification which will be held by the hundreds of survivors spared from abortion since this law's enactment.

In Vitro Fertilization

The March 16, 2006, issue of the *New England Journal of Medicine* was remarkable for an article titled, "In Vitro Fertilization with Single Blastocyst-Stage versus Single Cleavage-Stage Embryos." E. G. Papanikolaou et al. present a study of

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351 infertile women under the age of thirty-six years who were assigned to receive either a single blastocyst-stage (day-five) embryo or a single cleavage-stage (day-three) embryo in transfer implantation. Early termination of the study was necessitated by the interim finding that a higher rate of pregnancy was achieved with blastocyst transfer. There was also a higher rate of delivery in the blastocyst transfer group. There was no statistical or clinically significant difference in the rate of multiple gestations in this group of relatively young women.

It had been postulated that single embryo transfer would reduce multiple-gestation pregnancies. Selective fetal termination is often the result when the mother is presented with the potential difficulties of a multiple-gestation pregnancy. Adverse outcomes associated with a high number of gestations include serious perinatal complications and long-term child development disabilities. The authors had shown that waiting to a later blastocyst stage for embryo transfer did not have any associated risk. Blastocyst-stage embryos have a lower proportion of chromosomal abnormalities, and afford a potential advantage in the long-run success of pregnancies achieved by in vitro fertilization. Yet all of this seems like the fine tuning of a medical procedure while missing the point that the entire business of in vitro fertilization is immoral. The unitive and procreative aspects of marriage are radically broken. The embryo is now in the absolute dominion of fertility scientists and doctors, and the tragedies of selective fetal reduction and the disposal of frozen embryos cannot be ignored. Based on the Congregation of the Doctrine of Faith's document *Donum vitae*, the *Catechism of the Catholic Church* (n. 2378) notes that "a child is not something *owed* to one, but is a *gift*." Furthermore, "the child possesses genuine rights [including] the right 'to be the fruit of the specific act of the conjugal love of his parents."

Gay and Lesbian Health Care

In the Perspective section of the March 2, 2006, issue of the *New England Journal of Medicine*, Dr. Harvey Makadon argues for improvement in the health care of lesbian and gay communities. Makadon is a primary care physician at Beth Israel Deaconess Medical Center and an associate professor at Harvard Medical School. Makadon is distressed by the lack of discussion of important issues following his own disclosure of his homosexual orientation to his new physician. He had expected, at the least, a dialogue concerning HIV testing or the need for hepatitis immunization.

Makadon cites the formalized Center for Disease Control preventative recommendations for homosexually active men. He also notes the Institute of Medicine's report on "Lesbian Health: Current Assessment and Directions for the Future." Makadon laments the lack of formal educational materials dedicated to the unique health disparities and risks of homosexual persons, and he makes a good case for the need to develop physicians' expertise in addressing these issues. He clearly is concerned about the medical care of patients with same-sex attraction. Although alluding to the psychological difficulties facing homosexual individuals, the essay's author steers clear of the controversies concerning the degree of mental distress in homosexuals. Dr. Richard Fitzgibbons, a prominent Catholic psychiatrist, in unison with the Catholic Medical Association, has much to offer in this highly controversial field. The Catholic Medical Association's statement "Homosexuality and Hope" is a solid reference for Catholic

physicians and health-care providers. As a Catholic physician, I have always tried to balance my obligations to care for those with same-sex attraction with compassion and respect, but never to endorse homosexual genital activity or the promotion of gay lifestyles and cultures. As physicians we are often called to this twofold task of accepting our patients despite their moral failings while never encouraging or promoting disordered or sinful behavior. Rather than entering the current political debate, which is based on a false notion of civil rights as expressed by gay activists, it may be wise for leaders in Catholic health care to educate the public on the downside of homosexual behavior, in both its psychiatric and physical manifestations.

Capital Punishment

The March 4–16, 2006, issue of *The Lancet* featured an editorial titled "Lethal Injection on Trial." The editorial first summarizes the current controversial use of the death penalty in the United States, including the recent Michael Morales and Tookie Williams cases. Recent data on the use of lethal injection of barbiturates revealed a large minority of cases demonstrating postmortem thiopental concentrations consistent with consciousness at death. It should be noted that many professional U.S. medical organizations, including the American Medical Association, American College of Physicians, and the American Nurses Association, oppose physician participation in state executions. In the recent Morales case, two anesthetists who had volunteered to observe the execution refused to monitor Morales's vital signs, since such activity could constitute cooperation in the act.

The more we continue to grapple with legal implications, the more readily Church teaching can assist in assessment. Although the Church does not exclude recourse to capital punishment to defend human lives against an unjust aggressor, it does *not* see such recourse as frequently necessary. Nonlethal means are almost always sufficient to protect the innocent from aggressors. The *Catechism* (n. 2267), quoting John Paul II in *Evangelium vitae* (n. 56), states that executions deemed absolutely necessary "are very rare, if not practically nonexistent." As a Catholic physician I could not, in conscience, cooperate in any way in an act of state execution. It violates not only my professional ethic but my commitment of faith to the dignity of human life. I only hope that the medical organizations mentioned above will join their opposition to the death penalty with an opposition to abortion and euthanasia. Such a move would be more intellectually coherent and restore greater credibility to their voices in the public discourse.

End-of-Life Care

End-of-life medical decision making is often difficult, and it becomes more so when the patient at the center of a discussion is incompetent or lacks basic decision-making capability. The accuracy of surrogate decision makers was systematically reviewed by David Shalowitz et al. in the March 13, 2006, *Archives of Internal Medicine*. An extensive literature review covering nearly forty years of published studies was the basis of their work. Nearly two thousand six hundred surrogate–patient pairs and one hundred fifty hypothetical scenarios were analyzed. Surrogates predicted a patient's treatment preferences with 68 percent accuracy. Surprisingly, prior discussions of patient wishes or patient designation of the surrogate had no effect on improving accuracy. Physicians fared worse than surrogates when a direct

comparison was made. The authors were disappointed by the relatively low correlation between surrogates and patients on treatment options. The variables of the presence of dementia or coma in this scenario lowered the correlation even further. As a practicing physician I did not find the conclusions of this study very surprising. Treatment preferences are often dynamic, changing as the course of illness progresses. Making decisions about hypothetical situations is fraught with serious limitations and unexpected turns. The best remedy is a patient–physician relationship based on trust. The Catholic patient is also well advised to choose a physician who shares the Catholic vision of mortality and ethics in health care.

Role of the Supreme Court in Medicine

The March 9, 2006, Perspective essay in the *New England of Medicine* by M. Gregg Bloche, M.D., J.D., is devoted to "The Supreme Court and the Purposes of Medicine." The author rightly points out that the Supreme Court has been involved in the intersection of law and the practice of medicine for some time. Cases concerning abortion, assisted suicide, and health-care rationing have all found their way to the nation's final arbiter of law. Bloche remarks that the Court has been giving greater deference to the medical profession's understanding of its own purposes. In the most recent example, the Court's rejection of the Bush administration's effort to block assisted suicide in Oregon through federal regulation of controlled substances is thought to be representative of this tendency. The court decided in *Gonzales v. Oregon* that the attorney general has no authority in deciding the purposes of medical care. As Justice Anthony Kennedy pointed out in the majority opinion, the medical profession, within the framework of state law, needs to establish its own "boundaries." Justice Antonin Scalia dissented, pointing out that the medical profession's social role is a matter of "public morality" and therefore can be regulated by the legislative branch. From an editorial standpoint, I sense that Dr. Bloche is concerned about the expanding role of public authority over medicine's morality. That is a legitimate concern based on the experience of the medical profession in Germany during the rise of Nazism. Far too many physicians at that time abandoned their traditional ethic and cooperated in atrocities. However, if medicine is dedicated to restoring the health and protecting the human dignity in each and every person, it has nothing to fear when public morality rejects partial-birth abortion, physician-assisted suicide, and passive euthanasia of the permanently infirm.

Avian Flu Vaccination

The legitimate concern about the possibility of an avian flu pandemic has not abated. I found some reason for hope in the publication of an article titled "Safety and Immunogenicity of an Inactivated Subvirion Influenza A (H5N1) Vaccine" in the March 30, 2006, issue of the *New England Journal of Medicine.* Investigators from a number of vaccine research centers contributed to this study of 451 healthy adults given intramuscular doses of subvirion influenza A (H5N1) vaccine at various strengths of hemagglutinin antigen. For nearly two months, the participants were followed for safety and also for antibody response. Encouragingly, no severe side effects were documented and slightly more than 50 percent of the vaccinated adults developed neutralizing antibodies of sufficient levels. Two doses of the vaccine were required to produce the desired effect.

The study suggests the possible availability of a protective vaccine for avian flu sometime in the future. Unfortunately, time delays from vaccine development to full-blown production can be substantial. My own hospital ethics committee is struggling with the ethical dimensions of a potential flu pandemic. The dilemmas of limited resources, sufficient volunteers, and the fulfillment of the duties of health-care providers are clearly at the top of the list. Furthermore, public responses to limitations in freedom, travel, and health-care availability are daunting. The University of Toronto Joint Center for Bioethics gathered a working group to study all aspects of pandemic influenza, and I would certainly refer the reader to their publications, which can be found at www.toronto.ca/health/pandemicflu. The consensus group seems to have hit the right chord. Transparency and a justice-based response from appropriate authorities will be paramount. In more classical terms, courage and fortitude will be required by all, especially those in the roles of service. The Church will undoubtedly play her role in the concrete delivery of charity in such a crisis, given her large presence in health-care delivery and works of social justice. Despite the significant professional competency and material support to be offered through the Church in a health-care disaster, Benedict XVI reminds us in his encyclical *Deus Caritas est* that "we are dealing with human beings, and human beings always need something more than technically proper care, they need humanity. They need heartfelt concern" (n. 31*a*).

Media and Stigmatizing Language

Public opinion on health-care issues is influenced by a number of different venues. Newspaper coverage is more trusted by the public than television. Therefore, the accuracy and style of print media in medical matters are critically important. The March 2006 *Mayo Clinic Proceedings* addressed this topic with an article titled "Evaluation of Stigmatizing Language in Medical Errors in Neurology Coverage by U.S. Newspapers," by Joseph J. Caspermeyer et al. Nine newspapers, including *The New York Times*, were analyzed for medical accuracy and for the reporters' use of language, to document stigmatizing descriptions and terms. Stigmatizing language was defined as wording that depicts the patient with a neurologic disorder as undesirable or socially unacceptable or as having less personal worth. The reviewers looked at neurologic disorders, including Alzheimer's dementia, Parkinson's disease, migraines, and multiple sclerosis. They found that 21 percent of all stories contained stigmatizing language, with reporters being the most common source of such language. Medical accuracy fared no better with a 20 percent rate of medical errors or exaggerations. Given the trust we have in news print media, this study was truly sobering. I am reminded that Blessed James Alberione—the founder of a number of religious congregations devoted to using modern means of social communication to spread the Gospel—required his followers to take a vow of fidelity to the Pope in matters of their apostolate. I should hope that secular reporters would take to a higher level their own commitments to getting the story right and avoiding personal bias.

Intercessory Prayer

The national press expressed great interest in a recent study detailing a large report examining the effects of intercessory prayer. The STEP (Study of the Therapeutic Effects of Intercessory Prayer) for cardiac bypass patients was published in the April 2006 issue of the *American Heart Journal*. Herbert Benson et al. per-

formed a blinded study of the effects of intercessory prayer on cardiac surgery patients. The patients at six U.S. hospitals were randomly assigned to three study groups: patients who received intercessory prayer but were told there may or may not have been prayer intercession; those who did not receive intercessory prayer but were told there may or may not have been prayer intercession; and those who received intercessory prayer and were told about it. Each group had about six hundred participants. The primary outcome was the presence of any complications within thirty days of coronary artery bypass surgery. Secondary outcomes were death and any major medical event.

There was no statistical difference in the outcomes based on the intervention of intercessory prayer, with both groups having complication rates slightly higher than 50 percent. In fact, the complication rate was slightly higher among those who were told about the prayer intervention. The prayer was provided by three Christian groups who began praying for a patient the night before surgery and continued for two weeks postoperatively. Needless to say, the main story line was the absence of scientific proof of prayer's benefits. One may be reminded of the biblical injunction of not putting the Lord to the test! I suspect if the study showed a strong correlation of prayer and medical outcomes many people's faith would be confirmed. Yet, faith is trust in things unseen. The *Compendium of the Catechism of Catholic Church* reminds us in question 573 that those who pray can be discouraged in the face of difficulties and apparent lack of success. To quote directly, "Humility, trust, and perseverance are necessary to overcome these obstacles." I will continue to pray for my patients' health in body and spirit.

Exercise and Alzheimer's

The multitude of benefits associated with exercise has just increased. In the January 17, 2006, issue of the *Annals of Internal Medicine*, investigators from the University of Washington reported their findings in an article titled "Exercise Is Associated with Reduced Risk of Incident Dementia among Persons 65 Years of Age or Older." In this prospective cohort study of 1,740 elderly persons, the development of incident dementia was assessed by twice-yearly follow-up. Those whose results in a cognitive screening test were in the lowest twenty-fifth percentile were excluded from the study. Baseline measurements were extensive and included physical function, cognitive function, lifestyle characteristics, health conditions, and exercise frequency. After slightly over six years of follow-up, a reduction in the risk of Alzheimer's dementia was seen in those who exercised three or more times per week. The sex- and age-adjusted hazard ratio was statistically significant at 0.62. In other words, there was a 38 percent reduction in the incidence of dementia over time. The authors pointed out limitations to the stud,y including self-reporting of exercise and a large number of regular exercisers at baseline. However, in my opinion, exercise has a biologic basis for reducing neuronal damage by its ability to reduce inflammatory mediators. Once again, we are also reminded of the classic Catholic teaching to exercise both mind and body. The late John Paul II was a strong advocate for sports and physical activity. Despite his advanced Parkinson's condition, those closest to him often commented on his remarkable clarity of mind, even in the last hours of his life.

Ideal Physician Behavior

Finally, the ideal physician is someone we all would like to have as our personal doctor. The March 2006 *Mayo Clinic Proceedings* included an article titled "Patients' Perspectives on Ideal Physician Behavior." Random telephone-based interviews of 192 patients who were seen in fourteen different medical specialties at the Mayo clinics in Minnesota and Arizona were used as a basis of the study. A number of ideal physician behaviors were identified by patients and were confirmed by their own quotes in the interview. The ideal physician should be confident, empathetic, humane, respectful, and thorough. These are all personal attributes that are desirable in any professional, let alone any human being. The training of new physicians must continue to emphasize these timeless virtues if the profession is to retain the trust and respect of those in need of medical care.

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