# EPILEPSY IN CANON 984 AND MODERN MEDICAL THERAPY

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IT HAS been observed from time immemorial that some people are subject to fits or, to use a scientifically more acceptable terminology, "suffer from seizures." The nature of such seizures varies considerably, with regard to their duration, intensity, frequency, pattern, controllability, and cause. Some such episodes of an unpatterned nature are classified simply as "seizures," while others, whether the cause of them is known or not, follow one of several recognized patterns and are called "epileptic seizures." The victim is known as an "epileptic" and the disorder is called "epilepsy."

Epilepsy becomes a canonical entity in virtue of can. 984, 3°, which establishes an irregularity for sacred orders in those who are, or who ever have been, victims of epilepsy, insanity, or diabolical possession. The purpose of this article is to re-examine certain historical, clinical, psychologic, and prophylactic aspects of epilepsy which touch upon the disease as a canonical entity, and in the light of these considerations to re-evaluate the circumstances in which dispensation from the irregularity would seem to be indicated.

## HISTORICAL ASPECTS OF EPILEPSY

The history of epilepsy is as old as the history of medicine—indeed, as old as the history of man. Pagan antiquity believed that seizures were a punishment for offending the gods, and that the affliction was visited especially upon those who offended against the moon. The word "epilepsy" is derived from the Greek *epi* and *lambanō*, reflecting the belief that the victim was thought to be "seized upon" by the gods, and the affliction was also called "the sacred disease."[1]

Hippocrates (460–375 B.C.), or one of his school, wrote a treatise on epilepsy and attacked this concept. As a matter of fact, Hippocrates quite clearly seems to have recognized the disease as a disorder of the central nervous system. Five hundred years later Galen (131–201 A.D.)

[1] Cf. Harry Wain, *The Story behind the Word* (Springfield, 1958) p. 108.

likewise recognized that an affection of the brain was the basic cause of epilepsy and, in the primitive medical concepts of his day, listed the ingestion of powdered human skull as one of the remedies.[2]

Hippocrates, of course, and Galen after him were fighting a losing battle against the naive theories and atrocious therapies of early medicine. As medicine emerged from the darkness preceding the dawn of history, and down to the eighteenth century, therapy was based on a theory of combating adverse humors with everything from fresh air and water, through doses of the blood or liver of criminals, stones from a hawk's intestines or the gall of a boar, to concoctions of various herbs and minerals which were thought to have some therapeutic value for reasons no more scientific than that ascribing some value to mistletoe as a remedy for epilepsy: i.e., mistletoe grows in oak branches, cannot fall to the ground, and so must be effective against the falling sickness.

And so for thousands of years epilepsy was a fairly meaningless pattern on the warp and woof of folklore and fantasy, and, as Lennox points out, an epileptic who approached the Harvard Medical Faculty in 1850 would have received about the same treatment, based on the same scientific flickerings, as if he had approached Hippocrates some twenty-two hundred years before.[3]

The first significant medical break-through for epilepsy occurred around the middle of the nineteenth century when the English physician Samuel Wilks (1824–1911) introduced bromide of potassium to control seizures. The next major development in therapy came with the introduction of phenobarbital by Alfred Hauptmann as a new pharmacological approach to seizure control, more efficient than bromide and with less undesirable side effects. Hans Berger gave neurology the electroencephalogram in 1929, and deflections of a pen moving along a paper strip and recording electrical discharges of the brain down to millionths of a volt opened new horizons in the study of epilepsy. In 1937 Putman and Merritt, in the United States, discovered the anticonvulsant action of diphenyl hydantoin (Dilantin), and since then there has been a steady advance in the development and testing of new compounds for more efficient control of epileptic seizures. And

[2] Cf. William G. Lennox, *Epilepsy and Related Disorders* (Boston, 1960) p. 23.
[3] Cf. *ibid.*, p. 32.

as neurologists study the control of seizures from the pharmacological approach, neurosurgeons investigate the feasibility of surgical intervention in the area of the epileptic electrical explosion in the brain.

In even so brief a historical view of epilepsy, its concepts and its treatment, one cannot omit some comment on the matter from a scriptural viewpoint. The exegetical problem of epilepsy and diabolical possession in the New Testament cannot be solved here, but neither can it be ignored. That the problem is germane to this study is evident from the fact that modern medical writers cannot resist the temptation to wander into the theological field even if, in doing so, they leave their exemplary critical approach behind.

Many such authors simply see the pagan deitistic approach to epilepsy transferred, as just another superstition, into a Christian demoniacal approach. This concept, without distinction or qualification, is then extended through the history of the Church and even projected upon the present canonical concept of the disease. Lennox, for example, makes the statement that in the Middle Ages epileptics were considered to be diabolically possessed, and he supports the implication that this was the official ecclesiastical view by the assertion that epileptics made pilgrimages to churches.[4] The same writer's reference to the juxtaposition of epilepsy and diabolical possession in can. 984, 3° is thinly veiled when he says: "Schools with denominational or religious background should be more receptive [of epileptics], except of course certain theological schools that seem to retain the conception of the epileptic as demon-possessed."[5] There are two questions implicit in these statements which, although indeed not unrelated, need to be dealt with separately.

The question, whether or not epilepsy has been confused with diabolical possession in the New Testament, is brought to focus by the account in the Synoptics[6] of the young boy, brought to our Lord by his father, who is referred to by various commentators as a lunatic, a possessed boy, or an epileptic. There is no doubt that his symptoms as described in the text—alternate spasm and rigidity, labial froth, gnashing of teeth, convulsions and catalepsy followed by fatigue—present the clinical picture of a grand mal epileptic seizure. Yet our

[4] Cf. *ibid.*, p. 1039. [5] *Ibid.*, p. 948.
[6] Mt 17:14–20; Mk 9:14–29; Lk 9:37–43.

Lord seemed to address Himself to the disease as to an evil spirit. And even if this were to be construed as merely a way of speaking, there is still the mystery of His answer to the disciples' query as to why they had not been able to cure the boy: "As for this kind [of devil] it can be cast out only by prayer and fasting."[7]

This is a problem which must be left to further investigation by the Scripture scholars. It might only be pointed out here that it would be surprising to find the Evangelists endowed with medical knowledge available only in more recent times, or to find the apostles free from erroneous or superstitious beliefs regarding illness which were common in their time. Such errors would certainly not be inconsistent with the divine inspiration of Scripture. On the other hand, in view of our Lord's reported remarks on this occasion, the exclusion of the possibility that this case was one of epilepsy *and* diabolical influence would seem to be judging beyond the evidence. These questions, however, must be left to their own fields of specialization.

## THE CANONICAL QUESTION

Even a cursory reading of the medical, legal, and sociological literature related to epilepsy leaves no doubt that the wording of can. 984 has frequently given rise to serious misunderstanding in the minds of the laity.

It will be recalled that this section of the Code lists twenty-one impediments affecting the reception of sacred orders or the exercise of orders already received. These twenty-one impediments are divided into three numerically equal groups. The first two groups are referred to as "irregularities," and the third group is called "simple impediments" (can. 984–987).

The irregularities are further distinguished in their respective canons as arising *ex defectu* (can. 984) or *ex delicto* (can. 985). It is the irregularities *ex defectu* that are germane to this study, and precisely those personal afflictions listed under numbers 2 and 3 of can. 984 which would make the exercise of sacred orders either unsafe or unseemly, and would hence likewise be a contraindication to the reception of orders. These afflictions have been further classified by the commenta-

[7] Ferdinand Prat, S.J., *Jesus Christ* 1 (tr. John J. Heenan, S.J.; Bruce, 1950) 429.

tors as *defectus corporis* (can. 984, 2°) and *defectus animi* (can. 984, 3°). Epilepsy appears under the latter classification.

Can. 984–Sunt irregulares ex defectu:

2° Corpore vitiati qui secure propter debilitatem, vel decenter propter deformitatem, altaris ministerio defungi non valeant. Ad impediendum tamen exercitium ordinis legitime recepti, gravior requiritur defectus, neque ob hunc defectum prohibentur actus qui rite poni possunt;

3° Qui epileptici vel amentes vel a daemone possessi sunt vel fuerunt; quod si post receptos ordines tales evaserint et iam liberos esse certo constet, Ordinarius potest suis subditis receptorum ordinum exercitium rursus permittere. . . .

It should be noted that the afflictions listed under can. 984, 2° give rise to irregularities which continue only as long as the afflictions persist, and these are called *defectus corporis* by the commentators. On the other hand, the afflictions listed under can. 984, 3° give rise to irregularities which persist even after the affliction has ceased, and these are called *defectus animi* by the commentators. It is, in turn, this grouping, classification, and distinction of perpetuity which has led some to assert that the Church still recognizes an intrinsic relationship between epilepsy, insanity, and diabolical possession.

Such an assertion is totally unjustified, and the canonical grouping, classification, and distinction of perpetuity in can. 984, 2° and 3° is in no way unreasonable.

This is neither to assert nor to deny that articulate individuals in the early Church shared some of the erroneous medical and sociological ideas current in their time. But as far back as the documented sources of canonical legislation take us, there is no strong evidence of any supposed intrinsic connection between epilepsy and diabolical possession. On the contrary, the *Fontes* make it clear that for the past two hundred years, at least, there has been little hesitation to dispense from the irregularity incurred by epilepsy, even though the disease is still present, provided there was reasonable indication that the patient could perform ecclesiastical functions safely and decorously.[8] Not only would this not have been true if epilepsy were being identified with diabolical possession, but interestingly enough these documents show that the Holy See was completely abreast of current medical opinion

[8] Cf. *Codicis iuris canonici fontes* 4, n. 1444; 6, nn. 3929, 4040, 4041, 4047, 4087, 4333.

all the way, basing its decisions primarily on the testimony of physicians, even to the extent of including some minor medical errors current at the time (e.g., that the disease entity was not chronic but caused by strain and overwork, was curable, and that relapse was improbable).[9] Moreover, the same fundamental attitude towards epilepsy is indicated in the history of the early Church. There is evidence of recognition of the distinction between epilepsy as an organic disease and diabolical possession as a malign influence in the twelfth century and even, indeed, as far back as the fifth century.[10]

Secondly, the classification introduced by the commentators embracing can. 984, 2° and 3° as *defectus corporis* and *defectus animi* respectively is reasonable. The gross symptoms of the afflictions listed under 2° present themselves as predominately physiological, while those of 3° have been viewed as predominately psychological. The Code is using the terms without implying any scientific or clinical significance.

Finally, the fact that insanity, epilepsy, and diabolical possession, already grouped together under can. 984, 3°, are erroneously thought to have been viewed as pathologically interrelated because of their classification as *defectus animi*, does not imply that they should not be grouped together at all. The irregularities (by defect) which are listed in 2° and 3° of this canon are simply certain dispositions of body, of mind, or of both, which would make the exercise of sacred orders unsafe or unseemly. The three defects listed in 3° have this common denominator which distinguishes them from the defects listed in 2°: each represents a personal affliction in which the mere subsiding of symptoms does not necessarily imply that the affliction has been permanently overcome. In general, we might say that the more predominantly physical defects of 2° constitute quite evident irregularities when they are evidently present in the individual, and hence the irregularity endures only as long as the defect persists. If perchance, on the other hand, the defect were to cease, then it would be quite evident that it had ceased and there would be no danger, in general, that it would arise again.

With regard to the defects listed under 3°, however, the danger of

[9] Cf. *ibid.*

[10] Cf. Charles de Clerq, *Traité de droit canonique* 2 (ed. R. Naz; Paris, 1954) n. 281.

a recurrence is much more difficult to exclude, and hence the legislator has adopted a very realistic view in constituting the irregularity as present if an individual has ever been afflicted with one of these three defects. This by no means implies that, after the defect has evidently disappeared, the irregularity cannot be dispensed, but it does wisely insure that each individual case will be studied, and expert testimony regarding the prognosis will be sought, before the irregularity is dispensed. This is an evident common denominator—common to insanity, epilepsy, and diabolical possession—which makes the grouping together of these three afflictions quite reasonable, without implying any intrinsic relationship among them.

## MODERN MEDICAL OPINION

Subsequent to these considerations it is appropriate to review, at least in summary form, the present medical thought on epilepsy, in order to re-evaluate the significance of the disease as a canonical irregularity and to suggest some basic criteria for dispensation.

Several interesting concepts arise from the modern medical literature. First, it is evident that there is no satisfactory scientific definition of epilepsy. It has come to be looked upon as a "waste-basket diagnosis"—a receptacle for a number of similar sets of symptoms, many of which are clearly identified, others of which may or may not belong there but are put there for want of a more specific classification. Authors refer to "the epilepsies." Denis Williams says: "Scientifically all fits are epileptic, and yet all who have fits are not epileptics."[11] In other words, all convulsions can be called epileptic seizures, but when the convulsions are due to clearly identified causes, such as a rise in body temperature (febrile convulsion), a drop in blood sugar (hypoglycemic convulsion), or toxic urinary products (uremic convulsions), the patient is not an epileptic and does not "have epilepsy."

Merritt, in attempting to define epilepsy as a functional disorder characterized by recurrent attacks of loss of consciousness with or without convulsion movements, points out that "this definition is inadequate because convulsion movements may occur without any

[11] Denis Williams, "Modern Views on the Classification of Epilepsy," *British Medical Journal* 101 (1958) 660–62.

obvious loss of consciousness and loss of consciousness may occur without any convulsive movements."[12]

It may be said in general that convulsion and/or loss of consciousness are two of the usual reactions of the nervous system to overwhelming stimuli. If the source of the stimulus is well identified as being outside of the brain area (such as uremia or hypoglycemia), the subject of the disorder is not said to have epilepsy. If, however, the stimulus which initiates the seizure is due to a definable brain lesion, the patient is said to have "symptomatic epilepsy." If the seizure is of unknown origin but recurrent in an identified pattern of electrical discharges in the brain, the patient is said to have "essential epilepsy." Regarding the latter type, some of the medical synonyms for "essential" are "of unknown origin," "idiopathic," and "agnogenic."

There are several possible ways of grouping various forms of epilepsy for classification, aside from the broad division between essential (cause unknown, heredity-suspected) and symptomatic (due to organic lesion) already mentioned.

Another common classification used by neurologists divides the epilepsies according to type of seizure. This classification according to seizure type may be summarized as follows:

1) Motor seizures: associated with stereotyped muscle movement. The most common of these is the grand mal seizure, characterized by generalized convulsions and loss of consciousness. Another type is the focal motor seizure, which begins with a twitching or jerking of one part of the body and may then proceed in a characteristic march or progression to other parts of the body.

2) Psychomotor seizures: these differ from the above in that, instead of a convulsion, there is a pattern of organized but irrelevant behavior, such as tapping movements or repetitive gestures, temporary mental confusion, plus illogical and sometimes hostile behavior.

3) Momentary disturbances of consciousness, such as the short lapse or brief fixed stare of petit mal, or fainting episodes, which may sometimes foreshadow a grand mal epilepsy.

4) Other miscellaneous types of seizures, such as feelings of familiarity or unfamiliarity which contradict experience, or disturbances of sensation such as taste, smell, and hearing.

Still another broad classification of the epilepsies is made according

[12] H. Houston Merritt, *A Textbook of Neurology* (2nd ed.; Philadelphia, 1959) p. 672.

to the nature, intensity, and duration of the seizures together with their characteristic EEG recordings. The most common and broadest division here is between the above-mentioned grand mal and the petit mal seizures.

The grand mal seizure is what people most commonly recognize as an "epileptic fit." About half of these patients experience, briefly, a sensation or "aura," which warns of an imminent attack. Lennox points out: "The patient whose aura is prolonged enough so that he can lie down or seek seclusion is fortunate, but rare."[13] After this warning sensation, usually only momentary if present, the patient emits a shrill cry, followed by loss of consciousness and generalized spasmodic twitching. During the convulsion, saliva (mixed with blood in the event of tongue-biting) is blown from the mouth, there may be fecal or urinary incontinence and, rarely, ejaculation. Attacks vary in duration from less than a minute to more than thirty minutes; in severity, from violent convulsion to simple fainting without apparent convulsion; in frequency, from many in the same day to one in several years, and may occur at regular intervals or may disappear entirely for many years, only to begin again. After an attack, mental confusion may be present for hours or, rarely, even for days.[14]

Petit mal, on the other hand, has been called the epilepsy of childhood, with onset rarely after the age of twenty, although it may or may not persist into adult life. In the typical petit mal seizures there is no convulsion. The seizures are of briefest duration, the patient is out of contact with the environment for a moment or two, and the usual attack consists only in a brief fixation of gaze and blankness of expression which would usually not even be observed by others. The patient is immediately alert again and continues previous activity. Petit mal seizures may occur only occasionally but often are very frequent—sometimes many in a day or even in a single hour. These seizures are more common on arising in the morning, and likely to be less common during periods of physical activity. They may coexist with grand mal seizures or may be followed by grand mal epilepsy in later life.[15]

The other two types of epileptic seizures are categorized according

[13] Lennox, *op. cit.*, p. 176. This is interesting because in at least one case in the *Fontes* a factor in the petition for dispensation was that the particular patient experienced a prolonged aura, thus giving him ample warning of a seizure.

[14] Cf. Lennox, *op. cit.*, *passim*; Merritt, *op. cit.*, *passim*.

[15] Cf. *ibid.*

to the localized area of the brain where the initial erratic electrical discharge is initiated. For the purposes of this study it is sufficient to say that those associated with lesions of the motor cortex (motor-focal seizures, Jacksonian seizures) are analogous to grand mal attacks, while those arising from a disturbance in the temporal lobe (psychomotor attacks) are somewhat like exaggerated petit mal seizures.[16]

As knowledge of the nature and treatment of epilepsy has advanced in recent years, certain clinical observations which modify older concepts or crystallize new knowledge are emerging in the medical literature. Some of them which are pertinent to the canonical evaluation of epilepsy will be reviewed briefly here. These are the questions of mental deterioration and psychotic manifestations in epilepsy and the "epileptic personality," the prognosis in childhood and adult epilepsy, and the control of seizures by modern drug therapy.

A considerable amount has been written in the medical literature regarding the question, whether or not there is a progressive mental deterioration concomitant with the disease entity of epilepsy and whether or not the term "epileptic personality" as a label for manifestations of stubbornness, combativeness, introversion, intellectual limitation, and the like, is an added affliction likely to be identified in most epileptics. There is no doubt that in earlier decades judgments such as these were formed from observation of epileptics and found their way into the literature as accepted hypotheses. More recent studies, however, have questioned the scientific validity of these judgments.

Houston Merritt, for example, observes that the impression is widespread that mental deterioration is inevitable in epilepsy, but he attributes this impression to the fact that the studies supporting it were compiled from institutionalized cases, and he reports the findings of Lennox revealing that of 2000 clinic and private patients 67 per cent were mentally normal, 23 per cent slightly deteriorated, and only 10 per cent definitely deteriorated.[17]

Lennox himself likewise observes that several decades ago both physicians and the general public had a distorted view of epileptics in this regard because conclusions were based on observation of institutional cases, and that although brain damage may result from prolonged

[16] Cf. Merritt, *op. cit.*, pp. 679–82. [17] Cf. *ibid.*, pp. 684–85.

seizures or trauma, mental limitations or undesirable personality traits may result from causes quite outside the disease entity. In considering even the small segment of the epileptic population so affected, one must take into account the social isolations and repressions, the depressive and deleterious side effects of previously popular anticonvulsive bromides and barbiturates, and organic abnormalities of the brain which in these cases may rather have been the cause than the result of seizures.[18]

The controversy regarding mental deterioration and the "epileptic personality" is not yet settled, but it can be safely said that the views of Merritt and of Lennox reflect the more common modern medical opinion.[19] This newer concept might be summarized in the following quotations from Lennox:

> Tradition would have it that both the frequency of attacks and the mental state become worse with time. As shown elsewhere, the first of these assumptions is contrary to facts; the second is true only in a minority of cases and even in these there may be factors other than the epilepsy itself to account for the mental slowness.[20]
>
> Among persons who have no evidence of brain lesion antecedent to the epilepsy, some will experience intellectual decline after a few years or a few dozen convulsions, others will traverse decades of time and thousands of convulsions without evidence of mental loss.[21]
>
> Disuse of the words "epileptic personality" is one encouraging event in present day medical history. . . . Today we can say with confidence that the characteristics named are not confined to epileptics, and that when they do occur they are not cause but consequence, and not the consequence of epilepsy *per se* so much as of brain damage that either antedated the epilepsy or, rarely, resulted from it.[22]

Houston Merritt summarizes his conclusions in this regard with these significant words: "Abnormal personality traits are uncommon in patients whose seizures are controlled by treatment and are able to engage in the useful activities of life."[23]

In view of all this and the many similar expressions in the medical literature, it may safely be said that, in evaluating the controlled epi-

[18] Cf. Lennox, *op. cit.*, pp. 662–64 and *passim.*

[19] See also James F. Hammill, "Epilepsy," *Journal of Chronic Diseases* 8 (1958) 448–63; Francis M. Forster, *Modern Therapy in Neurology* (St. Louis, 1957) p. 418.

[20] Lennox, *op. cit.*, pp. 666–67. [21] *Ibid.*, p. 684. [22] *Ibid.*, pp. 699, 692.

[23] Merritt, *op. cit.*, p. 685.

leptic as a candidate for sacred orders, the generalized medical anachronism of future intellectual deterioration or personality problems related to epilepsy may be discounted in the absence of positive indication to the contrary.

It is generally agreed among the medical writers that once a pattern of epileptic seizures has been well established for a number of years, the chances of a total and complete disappearance of the disease, in present medical concepts, are poor. This does not mean that complete spontaneous remissions do not occasionally occur, or that a large percentage of patients cannot be symptom- and seizure-free with proper medication systematically sustained. Authors observe in this regard that spontaneous remissions have been known to terminate in seizures after ten or twenty years, and that seizures which have been completely cured by medication for several years may recur if the medication is withdrawn.

It is fortunate that, in general, the grand mal seizure, which is most dramatic and disconcerting, is the seizure type most amenable to medication control. Merritt's statistics can be considered both sound and representative, and he reports his experience as follows:

> Grand mal seizures can be controlled in 50 per cent of the cases, and the seizures greatly reduced in frequency in another 35 per cent; petit mal seizures are controlled in 33 per cent and 33 per cent are greatly improved; 28 per cent of the patients with psychomotor seizures are controlled and another 50 per cent are greatly improved.[24]

This same acknowledged expert in epileptic disorders spoke realistically of modern therapy in his presidential address to the American Neurological Association in Atlantic City (June, 1957):

> It cannot be said, however, that medical therapy is satisfactory, as yet. No one of these medications is effective in all types of seizures and no one of them is one hundred per cent effective in any one specific type of seizure. . . . The ultimate look, however, is promising, and it would not be rash to predict that . . . it will not be long before a compound is synthesized which will control the seizures in the majority, if not all cases.[25]

And so it is evident that the clinical picture of modern therapy must not be oversimplified. While it has been established that a high per-

[24] *Ibid.*, p. 699.

[25] *Transactions of the American Neurological Association* (Richmond, 1958) pp. 1–6.

centage of epilepsy can be controlled, there are still many cases in which this goal has not been reached. Nor is it possible to determine with certainty within which group an individual patient will fall.

The clinical picture which gradually emerges in those cases of particular interest to the canonist is perhaps best described by another recognized specialist in the field. Howard D. Fabing points out that each individual patient has a basic seizure pattern, and that as effective treatment gets underway this pattern ameliorates in all respects. In the successful therapy the amelioration progresses to a complete cessation of attacks. Then, when the physician has studied the individual patient over a reasonable period of time, he is able to determine the effectiveness of the therapy and on the basis of his total clinical impression he may well be able to certify that recurrence of seizures is unlikely and the danger of such recurrence is remote if treatment is continued.[26]

Incidental to a review of modern medical data and opinion with regard to the predictability of the course of this disease in various types of patients, it is interesting to recall a common point of canonical interpretation with regard to childhood epilepsy. The opinion is set forth and accepted among many canonists that if an individual was afflicted with epilepsy before the age of puberty and, at the time of candidacy for orders, good medical opinion attests that the disease entirely disappeared, the candidate is not irregular *ex defectu* because of his earlier epilepsy.[27] This opinion, arising from pre-Code legislation, represents a judgment of practical wisdom which is certainly safe to apply in practice, in spite of the fact that contrary exceptions are within the realm of possibility.

Regarding infant seizures, Merritt points out:

> It is generally agreed that the occurrence of seizures in young children with febrile illnesses does not necessarily presage the later development of epilepsy but the likelihood of this eventuality is great if the seizures recur with every febrile illness, if there are multiple seizures, or if there are paroxysmal abnormalities in the electroencephalogram in the seizure-free interval.[28]

[26] Cf. Howard D. Fabing, "Practical Considerations in the Management of the Epileptic Patient," *Journal of the Indiana State Medical Association* 40 (1947) 132–34.

[27] Cf. Francis Suarez, S.J., disp. 40, sect. 1, n. 4 ff.; Alphonsus de Liguori, C.SS.R., 8, 39.; Pietro Gasparri, *De sacra ordin.* 1, n. 278.; Felix M. Capello, S.J., *Summa iuris canonici* 2 (Rome, 1951) 268; T. Lincoln Bouscaren, S.J., and Adam C. Ellis, S.J., *Canon Law and Commentary* (Milwaukee, 1946) p. 378; *et al.*

[28] Merritt, *op. cit.*, p. 692.

In a very true sense, the criteria which will be proposed later in this study for evaluating the epileptic candidate for orders in relation to possible dispensation of the irregularity will be little more than a prudent extension of this long-standing canonical judgment in view of the recent medical data and advanced methods of therapy.

Without entering into a lengthy technical explanation of the modern pharmacological approach to seizure control, the following comments on the treatment of epilepsy are germane to the present study.

The array of modern drugs with their varying formulae is formidable. The most common, known best by their trade names, are Dilantin, Mesantoin, Tridione, Paradione, Phenurone, Mysoline, Milontin, and others which may have been tested and marketed since this writing. After study and observation, the physician tailors the therapeutic regimen to the individual patient, some drugs being more effective than others in various types of seizures, some which are effective in one type being actually aggravating in other types. The most widely employed are, perhaps, Phenobarbital and Dilantin, used independently or in combination.

The drugs in common use today are, for the most part, free of remarkable side effects in their proper dosage, are not habit-forming or addictive, and are not unduly expensive. The cost of such therapy might range from as low as $30.00 to as high as $150.00 per year. In most patients the medication is reduced gradually over a period of years and may even eventually be discontinued entirely.[29]

In addition to the drug therapy, there is little restriction of activity indicated for the epileptic. The amount of rest needed is that which is indicated for any normal individual. Sensible physical and mental activity need not be curtailed and indeed act as a deterrent to seizures. The diet is not specialized but the use of alcohol is controversial.[30] In general, however, physicians would impose restrictions on their epileptic patients with regard to immoderate drinking, with regard to some sports which are more liable to cause brain injury (such as boxing), and with regard to those occupations in which a seizure might endanger their own lives or the lives of others—particularly automobile driving.

[29] Cf. Forster, *op. cit.*, pp. 382–422.

[30] Cf. Virginia A. Duggins, *Epilepsy* (a pamphlet published as a guide for epileptics by the Federal Association for Epilepsy, Washington, D.C.).

This latter restriction will receive subsequent special attention in this study.

### LEGAL RESTRICTIONS ON EPILEPTICS

A quotation from a Connecticut court case of 1905 supplies a background against which some of the twentieth-century civil legislation regarding epileptics may be viewed: "That epilepsy is a disease of peculiarly serious and revolting character tending to weaken mental force, and often descending from parent to child, or entailing upon the offspring of the sufferer some other grave form of nervous malady is a matter of common knowledge, of which the courts will take judicial notice."[31]

The first civil law prohibiting the marriage of epileptics was passed in Connecticut in 1895. In the subsequent forty-four years, eighteen other states followed suit, North Carolina being the last in 1939. In the last twenty years, many of these laws have been mitigated or abolished, so that by 1960 only eight states retained such laws.[32] There are, however, in addition to these, other states without such statutes but within which fraudulent concealment of epilepsy is considered grounds for annulment. Moreover, more than half of the states have eugenic sterilization laws, and in not a few of these the laws apply specifically to epileptics.[33]

Comment on the morality of laws restricting the marriage of epileptics and implementing eugenic sterilization is outside the scope of this study. It might be noted parenthetically, however, that while a genetic factor in epilepsy is not to be totally discounted, it apparently has been vastly overrated.[34] Moreover, the recent trend in the medical literature is to regard eugenic sterilization laws as unscientific and unwarranted, and indeed likely to do more harm than good to the human race.[35]

Regarding restrictions relating to military service, it is interesting to

[31] Gould vs. Gould, 61 A. 604, Conn., 1905.

[32] Cf. Lennox, *op. cit.*, pp. 981–85.

[33] Cf. Irwin M. Perr, "Epilepsy and the Law," *Journal of Mental and Nervous Diseases* 128 (1959) 263–75.

[34] Cf. Merritt, *op. cit.*, pp. 676 ff.

[35] Cf. Kurt Hirschhorn, "Questions and Answers," *Journal of the American Medical Association* 174 (1960) 1685; and also from the same journal: "Medicine and the Law" 173 (1960) 1245 ff.

point out that United States Army policy provides that under normal circumstances an individual with proved epilepsy would not be acceptable for enlistment. But in certain cases, wherein manifestations of epilepsy were adequately controlled by medication over a significant period of time, the individual would be acceptable for induction and/or enlistment.[36] At present the policy of the United States Navy prohibits the entrance of epileptics to its service and demands their discharge if epilepsy develops or is discovered in service. At the time of this writing, however, thought is being given in the Navy's Bureau of Medicine and Surgery to a proposed modification of this policy.[37]

The American League against Epilepsy, under a grant from the United States Public Health Service, conducted a survey of laws and administrative practices affecting epileptics in the United States. The results of this survey have been published by Roscoe L. Barrow, Dean of the College of Law of the University of Cincinnati, and Howard D. Fabing, Past President of the American Academy of Neurology.[38] Aside from the marriage and sterilization laws already mentioned, other legislation which has an impact on epileptics includes Workmen's Compensation Laws, Federal Immigration Statutes (which exclude epileptics along with the insane, alcoholics, lepers, and prostitutes), institutional commitment laws, and others. These need not receive a detailed analysis here. Legislation, however, regarding the licensing of motor-vehicle drivers is of special importance to this study.

The civil laws regarding operation of automobiles by epileptics are based on a common danger to the public and therefore wisely tend to be strict. The canonical legislation might be viewed as based on an analogous danger, considering that the possibility of a seizure during the Holy Sacrifice or other ministerial functions would certainly prejudice the sacerdotal role, not only regarding custody of the Blessed Sacrament, but also regarding the offering of the common Sacrifice of the faithful with edification and appropriate dignity. Thus, these laws may provide some practical thoughts against which to suggest some considerations regarding canonical dispensation of the irregularity. The laws are proper to the individual states, hence provide a variety of

[36] Private communication. [37] Private communication.

[38] R. L. Barrow and H. D. Fabing, *Epilepsy and the Law* (New York, 1956).

thinking, and some of them which antedate newer therapies for epilepsy are interesting when contrasted with more recent legislation.

As is to be expected, almost every state in the Union confers on the administrator of its driver's-license law the discretion to deny a license to any person who is considered to be an unsafe driver. (The South Dakota law makes no provision for the qualification of the applicant.) And in most states information as to a history of epilepsy must be disclosed upon application for a driver's license. Sixteen states explicitly mention "epileptics" or "adjudicated epileptics" as persons to whom, in general, a driver's license may not be issued.[39] Moreover, it seems evident that in those instances where mitigating qualifications have been made, it has been in view of the newer drug therapies. Note the following examples, with the date of the statute revision. The Illinois statute (1953) denies the license to epileptics unless the applicant can furnish a medical statement that his driving is not inimical to public safety. The Wisconsin statute (1951) demands a medical certificate of freedom from seizures for two years. If there is medical certification of freedom from seizures, but the two-year period has not elapsed, the license will be denied with a right of appeal.[40] Moreover, eight of the other states whose statutes deny a license to an "adjudicated epileptic" do recognize that the statute does not preclude issuing a license to an epileptic after seizures have been brought under medical control.[41] On the other hand, three states specify that a license shall be granted to an epileptic only if he has been seizure-free *without* anticonvulsant medication for a specified period: Idaho, one year; New York, two years; New Jersey, three years.[42]

To look at the matter from a positive viewpoint, in at least twenty-five states medical control of seizures from a period of from one to three years is an important factor in granting automobile-drivers' licenses to

[39] Alabama, Arizona, Delaware, Illinois, Indiana, Kansas, Kentucky, Michigan, New Mexico, North Carolina (applies to grand mal only), Ohio, Oklahoma, Pennsylvania, Virginia, Washington, and Wisconsin (cf. Barrow and Fabing, *op. cit.*, pp. 40–41).

[40] Cf. *ibid.*

[41] Arizona, Delaware, Indiana, Kentucky, Michigan, North Carolina, Virginia, and Washington (cf. Barrow and Fabing, *op. cit.*, p. 49).

[42] Cf. *ibid.*, pp. 50–51.

epileptics, and in general the tendency in these states is to issue the license if there is medical testimony that seizures have been under control for a substantial period of time and reasonable certainty that seizures will not recur provided medication is continued.[43] The special Committee on Legislation of the American League against Epilepsy has recommended a seizure-free period of one year as an adequate basis for determining whether the medication-controlled epileptic is a safe driving risk.[44]

## CONCLUSIONS

It is hoped that this study will lend support to the following conclusions:

1) Epilepsy is a complicated and many-sided medical entity defying brief and accurate medical definition, and its inclusion in can. 984 simply as "qui epileptici sunt vel fuerunt" is the most practical way to identify the medical entity in a canonical context.

2) Its separation from the other physical defects listed in can. 984, and its grouping with insanity and diabolical possession, is a practical and appropriate separation and grouping from a canonical viewpoint, and in no way implies an intrinsic connection among these three conditions, but necessitates in each individual case examination by and testimony of experts before the irregularity is dispensed, since, with regard to each of these conditions, freedom from symptoms does not necessarily imply freedom from the defect.

3) Confessors and directors of souls might prudently judge that if an aspirant to the priesthood is qualified in other respects, has been seizure-free for at least one year, and is recommended by a neurologist who has some understanding of the sacerdotal life, he should be encouraged in his desire and assisted in seeking admittance to a course of preparation for sacred orders.

4) Superiors and ordinaries, when confronted by an aspirant to sacerdotal studies who has a history of epilepsy, should prudently investigate the history and type of epilepsy and, with the consent of the indi-

[43] Cf. *ibid.*, p. 50.

[44] Files of Committee; reported by Barrow and Fabing, *op. cit.*, p. 51.

vidual concerned, seek complete medical evaluation of the individual case by a neurologist.

5) Finally, after the above conditions have been fulfilled, even if his difficulty should recur briefly due to change of medication or adjustment of therapy, after he has been seizure-free for a period of three years, if his physician can predict with reasonable certainty that seizures will not recur with continued medication, his superiors might appropriately apply for a dispensation from the irregularity.