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The Burial of Fetuses

Rev. Thomas E. Simons
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FROM the time that the body of Jesus Christ was placed in a tomb to await His Resurrection, Holy Mother Church, has considered the burial of the members of His Mystical Body a serious and sacred act. In her legislation the Church requires that consecrated areas be set aside (Canon 1205) and securely guarded (Canon 1210) for the burial of the faithful, who in life were the temples of the Holy Ghost and who in death await their own resurrection from the dead. Canon 1203 of the Code of Canon Law clearly states the mind of the Church: "The bodies of the faithful must be buried and their cremation is condemned." This is the norm. Legitimate exceptions to this rule require a serious reason; e.g., the requirements of public health in time of pestilence.[1]

In the course of time cremation has also assumed an anti-Christian and heretical significance. Cremation is one of the indirect methods used in propagating materialism. It has been employed as an expression of contempt for the dignity of the human person and for Christian belief and hope in the resurrection of the body. The reverent regard for a human being in life, or of his remains in death is of the essence of Christianity. This reverent regard for a human being is something which is not restricted by his age, such as to the period only after his birth, or only after the age of reason, or only when he is an adult. There is Christian regard for a human being from the very first moment of his existence. And where an immortal soul is present, there is a human being who has an inviolable right to be so respected and so regarded by every other human being.

This article has particular reference to the burial of those human beings who die during the course of their uterine existence. They may be variously referred to by medical authorities insofar as they distinguish between ovum, embryo, fetus, and stillborn. In Pennsylvania the term "fetal death" has replaced the term "stillbirth" which was formerly used. (Act. 66, 1953 Penna. Legislature.) On p. 3 of this new Health Act "fetal death" is defined as follows: "Fetal death means the expulsion or extraction from its mother of a product of conception after sixteen weeks gestation, which shows no evidence of life after such expulsion or extraction." To a limited extent the terminology of the Pennsylvania Health Act in this regard follows the definition of "fetus" which is employed in canonical jurisprudence. We say "to a limited extent" because there is evidence here of a time limit, namely, "after sixteen weeks gestation." In canonical jurisprudence, fetus is referred to as "the product of conception at any and all stages of uterine existence, hence from the very moment of conception onward."[2]

Since a fetus is an integral human being, there is then no doubt as to the obligation of burial when a so-called "miscarriage" occurs.[3] The moral obligations in this matter may be summarized according to the *Ethical and Religious Directives for Catholic Hospitals*[4] as follows:

> n. 60. The normal manner of disposing of a dead fetus, regardless of the degree of maturity, is suitable burial. A fetus may be burned only if sanitation or some similarly serious reason requires it. In exceptional cases, there is no objection to retaining a fetus for laboratory study and observation; but it should not be preserved in its membranes unless it is so obviously dead that baptism would certainly be of no avail.
>
> (Note: It is imperative that all who are concerned with the disposal of a fetus should know and observe pertinent prescriptions of civil law. If there seems to be a conflict between the provisions of civil law and the instructions given here the matter should be referred to the hospital authorities for clarification.)[5]

There are certain difficulties connected with the burial of fetuses. These difficulties are of concern to cemetery and hospital administrators, physicians, and primarily, parents. A very practical difficulty in Pennsylvania was eliminated through the cooperation of the State Health Department. The difficulty was due to the fact that a cemetery could not accept remains for burial without a burial permit. It is not customary for the Bureau of Vital Statistics to issue such a permit unless a physician's death certificate is presented; and legally physicians have no obligation to issue a death certificate for those fetuses which are dead prior to sixteen weeks gestation. This difficulty was brought to the attention of the Department of Health in Harrisburg, and a ruling was obtained on February 20, 1956 to the effect that in such cases a burial permit would not be necessary. The Health Department also advised all local State Registrars concerning this matter.[6]

Catholic hospital administrators normally do not have a problem in this matter. They are familiar with the Church's teaching, and have regard for the human person. A recommended and practical Cath-

1 "It is the ordinary practice of cremation that is forbidden. For serious reasons, especially such as involve the public welfare, the Church allows cremation in particular cases." Abbo-Hannan, *Sacred Canons,* Vol. 2, p. 471.

2 *The Jurist* 7 (July, 1948) 307.

3 The most important consideration at such a time is the conferring of the Sacrament of Baptism. Attention is called to "An Instruction on Baptism" by Gerald Kelly, S.J. in *Medico-Moral Problems,* I, p. 48, published by The Catholic Hospital Association of the United States and Canada, St. Louis 4, Mo.

4 Published by the Catholic Hospital Association of the United States and Canada, St. Louis 4, Mo. (Second Edition, Nov. 1955)

5 In doubt concerning such reasons, hospital administrators should also have recourse to competent canonical and theological authorities.

6 Some such similar period is almost universally followed by various State Health Departments. This is purely an administrative ruling and not intended to define or delimit the morality involved. Secular references to "disposal" of fetuses by no means reflect, nor are they consistent with, Catholic teaching.

olic hospital procedure would be somewhat as follows:

1. All fetuses are baptized conditionally, unless it is definitely known that they have been dead for sometime; that is, days, weeks, or months; or, if the fetus is macerated.

2. Although parents have the responsibility of arranging for the burial of fetuses, the hospital usually assumes the responsibility in charity.

3. Signs of viability are recorded on the baby chart.

4. All fetuses are sent to the laboratory. Those that are baptized are so indicated and kept in a fitting container. The unbaptized are kept in a separate container. Periodically, a funeral director buries the fetuses in a Catholic cemetery. The funeral director is provided with a statement concerning the baptism of those who should be buried in consecrated ground.[7]

Catholic hospital administrators are also familiar with the Church's regard for the human person as revealed by the directives concerning the burial even of amputated members of the body. On this point ecclesiastical documents, text books, and Catholic periodicals are very clear concerning the decent burial of major amputated parts. If such is true concerning *members* of the body, it would be stating the obvious to emphasize again the importance of burial for an integral human being, since a ruthless disregard for a human being even in its fetal form by effecting its dissolution in either incinerator or commode is to be *condemned*

A study of birth statistics in the city of Philadelphia reveals that approximately only one half of Catholic births in hospitals occur in Catholic institutions. It is reasonable to suppose that in smaller communities where Catholic hospitals are in the minority the percentage of deliveries for Catholics is even less. Indications, therefore, are that the proportion of fetal deaths over which a Catholic hospital could legitimately exercise moral supervision for burial is not very great. The really small percentage of Catholic hospital supervision in this matter is further indicated by the fact that according to reputable medical authorities approximately ten to twenty per cent of pregnancies terminate in fetal abortion. This figure does not include estimates of "criminal" and of so-called therapeutic abortions.

When one considers the ultimate disposition of all fetal remains, regardless of period of gestation, actually only a very small percentage is being buried. Of the earlier gestation group, aborted at home, few are consigned to Catholic cemeteries. When the abortion occurs in the non-Catholic hospital, the fetus is usually sent first to the laboratory for examination and afterwards is disposed of, along with other pathological specimens, by means of incineration.

Even the late abortion, the premature or the full term so-called

[7] Hospital administrators normally have no difficulty in making these arrangements with a local funeral director. Where special difficulties exist they may appeal for advice and help to the Diocesan authorities and St. Vincent de Paul Conferences.

stillborn, is generally sent to the department of pathology. In Pennsylvania, in this latter group of pregnancies terminated after 16 weeks gestation, the parents, by signing a release or "disposal slip" automatically relinquish their right to the body and it then becomes the property of the State Anatomical Board. The Board may authorize an autopsy, or may designate the use of the body for some scientific research. When no longer needed, the remains are cremated.

Many doctors and nurses in these hospitals are of the erroneous opinion that "disposals" are autopsied and that the remains are buried in a cemetery by a funeral director under contract to the State. The bereaved parents are emotionally distraught and such expressions as: "You've never known the baby in life; why have a grave for the mother to visit and grieve over?" or "The baby will be suitably buried," have a telling effect. Believing that the purchase of a grave and funeral director's charges may be an expensive addition to their increasing financial worries, they may readily acquiesce to what seems like the logical thing to do.

As for the expenses of fetal burials, they are largely imaginary and over-rated. Catholic cemetery facilities are available without charge for Catholic families usually through the request of one's pastor in cases of financial stress. Funeral directors too usually are willing to be helpful at such a time. Since one would normally consult his pastor, if the miscarriage occurs at home, it is advisable to request his counsel concerning a funeral director and cemetery. In order to keep expenses at a bare minimum, funeral directors generally agree that fetal remains can be placed in a container with absorbent cotton and saturated with cavity fluid. With parental approval the fetus may then be kept in his establishment until the funeral director can conveniently bring the remains to a cemetery for burial.

Although the national trend is toward more and more hospital care, most early abortions occur at home. The responsibility for baptism and burial devolves upon the parents. However, it is the physician to whom they look for guidance, particularly the general practitioner and the obstetrical specialist. Any doctor might easily be confronted with an abortion, but it is the general practitioner to whom most parents turn at the slightest sign of trouble whether he is an obstetrician or not. He is in a position to advise them tactfully regarding the baptism and burial.

Recently in the Philadelphia Family Life Bureau's pre-marital instructions course, provision was made in the physician's talk to inform the young couples concerning the manner of identifying, baptizing, and burying an expelled fetus. Time does not permit during the instructions for lengthy and elaborate discussion regarding the physiology of abortion, etc. Furthermore, when dealing with large groups varying intellectually and emotionally, the aim is to avoid emphasis on the pathology of pregnancy. An attempt is made to tell the couples briefly how to dif-

ferentiate between blood clot and tissue; the appearance of a fetal sac, how to open it in a container of water, and how to recognize an embryo or fetus. The proper method of baptizing and burying fetal remains is then explained by the priest moderator, who shares the program and collaborates with the physician.

In any event, Catholics have a serious responsibility to follow the directives of the Church regarding burial. No attempt is being made to enjoin those who are not Catholics regarding burial of their offspring. However, the cooperation of non-Catholic physicians and hospitals is earnestly to be desired where Catholic patients are being treated. The personnel, even non-Catholic employees, in some of these hospitals frequently have misgivings concerning what they consider a ruthless disregard for a human being. Once this matter is tactfully called to the attention of hospital administrators, there is good reason to believe that Christian regard for the human person will include not only the fetal offspring of Catholic parents but of non-Catholic parents as well.

Many non-Catholics are instinctively in accord with the high regard for the burial of fetal offspring maintained by the Church. They realize that this tiny product of their union is their own flesh and blood. They are anxious, if it would be at all possible, to have their offspring baptized, for they also believe that baptism is necessary for the supernatural life of union with God in heaven. And it would be taking entirely too much for granted to conclude that they are not interested in providing decent burial.

In no small way the Catholic hospital can teach the correct moral procedure in this matter; first of all, by word in its training courses and staff meetings, and secondly, by example in its methods of practicing what it teaches. Particularly with the cooperation of its medical staff the Catholic hospital will be able to exercise an influence beyond the sphere of its service, if for no other reason than to prevent some of the heartaches and remorse of conscience which afflict many mothers whose fetal offspring went into an incinerator or commode.

Correct hospital procedure and good moral advice by physicians concerning the respect due even the remains of fetuses will be a challenging rebuke to some of the degrading materialistic practices so common in our time. Catholic hospitals, Catholic physicians, and Catholic personnel in other hospitals working together in upholding the dignity of the human person even in its fetal form will give expression to our belief and hope that being buried as members of Christ's Mystical Body, we shall with Him one day also rise glorious and immortal from the dead.

Father Simon's interest in this subject is asserted because of his association as Director of Diocesan Cemeteries of Philadelphia. Dr. Quindlen is an Associate in Obstetrics and Gynecology, Temple University Medical Center.

Doctor's Duty to Speak

T. Raber Taylor, A.B., LL.B.

Mr. Taylor, a frequent contributor to the ROCKY MOUNTAIN MEDICAL JOURNAL, *was invited to address the Medical Staff of St. Joseph's Hospital, Denver, Colorado, at their annual meeting in January. We believe his remarks will interest all of our* LINACRE QUARTERLY *readers.*

IT WOULD not be expected that a practicing attorney discuss medical questions. There are, however, legal concepts governing the relations of physician and patient that can be enumerated with profit.

Let us recall a few basic legal principles affecting the practice of medicine related to an ever timely problem — when does the word of the doctor or his silence help or injure his patient? We are not considering here the frequently and extensively treated question of medical secrecy — the doctor's ethical and legal obligation to his patient not to disclose to others information confided to him. Let us focus our attention on the problems arising from the practice of his profession with the help of speech or keeping silent.

Before the birth of Christ, the artful use of speech or its opposite — silence — and the proper amount of each challenged the physician. Publius Syrus, a Roman Advocate, when counseling physicians and others, set forth these maxims: "I have often regretted my speech; never my silence. Keep the golden mean between saying too much and too little." Conscious of such good counsel, most of our doctors strive to keep the golden mean. They strive to observe their professional ethics to "neither exaggerate nor minimize the gravity of a patient's condition." They seek to assure themselves that their patients have such knowledge of their condition as will serve the best interests of the patient and his family. (Chapt. 2, Sec. 3 — Prognosis, *Principles of Medical Ethics,* 1955 Edition)

Other doctors, however, have treated their patients behind the dark shield — "what they don't know won't hurt them" or "ignorance is bliss." This dark shield has been examined by the American Medical Association in an opinion - sampling survey and by others in several popular and professional articles. The A.M.A. survey reported that many people, 46 per cent of the laymen and 47 per cent of the medical profession, complained that most physicians are not frank enough with their patients. Last summer the *U. S. News and World Report* article asked, "Should Doctors Tell All?"[1] The *Saturday Evening Post* article answered, "Doctors Should Tell

1 *U. S. News and World Report,* July 13, 1956, p. 104.

the Truth."[2] In his inaugural address, Dr. Dwight H. Murray, President of the A.M.A., met the charge that doctors do not tell the truth to their patients. He urged them to take a new approach. "The patient," he said, "has a right to know."

A few physicians continue their accustomed non-disclosure. They believe that frankness with patients is dangerous. They point out the danger to the patient who, if he knows all, may lose his will to live when he hears he is seriously ill. Another mentioned danger is telling too much to the patient who lacks the emotional stability to take bad news. Some doctors say that distraught individuals, on learning the blunt truth, have committed suicide.

Long before the A.M.A. opinion survey doctors, moralists, and lawyers have been thinking and writing about the duty to speak. To mention a few, Dr. Charles C. Lund of the Harvard Medical School has an excellent article entitled "The Doctor, the Patient and the Truth."[3] Father Gerald Kelly, S.J., known to many of you as the author of the booklets *Medico-Moral Problems,* includes in this series an excellent chapter, "Should the Cancer Patient Be Told?"[4] The most extensive legal study has been made by Hubert Winston Smith, M.D., LL.B., and professor of legal medicine, first at Harvard Medical School, and later at the University of Illinois. His work is entitled, "Therapeutic Privilege to Withhold Specific Diagnosis from Patient, Sick with Serious or Fatal Illness."[5]

The question is asked, "Is there a legal duty to be frank with patients?" The legal answer, like most medical answers, is not an unqualified one. Doctors seek from lawyers an automatic rule-of-thumb legal prescription. At the same time, the doctor is conscious that a specific prescription to serve the patient's best interests is usually required in medicine.

The legal prescription or answer depends upon the facts in each case. The cases, however, divide into two groups. In the first group are the patients with a curable or controllable ailment. In the second group are the patients whose illness is fatal.

How does the doctor usually decide when the law requires him to speak and when to be silent? A review of our fundamental law will give a general guide and answer. Such a review can properly begin with our Declaration of Independence. It expresses the first and fundamental principles of our law. It is the beginning and source of medical law. The principles are found in these familiar words:

> We hold these Truths to be self-evident, that all Men are created equal; that they are endowed by their Creator with certain inalienable Rights, that among these are Life, Liberty, and the Pursuit of Happiness. That to secure these Rights, Governments are instituted among Men, deriving their just powers from the Consent of the Governed; . . ."

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[2] *Saturday Evening Post,* June 16, 1956, p. 23.

[3] 19 Tenn. L. Rev., 344, April 1946.

[4] Gerald Kelly, S.J., *Medico-Moral Problems,* II, 7, The Catholic Hospital Association, St. Louis 4, Mo.

[5] 19 Tenn. L. Rev., 349, April 1946.

We see here the three key philosophical and ideological concepts—

First, All men are created and endowed by their Creator with inalienable rights.

Second, Man's right to life is Creator endowed.

Third, Consent is given to Government to secure this right to life.

These concepts indicate that physicians, like government, are to make secure man's right to life. And, like government, physicians derive their authority from man's consent. The doctor receives his authority, if any, from the patient's consent and desire to secure his inalienable rights. These rights are: to have life, to have necessary care, and to ask others to see to his welfare. These rights the patient receives directly from the Creator, not from another man, or a staff of men, nor from the State, nor from any political authority.

The right of the physician to treat requires the prior consent of the patient. Consent means *with knowledge*. The law imposes an obligation on the patient, *once he has chosen his doctor,* to give full information and a full opportunity to the doctor to treat the case. On the other hand, the law imposes on the physician a two-fold personal duty: (1) to explain to his patient the general purpose, extent, and risks, if any, of the prescribed treatment or operation, and (2) to be reasonably certain the patient understands and then freely consents. The law will find the physician breaching his duty if he obtains the patient's consent to treatment or operation by concealment or half-truths.

For the treatment of a curable or controllable ailment, however, not only is the patient's consent needed, but the patient's intelligent cooperation is, for his best interests, necessary for successful therapy. The physician knows best how true this is in the case of the cardiac, the diabetic, the epileptic. The doctor has an obligation to instruct the patient in some detail as to the nature of the ailment and the precautions and the regimen which must be followed. The law finds that a doctor breaches his duty when he fails to give the patient proper instructions as to the care and attention calculated to effect a cure. (Beck v. Klinck, 78 Iowa 696.)

This rule of law does not mean that the doctor must explain all the details of his diagnosis and share them with the patient. The guiding rule of law, as well as medicine, is to use speech and silence just so far as they help the patient. Frequently there are details of a diagnosis or a prognosis that need not be disclosed, either because they would be of no particular benefit, or because through misunderstanding or exaggerated anxiety on his part, the words would injure more than do good. A doctor's anxious face and evasive silence can also injure. In every case the physician has the responsibility of prescribing the measure of speech and silence that will be for the best interests of the patient and his family.

The law imposes on the physician the duty of acting with the

utmost good faith toward the patient. If the doctor knows he cannot accomplish a cure or that treatment adopted will probably be of no benefit or of little help, he must so advise the patient. (Logan v. Field, 75 Mo. app. 594.) In a recent case a doctor has been held liable to a patient for costly deception by holding out false hopes of recovery which induced the patient to undergo expensive treatments he should have known were useless.

The second group of cases involves speech and silence with the patient fatally ill. In abiding by medical staff constitutions and by-laws, the physician is bound to give his moribund patient every benefit possible. This obligation is summarized in the *Ethical and Religious Directives for Catholic Hospitals.*[6] Directive 7 reads:

> 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 impart this information.

Different words have been used by lawyers when they express what is summarized in this directive. Louis J. Regan, legal adviser to the California State Medical Society and frequent contributor to the *American Medical Association Journal,* in his booklet *Malpractice and the Physician,*[7] says:

> It is extremely doubtful that a physician has a therapeutic privilege to withhold a specific diagnosis from a patient who is sick with serious or fatal illness. To the contrary, the confidential relationship requires in ordinary circumstances that the physician make a frank and full disclosure of all the pertinent facts to any adult and mentally competent patient.

Hubert Winston Smith, M.D., LL.B., in his work on "Therapeutic Privilege to Withhold Specific Diagnosis" tells us:

> There is another principle to be borne in mind from a legal point of view: in all such cases, the physician should make it a practice, wherever possible, to communicate the true facts immediately to near relatives. This will enable special arrangements to be made in respect to financial affairs, property matters or family dispositions, almost as effectually as if the individual himself knew the truth. Finally, it would seem that the attending physician, in late stages of such a malady, should do what he can to assure the patient of a chance to make a last will and testament and to have the solace and comfort of religious ministrations.

Again we are confronted with the practical question, how much speech and silence must be prescribed for a patient suffering from a fatal illness? The patient has a right to know the truth. All lawyers will agree that a doctor may not breach his duty to his patient through deceit or a lie. The doctor's duty to tell the patient of his critical condition so he can put his worldly and spiritual affairs in order does not require the doctor to disclose all of the diagnostic data in detail, nor to tell him the precise nature of his illness. A doctor may reasonably presume that a patient does not desire knowledge which would injure rather than help, but the doctor may not rely upon this presumption contrary to the patient's known desire for full knowledge.

Dr. Dwight Murray and many other physicians and surgeons believe that the vast majority of people have the emotional stability to take the shock of bad news. In their professional experience they have found that withholding information may cause the patient greater worry than knowledge of the truth. Dr. Lund tells us, "Almost always it does more good than harm to tell the patient who is in a hopeless situation the truth about his prospects. This must always be done gently, and perhaps indirectly." He further tells us that a question to the patient as to whether he would like to see his clergyman or to make his will is usually sufficient. Following such a suggestion, the patient often asks a direct question and is entitled to a direct answer.

A patient's knowledge of a fatal illness may depress him to a point of attempted suicide. However, Dr. Walter Alvarez of the Mayo Clinic reports, "In forty-odd years of practice I cannot remember anyone's committing suicide because I told him the hopeless truth. Instead, hundred of persons thanked me from their hearts and told me I have relieved their minds."

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[6] Second Edition, Catholic Hospital Association, St. Louis 4, Mo.

[7] J. A. M. A., 147, 54-59, Sept. 1, 1951.