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JOURNAL OF THE CATHOLIC MEDICAL ASSOCIATION (UK)

PRAYERS BEFORE MEETINGS

Come, O Holy Spirit, fill the hearts of Thy Faithful,
and enkindle in them the fire of Thy Love.
V. Send Forth Thy Spirit and they shall be created.
R. And Thou shalt renew the face of the earth.

Let us Pray,
O God, who hast taught the hearts of the Faithful by the light of the Holy Spirit, grant that by the gift of the same Spirit we may be always truly wise and ever rejoice in His consolation. Through Christ our Lord
R. Amen

V. S. Luke
R. Pray for us.
V. SS. Cosmas and Damian
R. Pray for us.
V. St. Elizabeth of Hungary
R. Pray for us

PRAYERS AFTER MEETINGS

O Mother of God
we take refuge
in your loving care.
Let not our plea to you pass unheeded
in the trials that beset us,
but deliver us from danger,
for you alone
are truly pure,
you alone
are truly blessed.

TRANS:- ABBOT PATRICK BARRY, OSB,
MONK OF AMPLEFORTH

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We welcome articles on all aspects of Catholic health care. Articles will be subject to editorial review and may be reviewed by external peer reviewers. Where articles discuss matters of faith, peer review may not be by medical or other Health Practitioners. Articles should generally be between 400 and 1600 words. We prefer references to be in the Vancouver style. Articles should be submitted to the editor electronically at: Editorial email: editor@catholicmedicalassociation.org.uk

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EDITORIAL

HUMANAE VITAE – FIFTY YEARS ON

BISHOP JOHN WILSON - AUXILIARY BISHOP OF WESTMINSTER

'I think, first, that it is important to realise that most people have got the contraceptive aspect of Humanae Vitae entirely out of proportion. As Cardinal Heenan said: If the Pope had wanted to confine himself to a prohibition of contraception, he could have done it in a simple sentence. Instead, he wrote a lengthy document which covered a much wider field and we should all realise that there is a great wealth of positive teaching to be found in Humanae Vitae which has considerable relevance.'[1] With these words Bishop William Gordon Wheeler of Leeds began an address to his clergy following the promulgation of Pope Paul VI's 1968 Encyclical Letter on the subject of how spouses are to properly regulate the transmission of new human life.

To say that *Humanae Vitae* was controversial would be an understatement. The well documented response and ensuing crisis sent shock waves which still reverberate today. For those eager for change in Church teaching it was a tragic missed opportunity to extend the *aggiornamento* of Vatican II into the sexual ethics of marriage. For those convinced by the pre-existing tradition and teaching, it confirmed an essential and integral vision of the human person and spousal relationships.

Sadly, disagreement led some to depart from ministry and from membership of the Church. Despite best attempts to maintain unity, the fallout opened deeper questions about magisterial authority, the exercise of conscience, the place of lay consultation, the status of human experience, and pastoral strategy. The negative reaction was forceful and outspoken. Yet, there was also another narrative, that of those who believed Pope Paul VI was speaking a timeless truth, even if few doubted it was not an easy one to live by. For couples and clergy who embraced the message of *Humanae Vitae*, there was more here than a prohibition of artificial contraception.

The fiftieth anniversary of *Humanae Vitae* will inevitably bring forth a rehearsal of the history and arguments of 1968 and its aftermath. The most convincing witnesses to the beauty of its teaching are spouses who inhabit the divine and human truths it sets forth. The spiritual and moral virtues required are not to be underestimated and those who struggle must always be the subject of the Church's compassionate and merciful accompaniment. To whatever degree claims are made that *Humanae Vitae* is ignored in practice, there are, nonetheless, husbands, wives, and families who, today, fifty years on, make Pope Paul's words become flesh.

The *'wealth of positive teaching to be found in Humanae Vitae'* was highlighted by the philosopher and theologian Janet E. Smith in her 1991 treatise *Humanae Vitae: A Generation Later.* [2] Two particular insights help to tease out the richness of Pope Paul's affirmation. The first concerns the concept of *munus*.[3]

> 'God has entrusted spouses with the extremely important (munus) of transmitting human life.
> In fulfilling this mission spouses freely and deliberately render a service to God, the Creator' (HV 1)

The Latin word *munus* can be translated in a variety of ways and is used often in Church teaching on marriage. We find it both in ***Gaudium et Spes***, Vatican II's ***Pastoral Constitution on the Church in the Modern World***, and in ***Humanae Vitae: 'Let all be convinced that human life and [the munus of] its transmission are realities whose meaning is not limited by the horizons of this life only; their true evaluation and full meaning can only be understood in reference to man's eternal destiny.' (GS 51) 'God has entrusted spouses with the extremely important [munus] of transmitting human life. In fulfilling this mission spouses freely and deliberately render a service to God, the Creator.' (HV 1)***

Smith notes that *munus* could be translated as *'gift,' 'wealth and riches,' 'honour,'* or *'responsibility.'* It could also be rendered as *'duty,' 'role,' 'task,' 'mission,' 'office'* or *'function.'* She states that both in Scripture and in St Thomas Aquinas, *munus* is linked with the grandeur and distinction of mission, ministry, and apostolate, and with duty in the sense of holding an important office. In relation to spouses, *munus* conveys the special assignment of childbearing which God entrusts to them. Translations of *Humanae Vitae* which begin speaking of the 'serious

> Munus could be translated as 'gift,' 'wealth and riches,' 'honour,' or 'responsibility.' It could also be rendered as 'duty,' 'role,' 'task,' 'mission,' 'office,' or 'function.'

duty' given by God to parents therefore set the wrong tone. While one may perform a duty reluctantly, out of obligation or responsibility, the invitation here is to achieve something far more honourable and majestic. [4]

Smith traces how this varied understanding of *munus*, as mission, role, office and vocation, is used in the documents of Vatican II; but always with the emphasis on its God-given nature and origin. It is prevalent throughout ***Lumen Gentium***, the ***Dogmatic Constitution on the Church***, and in ***Gaudium et Spes*** in the sections dedicated to marriage and conjugal relations. Spouses are described as having a ***'lofty calling'*** (***'praecellenti...munere, 47***), and the '***sublime office***' ('***sublimi munere,' 48***) of parenthood, fortified by their loving conjugal relations. Spousal parenthood is depicted as having specific roles and obligations ***(munera)***, dignity and office (***munus***), strengthened by the sacrament of matrimony (48-49). [5]

It is ***Gaudium et Spes*** 50 which draws together the implications: '***Married couples should regard it as their proper mission (missio) to transmit human life (officio humanam vitam transmittendi) and to educate their children; they should realise that they are thereby co-operating with the love of God the Creator and are, in a certain sense, its interpreters. This involves the fulfilment of their role (munus) with a sense of human and Christian responsibility...***' [6] Further emphasis follows on the '***duty (munus) of procreating***' and of carrying out such a '***God-given munus (mission or task, commissio a Deo) by generously having a large family' (GS 50). For '...human life and its transmission (munus eam transmittendi) are realities whose meaning is not limited by the horizons of this life only…' (GS 51).***

The marital ***munus*** conferred externally by God on spouses has, for those who accept and attempt to live it out, corresponding ***'internal benefits'*** namely ***'the growth in virtue and perfection.'*** The tremendous good for spouses of begetting and raising children in turn helps them advance virtuously in holiness. [6]

This 'internal aspect' of the ***munus*** draws upon the personalist philosophy of Karol Wojtyla, subsequently Pope St John Paul II, which emphasises the development of the 'self' as closely connected to the moral choices we make. It is through our moral choices, through personalist values, and especially the values of generosity and self-mastery, that we can progressively and continuously transform ourselves into better and more authentic human beings. This is not some kind of 'muscular Christianity,' but the exercise of the virtues and the practice of chastity. In this process of self-transformation, through our good moral choices, we not only become more like Christ, but we participate in Christ's office and task, his ***munus***, as priest, prophet and king. Thus, to share in Christ's mission, his ***munus***, is not just a matter of external action, but also of internal attitude: ***'to be a priest, one must be self-sacrificing; to be a prophet, one must evangelise; and to be a king, one must govern - and govern one's self above all.'*** [7]

For Smith, numerous and great goods result from the ***munus*** of transmitting life, from the experience of parenting, and from establishing a family, and raising children. Besides being a place for the cultivation of virtues and Christian values, the family helps parents to mature as human beings and provides a valuable and stable reservoir of love for the whole of society. When spouses impede the procreative power of their sexual acts they impoverish the full grandeur of the ***munus*** entrusted to them. Smith says this undervalues the position of the family, leads to selfishness, and, by limiting God's action, therefore spouses also limit his blessing of children consequently removing a source of their own human and Christian maturation and perfection. Through marriage God offers spouses a share in the goods of his kingdom and calls them to co-operate in the ***munus*** of initiating new life, so benefiting themselves and society. This is not merely biology, but providence. Conjugal sexual intercourse, furthering both the unitive good, the strengthening of the spouses, and the procreative good, in having children, forms the essential component of this ***munus***, ordered by God to the flourishing of spousal love and the creation of new sharers in his kingdom.[8]

A second insight from Janet Smith into ***Humanae Vitae*** concerns the notion of openness to life. What is often described as the core teaching of ***Humanae Vitae*** occurs in paragraph 11 which Smith translates as: '…***it is necessary that each and every conjugal act remain ordered in itself (per se destinatus) to the procreating of human life.***' The phrase '***ordered in itself,***' replaces the more common translations based on the Italian text which read: '…***each and every conjugal act must be open (from the Italian 'aperto') to the transmission of life.***' [9]

The latter translation can cause confusion. Smith comments that some understand this to mean that ***Humanae Vitae*** teaches that whenever a couple engage in sexual intercourse they must be open to new life being conceived, that is, they must be intending and desiring to have a child.[10]

The teaching that each and every conjugal act must be '***ordered in itself to procreation***' refers not to the subjective nature of the act in terms of what the spouses desire or intend. It is not about whether they want a child or not when they make love. The teaching that each and every conjugal act must be '***ordered in itself to procreation***' refers to the objective nature of the act of sexual intercourse. It is about respecting procreation as an essential aspect of why God made us male and female destined for one flesh union. Spouses should, therefore, do nothing themselves to artificially inhibit this natural end of procreation.

It is about respecting procreation as an essential aspect of why God made us male and female destined for one flesh union. Spouses should, therefore do nothing themselves to artificially inhibit this natural end of procreation.

Thus, a couple who use thermo-symptomatic family planning, for instance, and a couple who use barrier or hormonal methods may both have the same subjective desire that they do not wish to conceive a child at the present time. Similarly, both consciously intervene to effect this desire, and to the same extent given the capacity for objectively similar rates of success or failure. For Smith,

however, the distinction arises in that the couple using the former methods co-operate with God-given nature – that is to say with the natural programme of fertility/infertility - to conceive or space births. Natural fertility awareness respects the processes God has created, and engenders in the couple the virtues of mutual respect, self-restraint and generosity. It offers a distinct and unique approach to conjugal living and loving.

More recent theological exposition of ***Humanae Vitae***, through the work of scholars like Janet Smith, and especially through Pope St John Paul II's monumental ***Theology of the Body***, provide an articulation of the Encyclical's teaching to new generations. Within a spirituality of spousal communion, those born decades after 1968 are finding wisdom and beauty in its truths, summarised in the ***Catechism of the Catholic Church***: '***The acts in marriage by which the intimate and chaste union of spouses takes place are noble and honourable; the truly human performance of these acts fosters the self-giving they signify and enriches the spouses in joy and gratitude. Sexuality is a source of joy and pleasure.' (CCC 2362)***

The most recent endorsement of ***Humanae Vitae*** comes from Pope Francis in his Apostolic Exhortation ***Amoris Laetitia***, on the joy of love in the family. It emphasises ***Humanae Vitae's*** teaching on '***the intrinsic bond between conjugal love and the generation of life***.' This, he writes, is a message '***we need to return to***,' one in which the methods used to regulate birth are based on the '***laws of nature and the incidence of fertility***,' thus respecting '***the bodies of the spouses***,' encouraging '***tenderness between them***,' and favouring the '***education of an authentic freedom***.'[11] Spouses who live this teaching are the expert witnesses and teachers of the Church in this arena.

In 1968, Bishop Wheeler asked people to consider ***Humanae Vitae*** '***from the point of view of God and eternity***,' making room for those '***spiritual values***,' which take us beyond '***a merely materialistic outlook***.' This remains good and pertinent advice fifty years on.

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CATHOLIC MEDICAL ASSOCIATION AGM FOCUSES ON CONSCIENCE APRIL 15TH, 2018

By: Donato Tallo First published in Independent Catholic News 16th April 2018.

The Catholic Medical Association UK held its annual conference on Saturday, 14th April, at St Mary's University, Twickenham. The theme for the conference was conscience matters in the workplace and the Waldegrave Suite at the university provided an excellent venue for the event.

Conference delegates were able to listen to a range of interesting and motivating speakers talk on a wide range of different subjects related to matters of conscience in the workplace, and the theme of conscience was explored from several different perspectives. Legal matters related to conscience and the ethics of conscience in clinical practice were discussed, along with talks and presentations from personal perspectives related to matters of conscience in modern day healthcare and modern society in general. A panel discussion also took place during the afternoon and enabled some lively discussion and debate.

Aside from listening to the speakers, delegates were able to network and enjoy conversation with other delegates during the day. They came many different parts of the country and also overseas to be part of this event.

The theme of the conference is a matter of great importance and it was good for the subject to be explored throughout the day in a professional manner with various viewpoints and opinions being discussed and debated. The conference was a great success.

Dr Adrian Treloar writes ***"Talks from the conference were recorded and we hope also to publish articles based upon the talks presented.***

A particular highlight of the day was the talk from Clare McCullogh who runs pro-life vigils in London. Many women have been helped by these vigils, including those who are destitute, homeless and who have no recourse to public funds. Delegates were really moved by the deep compassion of what the prolife vigils offer to women in crisis."

Holy Mass was celebrated in the early evening at the University Chapel, by the Catholic Medical Association Chaplain. Afterwards a buffet dinner was enjoyed by many delegates in the Waldegrave Suite.

In addition to the day's event on Saturday, the Annual General Meeting of the Catholic Medical Association was held on the morning of Sunday, 15th April.

Dr Dermot Kearney was congratulated on his election as President.

BEFORE I FORMED THEE IN THE BOWELS OF THY MOTHER, I KNEW THEE.

This is the second editorial by the Committee of the New Evangelisation in the CMQ. The Committee of the New Evangelisation is a group within the Catholic Medical Association of England and Wales that is concerned with young people in healthcare, from students in healthcare sciences to young professionals in healthcare.

"Before I formed thee in the bowels of thy mother, I knew thee; and before thy camest forth out of the womb, I sanctified thee, and made thee a prophet unto the nations."

Vocation is a hard enough subject to ponder on in the Catholic sense of the word, so pondering on the vocation of the healthcare worker is indeed a challenging task. At a glance, it seems quite simple – vocation is a call from God unique to each of us. For our part, we believe that God called us to be in the medical profession as a means to be happy, to sanctify us in this life and to get us to heaven in the next.

However, how are we to live the part? We ARE, after all, "a royal priesthood, a people set apart."

There is no denying that there are many really good and conscientious Muslims, Hindus and even atheists in the healthcare field alongside us, some even sharing similar views and ethics as us. How are we Catholics in healthcare different from any one of these well meaning people?

We are blessed to have here an article written by Rt Rev. Philip Egan, Bishop of Portsmouth on the vocation of the healthcare worker. A nurse has also written on her search for her vocation on the Camino de Santiago. Following two very successful conferences for young people in healthcare, our next conference will explore the culture of life as part of our mission in September. Keep a look out for further details!

THE VOCATION OF THE HEALTH-CARE WORKER

Rt. Rev. Philip A. Egan BA, STL, PhD
Bishop of Portsmouth

A few years after I was ordained a priest, the Bishop appointed me to be the full-time Catholic chaplain to a large hospital on Merseyside. The hospital had over a thousand beds, with a major Accident and Emergency department, plus hundreds of staff. As with anyone in a new assignment, it took me some time to get used to the role, and not least to being constantly busy on call 24/7. In time, I began to appreciate the crucial function a chaplain can play for both patients and staff, a supportive role of prayer, Word and sacraments. I also came to appreciate the genuine dedication and generosity of the medical staff caring for the sick. Indeed, it seemed to me that most health-care workers, people of faith or not, saw their work as a 'vocation,' a calling in life to which they found themselves especially suited and personally fulfilling. For Catholics, however, health-care has a sacred resonance. It is not simply that we care for others in their hour of need; it is a sacred 'philanthropy,' a work of mercy, and one that is modelled on Christ. As we read in the Gospels, Jesus Himself spent much of His public life among the sick, loving them, healing them, exorcising them, and restoring them to life. One of my favourite episodes is the leper in Mark 1: 40-45, who comes up to Jesus and begs Him to cure him. "Of course I want to: be cured!" Jesus retorts. Another is the woman with the haemorrhage in Mark 5: 25-34, who creeps up to Jesus in the crowd, thinking "If I can touch even his clothes, I shall be well again." When she does, we are told, Jesus was immediately aware "power had gone out from him" and the "source of the bleeding dried up instantly."

Sickness is a result of the Fall, the original sin of Adam and Eve. But by His death and resurrection, Jesus has overthrown sin, suffering and death. This is why after the Ascension, Jesus told the Apostles and the early Church to continue His ministry to the sick: that "they would lay their hands on the sick, who will recover" (Mark 16: 18). Jesus wants to give His grace, that is, the power and energy of the Holy Spirit, to those who are sick that they might share in His resurrection. In this way, those who are suffering can bear more readily their Cross, offering their sufferings for the salvation of others, and, if it is in accord with God's will, be healed. Not only did Jesus institute one of the seven sacraments precisely for the healing of the sick (cf. James 5: 14-16), He asked us all to pray for the sick, to assist them with our prayers and to care for them. Down through history, many have turned to the merciful Heart of Christ in their moment of need, assisted by the prayers of the Blessed Mother and their patron saints. All of us can tell a story of praying for a sick person, and all of us can tell a story of how, against the odds, our prayers were graciously answered.

In the late 1980s, the then Cardinal Ratzinger came to Cambridge to give a lecture. During the Q & A afterwards, someone in the audience asked a fascinating question: "When we pray for the sick, does God, if He wishes to make them better, heal them directly, or does he usually work through the medical staff?" The future

pope paused to think about this for a moment. "This is too complex a question to answer here. But I would say that God works in the world by causing love. Yes, God works in the world by causing love." I have always found that a deep and all-embracing answer. For love is stronger than death; indeed, "love no flood can quench, no torrents drown" (Songs 8: 6-7). That is the role of Christianity in the world: to 'cause' love, to spread it, to fill people with it, so that, through the death and resurrection of Christ, they can rise above sin, suffering and death. If we Catholics took seriously this mission of 'causing love', it would surely bring about a world-revolution.

Yet, if many health-care workers already see their work as a vocation, what is the specific vocation of a Christian health-care worker?

I would say there are two points here. First, the vocation of a Catholic health-care worker is the same as that of St. Luke, patron of doctors and surgeons. Indeed, it is the same fundamental vocation that any Christian has: namely, the personal call of Jesus Christ to be His disciple. Jesus says to each one of us personally "Come follow me" (Luke 5: 27). To be a disciple, from the Latin ***disciplina*** discipline, means to be a learner, a student, an apprentice to a master. As Christ's disciples, all of us are 'works in progress,' persons led by the Spirit, under the Word of God. This is why it is important to spend time with the Lord each day in prayer and study, that we might experience the personal love of Jesus for each one of us, refreshed by His sacraments, and also that we might gain an ever deeper knowledge of what our faith in Christ means. We need to know not only what the Church teaches, but why. A great help to this is the new, updated ***Charter for Health-Care Workers*** that the Holy See published on 11th February 2017, the Memorial of Our Lady of Lourdes, the annual World Day of Prayer for the Sick. The Charter gives guidance on many of the ethical dilemmas that arise with the new medical techniques and procedures.

Secondly, in today's secular culture the Church is calling us to the work of new evangelisation, that is, to an evangelisation "new in its ardour, new in its methods and new in its expression" as St. John Paul II once put it. In other words, in calling us to be His disciples Jesus wants us to be missionary disciples, people who radiate the Gospel through their character, their work, all that they think, say and do. The problem with the word evangelisation is that it can sound like 'bible-bashing' or 'tub-thumping'. There are occasions when we must take a stand, such as on abortion, euthanasia, an injustice, etc. But in its broadest sense, evangelisation is a constant two-way activity, like breathing-in and breathing-out. Evangelisation is as much about myself growing deeper in my faith as it is about reaching out to others and witnessing to them. There is a myth going round that St. Francis of Assisi once said "Preach the Gospel at all times, but if necessary use words." I say a myth, because this saying is not found in any of his actual writings and reported words. In fact, St. Paul says the opposite: "Faith comes from what is heard" (Rom 10: 17). I suppose it is true, witness of life must come first, but in some way this must lead to the proclamation of the Word of life. Each one of us will need to find the best way to do this.

A hospital is an 'areopagus,' a cross-roads where different people from many different professions come together to work for a common good, the health of the sick. This includes peoples of different religions and none. How the Church participates in this enterprise needs to be carefully thought through. In Britain, Catholics constitute about 7% of the general population. But in a hospital, given the large number of international staff in the NHS, the percentage might in reality be higher. This is why it would be good for Catholic health-care workers to 'network' with each other for support, friendship, prayer and formation. Does your hospital have a Chaplaincy? Does your hospital have a Cath-Soc? Becoming involved in these ways is a practical contribution to the mission of the Church in its service of the common good.

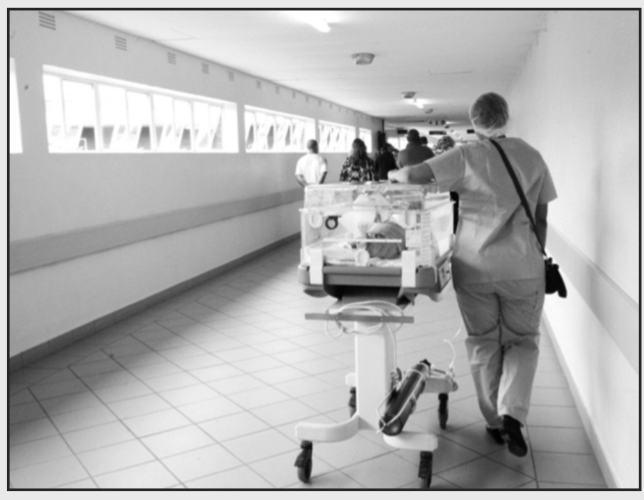

photo by Hush Naidoo

At some point, all health-care workers will also be health-care recipients. It would be good, if you are a Catholic health-care worker, to pray often during your daily work for those for whom you are caring: a quick mental prayer "Lord, help this person." St. Leo once said, "He came down from heaven that we might go up to heaven." As we pray for the sick, let us pray also for those who care for them. The vocation of a Catholic health-care worker is to persevere in the practice of the faith so that one day they can come to faith's reward, when they hear the Lord say to them: "Well done good and faithful servant; come and join in your Master's joy" (Mt 25: 23).

A NURSE ON THE CAMINO DE SANTIAGO

When I told people that I was taking a career break, I got a variety of reactions, the most common of which was a look of concern, in case I was on the edge of something empathetically referred to in healthcare as 'emotional burn out'. I have worked as a Nurse for the NHS for 11 years and it took me about a year to make the decision to step out for a breather. I came in to nursing specifically wanting to work within oncology. I had no big career plan after that, I just took every opportunity that came my way. At the age of 32, through God's grace, and most likely led there by the Rosary, I realised that my nursing career was starting to be cemented in management and I was not sure I wanted to commit to this for life. For me, Nursing is certainly my calling, but I felt that I had got lost and needed to rediscover my vocation within my vocation. Granted the career break by a supportive manager, I made plans to kick off this time out by walking the Camino.

The traditional pilgrimage, known as the 'Way of St James', has been the most popular pilgrimage amongst Catholics in western Europe since the 9th century when the relics of St James the Apostle were discovered. Often referred to as 'James the Great', he was believed to be the first of the twelve apostles to be martyred. Thousands walk the paths every year and there are eight main routes through Spain which lead to St James' relics within the Cathedral of Santiago De Compostella. I chose the route of the Camino Frances, setting off from St Jean Pied de Port, taking me across the Pyrenees Mountains and walking 500 miles west across Spain.

So I waved goodbye to my NHS colleagues, moved out of my rented London flat, sold my car and swapped my iPhone for a simple Nokia brick. I coined a phrase which was that I was "giving up stability to find some stability".

It's ironic that nowadays the phrase 'soul searching' is over used and has become a cliché for people travelling solo, but this really was what I was doing. I set off with a bag weighing less than 5kg and a Rosary in my hand, feeling as free as I ever have.

The majority nowadays that walk the Camino are not Catholic and few even tick the 'spiritual' box when it comes to registering at the end, but the title of 'pilgrim' has remained for everyone who walks 'The Way'. I met so many people who shared stories of grief, heartache and confusion. I ticked some of these boxes too. Many were looking for answers or direction in their lives and strangely enough, many I met had a healthcare background. The question on pilgrims' lips when you first met was often "Why are you walking the Camino?" It was important for me to tell people that I am Catholic, and this was a pilgrimage above everything else. As Catholics, we know that with a pilgrimage often comes suffering; and with suffering often comes growth. Of course I didn't escape unharmed, impossible when you are walking 12-18 miles a day. The wonderful thing about blisters, is that they unite people; everyone had a story or a tip to offer and often, people nursed each other or slowed their pace to help you from A to B.

One thing that the guidebook had not told me, which was a welcome surprise, was that there was Mass every day. Whether in a Cathedral or a small village chapel, an evening Mass was found. By week two, my daily routine was embedded. I started walking early and stopped before the mid afternoon sun took hold, I would find a (bunk) bed for the night, have a siesta and then attend evening Mass before repeating it all again the next day.

Photo by Jorge Luis Ojeda Flota

The yellow arrows which mark the way are laid out to lead you past every Church on route. The best advice I received was "If you get lost, just look for a Church spire." This is a lovely reminder of the original purpose of the Camino, to grow in Faith. But the question I am now faced with is "So what did you learn, what's next?" Well, my 'Camino moment' did not deliver the man of my dreams or a definitive career plan waiting for me in Santiago. But through the 6 weeks I spent walking, my heart relaxed, I realised that I needed to trust God more and let him lead the way.

Walking with minimal material things, without even a camera, enabled time for reflection. We talk of reflection a lot in healthcare but so rarely allow ourselves the time to truly enter into it. We live in a world of noise, screens and bright lights. Cardinal John Henry Newman said that God created everyone to have "Some definite service/some work that He has not committed to another". I just needed some time out of the rat race and in to the silence in order to find mine. It has been 3 months since I returned and after digesting it all, I have realised that my vocation within nursing is to care for the dying. 2017 was my year of walking and now 2018 will be my year of getting to where I am meant to be, to do the specific work that God intended me to do. If you are at a crossroads in life or just feeling a little lost, look towards the Church and remember the wise Latin words of St Augustine –'Solvitur ambulando' meaning 'It is solved by walking'.

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MEN AND WOMEN OF CONSCIENCE:
REPORTING THE CATHOLICS IN HEALTHCARE CONFERENCE AT TYBURN

On the 10th March the CMA hosted a day conference for young healthcare professionals at Tyburn Convent. The conference started with Mass in the extraordinary form, complete with Gregorian chant, a wonderful opportunity to expose young professionals to a beautiful celebration of the Mass they may seldom have encountered in their own parishes.

In the first talk of the conference, one of the Tyburn nuns reminded us of the historical precedents of conscientious objection in a fascinating and moving account of the lives of the Tyburn martyrs. Her talk was a reminder of three important facts:
Firstly, whilst we may feel challenged at times, our lives are not literally on the line;
Secondly, the battle has already been won, just as the blood of the martyrs is now glorified, so will our small battles give way to glory in the future;
Lastly, we have the prayers of so many religious (and lay) people around the world to support us in our endeavours to do what is right.

The ensuing discussion on conscience was thus set up in the context of eternity and placed us in a humbling lineage of figures now gone before us, who had remained true to their convictions to the last - the martyrs of course, but also more contemporary figures such as Dr Jerome Lejeune who fought so voraciously to defend the rights of people with Down's Syndrome. The two talks on conscience, delivered by Dr Joseph Shaw from the Anscombe Bioethics Centre and Mr John Smeaton from SPUC provided us with a thorough philosophical grounding and practical grounding in the nature of conscience within the healthcare setting, both what it is, and perhaps more importantly, what it isn't. The day ended with a panel discussion enabling the attendees to enquire about some of the practicalities raised by the talks and so engage directly with the speakers. The Q&A session also provided the opportunity for various professionals from the floor to offer their insights, demonstrating the diverse range of knowledge and experience present at such a meeting.
Overall, the day was a great success and it was a real privilege to listen to such fantastic speakers in such a beautiful and apt venue.

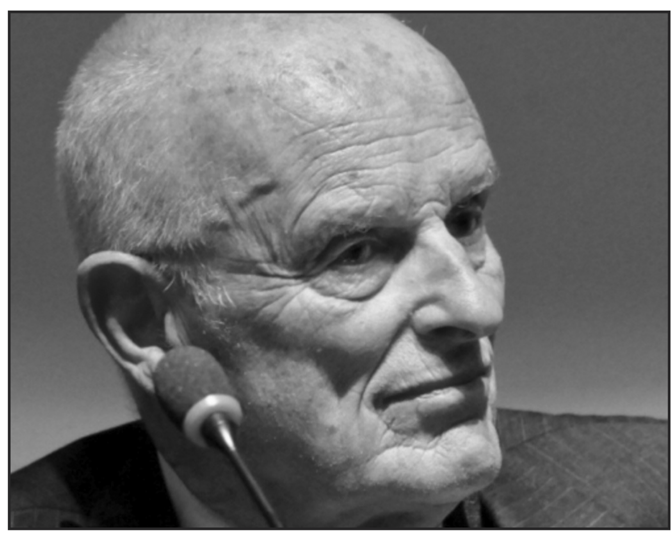
Many thanks to the Tyburn nuns for their hospitality and prayers. They are, of course, assured of ours. Many thanks also to the CMA for organising such a stimulating conference!

Tyburn is the site where many of the English Martyrs were executed. The convent now situated there has had perpetual adoration for over a century. It is just beside Hyde Park and it is very well worth visiting and praying there.

NEWS

HUMANAE VITAE AT 50

A CONFERENCE IN ROME LAST OCTOBER PRODUCED SOME COMPELLING TALKS ON HUMANAE VITAE.



Dr Philippe Schepens gave a medical doctor's testimony and stated that *"this Encyclical[Humanae Vitae] explains with great clarity the true and ultimate purposes of the human sexual relationship. Unlike in the animal kingdom, in addition to the procreative purpose, the human sexual relationship is intended to keep alive the conjugal love between husband and wife through mutual giving. This is why the total separation of the procreative purpose from the purpose of love between husband and wife is contrary to the mission of man on this planet and hence becomes the source of multiple disorders." And yet "When the Encyclical Humanae Vitae appeared in the Belgian press in 1968, I was a young doctor fulfilling my military service as a medical assessor of prospective recruits at the military selection centre in Brussels. In total we numbered 20 young doctors. At lunchtime, there was immediate lively discussion of the Encyclical. Of the 20 or so doctors present, half were Catholics, but only two of us defended Humanae Vitae. It is enough to say that the mindsets in question, even those of Catholic doctors, had already been seriously distorted with regard to hormonal contraception"*

Dr Schepens concluded by reminding us that *"The Encyclical rightly upholds the viewpoint of the prohibition of artificial separation of the sexual act from procreation. This …..reasserts the dignity of the woman, who then has* a say in the practice of the sexual act." And that the price of departure from *Humane Vitae* is the depopulation of Europe.

He registers his *"gratitude to the various popes who have tackled the matter of conjugal life in Encyclicals and other works, from the 19th century onwards. I think in particular of Paul VI and Saint John Paul II, not forgetting my wife, who has given me fifty years of happiness, among other things thanks to Humanae Vitae, and Evangelium Vitae".*

You can read his full speech at http://voiceofthefamily.com/?s=schepens

Dr Tom Ward, a retired GP in Suffolk described how the Gillick case came about and describes the way in which school children were so badly let down in both Catholic and non-Catholic schools. His speech is available at http://voiceofthefamily.com/dr-thomas-ward-the-war-on-parents-and-humanae-vitae/

Both speeches are well worth reading and they are therefore highly commended.

EUTHANASIA REGULATOR RESIGNS

A Dutch euthanasia regulator quit her post in January 2018 in protest at the killings of patients suffering from dementia. The Catholic Herald observed that the number of dementia patients killed by euthanasia has risen four-fold over the past five years.

Berna van Baarsen, a medical ethicist, said she could not support "a major shift" in the interpretation of her country's euthanasia law to endorse lethal injections for increasing numbers of dementia patients: *"I do not believe that a written declaration of intent can replace an oral request for incapacitated patients with advanced dementia."*

Van Baarsen's resignation follows that of ethicist Theo Boer in 2014. Mr Boer has become a harsh critic of the Dutch euthanasia system, warning British parliamentarians not to follow the Dutch example and to vote against Lord Falconer's Assisted Dying Bill in 2014.

In the Netherlands, euthanasia is also a legal option for children (ages 12 - 18) with parental permission and to newborns, who are younger than one, based on the "Groningen Protocol."

"I have seen a major shift in the interpretation of this article in recent years. I cannot support that,"
Miss van Baarsen said.

PAPERS

DISCUSSION PAPER ON NFP IN THE UK

NFP, THE COUPLE AND THE CHURCH - MOVING THINGS FORWARD

DR JOHN-PAUL O'SULLIVAN

Fifty years have passed since Paul VI's now famous encyclical ***Humanae Vitae*** but an open and honest discussion about NFP (Natural Family Planning), the real life application of this doctrine is urgently needed within the Church. Confidence in NFP is down. Couples lack confidence in using NFP methods, use of those methods is down and lack of users means stagnating progress for NFP teaching organisations. Declining confidence becomes contagious – new couples, Clerics and young people in particular are dismayed at a situation where a publicly promoted Church doctrine is privately considered impractical by many. An uneasy silence then develops that doesn't help anyone. Reports abound of some Catholic couples feeling unable to speak to their healthcare professionals about using NFP and healthcare organisations in the UK have become largely dismissive or ignorant of NFP altogether in the absence of any real patient demand for these services. Healthcare providers and patients can become set as opponents in situations where one of the parties is open to the inclusion of NFP in discussions about family planning. Chronically understaffed and underfunded NFP organisations are struggling and perhaps, sensing the poor capacity in those organisations, healthcare professionals and Clerics feel reluctant to refer couples to them which reduces their referrals further still. The situation has been bad for some time but toxicity from this issue will become corrosive if left unchecked. We are at risk of losing vital resources and skills that future generations may wish to use. Perhaps most of all we risk losing the central vision of ***Humanae Vitae*** - that fertility is not a disease which needs to be controlled but rather a normal human function in which humans participate in the awesome creative power of God.

Ironically all of this occurs in the UK as the tools and systems of NFP continue to evolve and advance. Using the Creighton System, Dr Tom Hilger's work in the United States developed NaProTechnology which extended NFP into women's healthcare and gynaecology providing hitherto unforeseen benefits in those fields. Whilst contraceptive technology continues to exert a collective form of amnesia on the medical understanding of fertility and menstrual disorders, Hilger's work showed that cycle-timed interventions can be extremely advantageous and menstrual biomarkers are ignored at the physician's peril. His colleague in the US, Prof Richard Fehring went on to develop a system of NFP using the ClearBlue Hormone Monitor in association with natural signs of fertility. Prof Fehring's 'Marquette Method' has innovated protocols for women across various stages in reproductive life. At the University of Utah, Prof Joe Stanford is undertaking pioneering research using the Creighton System to study how exposures around the time of conception affect later life and develop even further lines of study in NFP. Dr Petra Frank-Herrmann and her colleagues in Germany used the Symptothermal Method to develop an enormous database of user cycles showing excellent levels of user effectiveness from German couples using Symptothermal in a widely-acclaimed (and cited) prospective longitudinal cohort study[1]. Various groups from Scandinavia to North America and Australasia are using new technologies like video-conferencing, mobile phone apps and cycle-timed interventions to assist NFP couples in ever new and creative ways.

Those of us who work in the field of women's healthcare are aware of the enduring popularity of contraceptive technologies for both family planning and 'menstrual regulation' however this need not impede progress in NFP. Other methods of fertility regulation should naturally find a niche for women and couples of various motivations and only this month in an open letter to the editor of the New England Journal of Medicine one woman requested ".. renewed research on new or better birth control products — ones that are safe and convenient, and more equitably incorporate men in pregnancy prevention"[2]. As ever one wonders if this lady, or her healthcare providers have heard of NFP.

I have read the CMQ articles and letters on this topic over the past year with interest. Surely the most pertinent questions going forwards are: How do we move things forward for NFP in the UK? Can we come any closer to realising the benefits of ***Humanae Vitae*** or will we fall further behind other countries in the next 50 years? What will our legacy be to future generations of Catholics in the UK?

The Current Situation

Broadly speaking we currently have 3 Systems of NFP available in the UK: Sympto-thermal, Billings and Creighton. To the best of my knowledge none of these systems are available through NHS Clinics currently (although arguably they should be). All are run on a fully or semi-voluntary basis and various organisations exist to support their use – NFPTA (Natural Family Planning Teachers Association UK), Couple to Couple League UK, Billings groups include: Fertility Care Scotland & Billings South West. The Creighton System is facilitated through the Prolife organisation 'Life'.

All the groups highlighted above are prolife in their approach and do not include artificial forms of family planning as part of their systems. A further group called Fertility UK also supports women and couples to learn about natural signs of fertility; however they incorporate use of barrier methods and other forms of contraception as part of their approach. In association with the Faculty of Sexual and Reproductive Healthcare (part of RCOG), Fertility UK contributed to a recent Green top Guideline from FSRH in 2015 on 'Fertility Awareness Methods'.

The correct and modern term for NFP is Fertility Awareness Based Methods ('FABMs') & this term will be used synonymously with the term 'NFP' henceforth in this article.

Separating out the main stakeholders to assess their roles

The principle stake-holders in NFP are users and teachers. That may seem like a straightforward point but it's foundational in our understanding of the problems that NFP is facing. Users' main objectives are to learn a system that a. Is suitable for them & integrates easily into their lifestyle & b. Is effective in helping them to achieve the pregnancy intentions they set-out to achieve [and/or gain assistance / facilitation towards appropriate healthcare support if medical problems are identified].

It's important for NFP supporters to be earnest in this field. Both experienced healthcare professionals and NFP teachers are well aware that pregnancies do not always occur at times which couples identify as most ideal for them [as is the case with all behavioural methods of family planning including the contraceptive pill & condoms]. Nonetheless, NFP organisations must take the pregnancy intentions of users very seriously indeed and I would suggest that they make this the standard upon which their Organisation's success rates are judged. Not only do modern NFP users seek this but a full & adequate understanding on this point is essential towards effective consent also. Whilst ***Humanae Vitae*** provides guidance to spouses on how they may wish to plan their families, in NFP, those decisions should never be second guessed and teachers ought to make couple's pregnancy intentions their primary aims and objectives during meetings with couples.

Considering pregnancy intentions also makes one cognisant of the increasing burden in our society from subfertility, miscarriage and stillbirth. There is a greater need for Christian support for these conditions in general and modern NFP organisations are ideally placed to provide support for those conditions, especially to couples using NFP. Modern NFP organisations ought to have clear referral pathways for couples who are suffering from these conditions, ideally to Restorative Reproductive Centres where further medical investigation can be undertaken as well as provision of appropriate guidance and advice to women / couples suffering from these conditions. Thus far only Creighton Method with NaPro Technology has extended medical protocols that assist NFP users with these type of problems. In many cases, addressing undiscovered underlying causes like PCOS, endometriosis & hormonal imbalances are vital to achieving conception and sustaining pregnancies.

The other main stake-holders are NFP teaching organisations. NFP Teaching Organisations train and equip individuals to become NFP teachers and NFP teachers are one of the most valuable assets we have in NFP. Couples who are NFP users themselves are often well placed to take their understanding further and train as teachers. More healthcare professionals are also needed to support the development of these organisations.

It's unfortunate indeed that understanding of natural fertility has fallen so low in the healthcare professions but also that the call for support from Catholic healthcare professionals in ***Humanae Vitae*** is not more widely addressed. NFP organisations must also monitor the performance of their teachers, update them on a regular basis and re-accredit them for ongoing practice. Given the nature of NFP which is relatively heavy on user-support in the early phases but lighter over the long-term, NFP organisations need to be flexible in their capacity & have the ability to welcome back existing users as problems crop-up as well as taking on new users. This matching process is difficult to manage as at any one time the pool of available NFP teachers fluctuates alongside the fluctuations in demand for NFP.

The Church, environmental groups and other organisations are secondary stake-holders. Whilst their promotion and participation are welcome to make progress going forward NFP needs to focus on the needs of NFP users and organisations foremost I think.

FABM Users

FABM users need good quality teaching and access to an NFP teacher over the time. Ideally users are able to access teaching in their own location but technologies like Skype, video-conferencing & smartphone apps can facilitate access to teaching support, as could effective online learning resources. Access to teaching support is vital for users as their reproductive category changes over time e.g. not-pregnant avoiding or not-pregnant achieving, pregnant & receiving antenatal care, puerperal / breastfeeding phase, perimenopause etc. Users ought to be able to find support whatever their reproductive category and whatever their ongoing situation is. In all NFP consultations, the women's general and reproductive health should be considered if not assessed formally in addition to her pregnancy intention and any concerning signs or symptoms which are identified. There is frequently a need to link in with Primary Care, Counselling groups &/or other organisations from NFP as necessary. This aspect of NFP, in and of itself makes FABMs a superior family planning system to several artificial methods and we don't need to be bashful about this point. Artificial methods of family planning tend to ablate or mask important pathologies like PCOS, ovarian cyst & endometriosis (and again in the interests of full consent individual users may wish to discuss this possibility with their GP or Practice Nurse).

Whilst setting-out the needs of NFP users it's equally important to set-out their responsibilities. Clearly no couple are tied to the use of any one particular family planning system and whilst couples are free to switch their method at any time it is vitally important that couples are completely honest with their teachers about

a. What family planning systems they're using at any one time & that
b. NFP organisations are notified immediately when a couple stop using an NFP system.

This is because historically, analysis of NFP effectiveness has been disenfranchised by couple's who stop using their NFP system, neglect, forget or omit to tell their teacher that their method use has stopped and the couples time-in-use analysis remains included in effectiveness statistics which as highlighted above are of paramount importance

to NFP groups.

In addition to this, NFP users in the UK have historically not been asked to fund their teaching but in the future this situation may need to change if NFP organisations are to develop and indeed survive. The main beneficiary of NFP teaching is the couple themselves. In the absence of funding from healthcare groups users should therefore contribute directly towards the costs of NFP organisations allow them to maintain and develop their services. In a pluralistic society with a single healthcare provider (like the UK) there is certainly an argument that the healthcare provider should also contribute toward the costs of NFP-use for couples who request this service; however strangely this point appears to go untested in the UK. As noted, FABM users require higher levels of teacher input at the beginning of their FABM use but if a couple sticks with an FABM system, high initial costs are recouped over the longer term. It's possible that lower costs may be achieved in other ways also, especially in terms of couple harmony and family stability.

Some couples will wish to come and go between natural methods and artificial ones and NFP organisations need to be flexible in their capacity to accommodate these users back to charting and NFP use as situations change for couples.

Fertility Awareness Based Methods (FABM) Organisations

To be effective, FABM organisations need to be accessible and supportive. To address the concerns about efficacy they need to be research focused, open and transparent about their ongoing performance. Systems which monitor and publish local effectiveness statistics are to be encouraged. In the modern healthcare climate, NFP organisations should look to continually improve their success rates and capitalise on all means of doing this on an ongoing basis.

Fertility education is a far larger task than any single NFP Group or Organisations could hope to undertake and discussion about fertility really need to begin in the home and the school. Users who come from a background of fertility awareness often find NFP relatively easy to understand & integrate into their lifestyle. Couples and individuals coming from a contraceptive background sometimes find fertility awareness more challenging.

All of this requires funding. In the absence of NHS funding, NFP organisations should both fund-raise and seek to recoup their costs from FABM users. Whilst fund-raising from secondary stakeholders is helpful, a shift in financing is needed to secure the future of NFP on a long-term basis. The current approach to running organisations on a voluntary basis may not be the best way to achieve that aim going forwards and further discussion on this point is needed. Groups which take up opportunities to invest in Restorative Reproductive healthcare opportunities could presumably plough any profits from those enterprises back into the NFP side of their business so to speak. Groups could operate as not-for-profit organisations. Teacher training, accreditation and re- accreditation are expensive activities and NFP Organisations may wish to start charging teachers for these services also.

Switching from voluntary to paid NFP teachers might attract more individuals to the position of NFP teacher and provide a further stimulus for growth. The Palliative Care movement in the UK has had similar challenges with fund raising over the years and has developed creative ways to address this problem.

NFP organisations have a real opportunity to assist couples in managing their fertility, to provide Christian support in times of suffering (subfertility, miscarriage etc) and to promote monitoring and improvement in couples reproductive health. It must always be clear however that NFP stands quite separately from contraceptive techniques and abortion services. Whether couples use artificial or natural family planning means, no system is 100% full-proof and all pregnancies achieved during NFP use are welcomed while sensitive enquiry pursued if any breakdown in teaching or method occurs (& this should be clear from the outset).

How can the Church can assist her members and FABM organisations?

The Church has been a stalwart supporter of married life for centuries and thank God for her concern and pastoral care in that regard. Care and concern for marriage is clearly a far bigger issue that family planning and NFP will only ever form part of the larger jigsaw puzzle.

In relation to family planning however, the Church's position infers a need to directly support either NFP organisations or to assist her members in some other way with the directives of ***Humanae Vitae***. Whilst support for NFP is welcome from all quarters, to grow and develop NFP organisations need to move more towards the healthcare world and to an extent stand apart from the Church in doing this. I would argue that the natural setting for NFP clinics should either be the healthcare clinic or the home and not the Church hall. NFP teachers currently are often inspired to work in this area as a result of their Catholic faith and whilst this inspiration is welcomed, NFP teachers must remain cognisant of their own background vis-à-vis the different backgrounds NFP users come from. It deserves to be said that Catholic parents and teachers (including Clerics) play an essential role in educating members of our Church about NFP and being able to appropriately signpost individuals towards these services. It is wrong when parents, teachers or Clerics signpost people towards artificial family planning services in a Church context.

Given her stance on family planning the Church should do all she can to ensure that members who are marrying in the faith are adequately informed about modern NFP methods and this has implications for marriage formation / preparation courses as well as organisations the Church supports directly in other ways. It is disheartening to hear about marriage preparation courses where the Church position on family planning is not articulated clearly. Whilst the use of a family planning method is entirely down to to couples themselves it is certainly possible for the Church to support NFP and promote effective NFP teaching being available to all her members rather than the perennial refrain which all NFP Teachers in the UK will likely have heard a hundred times "..I wish someone had told me about this 20 years ago".

Conclusions

A common comment on *Humanae Vitae* is that the doctrine hasn't been tested and found wanting so much as effective knowledge, understanding and application of it has. If this is the case then we have urgent work to do. Healthcare professionals are needed to advance this work and Catholic lay people and healthcare workers have a role to play. Changes need to take place in the Church; within her lay members, her Clerics and within NFP organisations as well. Reforms in all these areas are overdue.

NFP organisations need to find ways to grow and develop. They need to find ways to incorporate modern healthcare standards into their work whilst providing flexibility towards the needs of modern users. NFP organisations must be equally able to educate the enquirer who might never use the NFP system as well as the couple who are committed to using it and the whole spectrum of users in-between. It's important to continue to naturalise NFP use but also to upskill NFP teachers so that important conditions are picked up more efficiently in future and referred where appropriate. For couples who are healthy the aim remains to educate, facilitate (& measure) method use. NFP organisations need to think through and develop protocols for women and couples who are suffering from subfertility and recurrent miscarriage.

As Catholics, if we want these type of services to be available in the future I think the time has come to pay for them. We should pay for them both financially and in terms of our service. NFP in the UK needs new FABM teachers and healthcare personnel. It requires administrators, receptionists, people with expertise in website design, smartphone apps, accountancy, statistics and a whole host of other skills. As the FSRH Guideline commented in 2015, FABMs have a legitimate role to play in our healthcare system and Catholics should be able to speak to their GPs, their Practice Nurses, Health Visitors and others (honestly) about the family planning system they're using. They should be able to seek support from those groups and find that support for using systems of family planning which are healthy, safe and promote reproductive health for both sexes. The past 50years have been a mixed bag for NFP in the UK and we're drifting. Let's make the next 50 years better.

Dr J-P O'Sullivan is a GP practicing in Paisley

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A FEW WORDS ABOUT AUGUSTINE ON SEX AND MARRIAGE

PROFESSOR JOHN RIST

It has often been observed that of all Western thinkers Augustine has probably been more abused than any others by those who have hardly read a word of what he has written.

Perhaps that needs to be slightly modified: people often also abuse Augustine in complete ignorance of the world in which he lived and wrote, and with little understanding of how culture-bound are their own judgments and prejudices. And such blindness still affects Catholics, some of whom even join more radical secularists in claiming that Augustine has inflicted substantial damage on Western culture. Nowhere is this more apparent than in comment on his thoughts about marriage and sexuality. Hence before looking at some of those views we need to understand rather more about how most of the inhabitants of the late Roman Empire regarded sexual behaviour and the nature and purposes of marriage.

First, then, the sexual distinction between males and females. The dominant view (even among most Christians, a substantial number of whom – but not Augustine - believed that women are not created in God's image) was that women are inferior versions of men: not only inferior in their physical strength and emotional stability, but even in the role they play in the generation of new human beings. For it was widely assumed that women were nurses both before and after birth. When the child is in the womb, the mother's role is to nourish the seed implanted in her by the male: the seed, that is, being itself regarded as an embryonic human being. That is why the ancients found it easy to confuse contraception and abortion: both seemed to involve killing the undeveloped seed. The acceptability of doing that, of course, depended on social, and especially on religious beliefs. Given such ideas about the basic inferiority of women and female weaknesses of varying kinds, it is hardly surprising that sexual relations were widely regarded as the imposition of the will of the stronger (and better) male on that of the hopefully submissive female. In other words, as Augustine would put it, sexual intercourse was normally mere lust masking a kind of power-play, an example of what he called (more widely) libido dominandi: the lust to dominate. The passive party in sexual acts was thought to be humiliated by her (or in the case of passive homosexuals his) subjection or submission. Such humiliation could also therefore be imposed as a punishment; thus a master might tell his slaves to have a bit of fun by raping a captured burglar. Hence sexual relations were widely regarded as a macho

right of the male which should only be restrained by the fear that impregnating someone else's woman would cause problems not only about who would be the rightful heir to the property of the woman's rightful lord, the husband, but about the dangers that could arise if that husband tried to vindicate his offended honour. Even the very Christian Monica, warning her son Augustine about youthful sexual transgressions, only urged him to avoid relations with married women. None of this is to suggest that more 'romantic' and respectful love affairs, even marriages, did not exist in the late Roman Empire, but they should not be thought of as any kind of norm.

In Augustine's time, as he himself points out, the law of marriage indicated that the wife was to become the handmaid of the husband for the sake of bearing legitimate children. And children were not only required as heirs; in many ancient communities to have children 'for the city' meant generating males who could fight for it, and thus contribute, literally, to its continuing existence. For if you lose an ancient war, you can expect (and often witness) your men being killed, your women being raped (normally gang-raped) and together with their children, sold into slavery.

If you lost an ancient war, you could expect (and often witness) your men being killed, your women being raped (normally gang-raped) and together with their children, sold into slavery.

We can now look at Augustine's own view of sex and marriage against a rather more informed background. Famously, Augustine taught that there are three goods of marriage: 'faith': by which he meant that the marriage should be monogamous (but certainly not serially monogamous in the lifetime of an estranged spouse); 'offspring': by which he indicated that he accepted that the main purpose of marriage as an institution is the begetting of legitimate children; *'sacramentum'*: a term hard to explain even to modern Catholics, not least since the doctrine of the seven sacraments had not yet been developed. Augustine considers that to accept a sacramentum, an oath demanding the shouldering of specific responsibilities – in this respect parallel to the military oath which in the Roman army was administered in a religious context - is to perform an activity which directs those involved - in the case of marriage the couple – towards obedience to the will of God.

Augustine was insistent that the implications of these principles – especially the principle of monogamous loyalty - should be very strictly observed. However submissive a wife should be to her husband, she should not tolerate his having sexual relations with other women, not only not with whores but not even with slaves – even if they are his own property. This rule, Augustine pointed out time and again to his sceptical and, as he knew, disobedient, even hostile congregation, is absolute: monogamy means one man, one woman.

What seems absent from this account is the lack of emphasis on the possibly unitive function of sexual activity: not that Augustine is silent about such a function for marriage itself, for he thinks that marriage should be a form of social friendship ***(amicitia socialis)***, but in the case of

However submissive a wife should be to her husband, she should not be tolerate his having sexual relations with other women, not only with whores but not even with slaves - even if they are his own property.

the sexual act itself. Since, as I have indicated, Augustine's world took the sexual act to be humiliating to the 'passive' partner (even deliberately so) apart from its service to procreation, it is hardly surprising that, following many pagan as well as Christians thinkers, he believed that it should only occur if procreation is the aim (though he also recognized that that is a forlorn hope and that the sin committed is minor!). Otherwise, it would be, in terms of his society, merely a lustful search for pleasure, and Augustine also agreed with most of the philosophical and religious thinkers of his day that actions – or at least actions related to important goals in a man's life - should not be performed merely for pleasure, though the enjoyment of pleasure in the performance of virtuous actions is itself a good.

What all this tells us is that Augustine's attitude to the sexual act itself was still culture-bound; it was almost inconceivable in light of the psychological knowledge of the time that sexual activity, even within marriage, could in and of itself be beneficial (apart, of course, from providing pleasure) to its agents. We know, but Augustine did not, that this is an error. He did know, however, and we frequently forget, that sexual lust is common, hard to control and frequently leads to other (and in his view greater) ills in society. Adultery, fornication, homosexuality and other deviant practises, in his view, not only damage the character of those who engage in them but have disastrous effects on the society in which they are performed. If Augustine was ignorant of the benefits that can accrue from sexual activity in marriage even apart from procreation, he was certainly not unaware of the fact that treating sex as mere fun or as something to consume (as is common enough in our own society) is an offense against God, against his will for the human good and against the good of humans themselves. And he also knew that the sexual manipulation of one partner (including one marriage partner) by the other could never be ruled out in any realistic evaluation of human sexual activity; after all, sexual activity is not an original-sin-free zone.

My conclusion: we should be grateful for what Augustine thought and taught about sex and marriage, while simultaneously recognizing that in important respects his construction remains unfinished. But in trying to complete it, it would be very unwise to deny – let alone to ignore - the magnificent start he made on what is still a far from completed project.

John Michael Rist, a Fellow of the Royal Society of Canada, is a British scholar of ancient philosophy, classics, and early Christian philosophy and theology, known mainly for his contributions to the history of metaphysics and ethics. He is Professor of Classics Emeritus at the University of Toronto and part-time Visiting Professor at the Institutum Patristicum Augustinianum in Rome. The illustration is from his book Augustine: Ancient Thought Baptized published in 2003 by Cambridge University Press.

CONSCIENTIOUS OBJECTION: ARE MEDICAL PROFESSIONS "FREE"?

BY WILLIAM KENT

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On 26th January a new Bill was discussed in the House of Lords – the Conscientious Objection (Medical Activities) Bill. This Bill, which proposes to clarify the role of conscience in the medical profession, will continue its progression through parliament over the next few months. The time is right therefore for all of us to reflect on the place of conscientious objection within the field of healthcare and to contribute to the public debate that this new Bill will hopefully stimulate.

The sort of questions that form the context to this newly proposed legislation are: "does a healthcare professional have the right to refuse a procedure if they are morally opposed to it?" or "should a nurse or GP be allowed to avoid any involvement with providing abortions or facilitating the end-of-life if they deem it immoral"? Such lines of inquiry have an ever-growing relevance. In 2014 two Scottish midwives were removed from their profession for refusing to have any oversight over the provision of abortion. They claimed that the conscientious objection clause contained in Section 4 of the 1967 Abortion Act excused them from any involvement. Initially a Scottish Court agreed with this interpretation but following various interventions the case came to the Supreme Court where it was decided that medical professionals could only refuse to be involved if they were required to have a "hands-on role". Thus, Mary Doogan and Connie Wood, who had served as midwives for years, were removed from their profession for refusing to go against their convictions.

Many have argued that the legal ruling in the midwives' case has softened the position of conscientious objection within the medical profession and that as a result many potential medics and midwives are now wary of entering such jobs because they are afraid they will be forced to go against their consciences. Many believe that the law needs to be changed to clarify the right of medical workers to conscientious objection – that is why the Conscientious Objection Bill has been introduced into the House of Lords.

The first thing to note is that no one, or rather very few, want healthcare workers to go against their beliefs simply for the sake of it. In this country there is widespread recognition of the importance of freedom of religion, conscience, and belief. Why, therefore, do many deem that it was right for the two Scottish midwives to be struck off from their lifelong profession for following their strongly held convictions? The answer – because they wish to maintain the patient at the heart of healthcare. They believe that if all medical professionals are free to object to involvement with certain procedures then patients will suffer from a diminished quality or access to care. They believe that if a woman wants an abortion then she should not have to face being judged and rejected treatment.

It is important to observe that most proponents of this view do not believe that doctors should be entirely stopped from acting on their conscience, but rather that this should never be allowed to interfere with the rights of patients. Thus, they argue that a doctor is obliged to refer a patient on for a procedure if they themselves are not comfortable doing it. They believe that the current law in this country provides a good balance between meeting the needs of patients and allowing doctors to object in conscience. With cases like Mary Doogan's, however, it is important to ask if such a balance has properly been reached. If a doctor believes that abortion is the ending of a human life, then even to refer a patient to someone else is a considerable violation of conscience – should they be allowed then to refuse to make even a referral?

Mary Doogan and Connie Woods

What is essential to consider when discussing the role of conscience in the medical profession, and indeed other areas of work and life, is that if a person is forced to go against their conscience their moral integrity is undermined. Freedom is a principle upheld widely throughout Western society, this includes the freedom to hold moral convictions. To undermine someone's moral integrity is to undermine their freedom and their ability to determine whether certain actions are permissible or not. Defending an individual's moral integrity is not the same as arguing that a person can impose their moral code on others.

However, it does mean preserving a person from being coerced into acting in way they find objectionable.

Having moral integrity is an essential part of our lives, to undermine it would reduce people to passive rather than active agents. In the case of medicine, undermining healthcare professionals' freedom to oppose to some procedures reduces them to mechanised dispensary units. How can trust, respect, and authentic relationship be developed between a patient and their doctor if the latter is required to suspend their sense of morality? This side-effect of opposing conscientious objection is, therefore, to reduce the quality and consistency of overall patient care because the healthcare worker is reduced to a passive agent that must meet every request of their patient, even if it violates their deeply held convictions.

Many assume that religious beliefs are the main source behind the demand for conscientious objection and conclude that the law should not be adapted specifically to cater for the needs of religious people, arguing that this is a form of legislative favouritism. However, it is essential to note that freedom of conscience is not only concerned with religious convictions. There are many non-religious examples of why a healthcare professional migh tbe opposed to abortion. For example, currently the law allows abortion up to birth for a foetus with a disability. Many doctors see this as discriminatory legislation and may refuse to carry out an abortion after the 24-week limit that applies to an unborn child without a disability. The right to freedom of conscience extends to these circumstances as much as any healthcare professional with religious reasons for opposing certain procedures.

As the debate around conscientious objection reopens in this country, it is essential that the role of moral integrity, the place of freedom of belief, and the true nature of doctor-patient relationships all be duly examined. It is important to defend the right of conscientious objection both to maintain the freedom of individuals and to maintain the quality of the medical profession. Evidence does not suggest that widening the law around conscientious objection will have a dramatic impact on access to care for patients. If it does, the question should be asked – if so many professionals are opposed to a procedure and would cease to carry it out if a change in the law allowed them to do so, is such a procedure one that should be so readily offered by the health service at all?

FAITH IN MEDICINE

CURES, MIRACLES, DOCTORS AND MEDICINE IN LOURDES
A BRIEF HISTORICAL OUTLINE

DR ALESSANDRO DE FRANCISCIS PRÉSIDENT DU BUREAU DES CONSTATATIONS MÉDICALES DE LOURDES

In a Sanctuary like Lourdes, some pilgrims may reckon they have benefited from an exceptional cure and wish to bear witness to this, so they approach the Bureau des Constatations Médicales (Office of Medical Observations), located in the Sanctuary, to make a declaration of an alleged cure. Why is there such a Bureau available in Lourdes (France) and in no other place of pilgrimage in the Christian and non-Christian world ?

At the time he signed his Decree of 18 January 1862 with his judgement concerning the Lourdes Apparitions, Mgr Bertrand-Sévère Laurence, Bishop of Tarbes, used three criteria to establish that the Immaculate Conception had actually appeared to Bernadette Soubirous: the reliability of the seer, the spiritual fruits and the cures of the bodies. On that same day he declared by Decree that seven cures, among the hundreds examined by his medical expert, Prof Henri Vergez, were "Miraculous".

Since there were too many of alleged miraculous cures in Lourdes, at the request of Father Rémi Sempé , Father of Garaison, first Rector of the Sanctuary, Dr Georges-Fernand Dunot de Saint-Maclou established the Bureau des Constatations Médicales in 1883. The Bureau would serve the purpose that no-one, who thought having been "cured", could leave Lourdes claiming being cured if he/she had not submitted that cure to a rigorous and collegiate medical assessment. In this way, Dr Dunot turned his consultation activity, which he had been performing occasionally every summer since 1879, into a permanent activity. The letter by the Archbishop of Cagliari, Mgr Vincenzo Gregorio Berchialla, dated 3 September 1886 and sent from Rome to Dr Dunot de Saint-Maclou relates the assent of Pope Leo XIII to the Bureau's rigorous procedures.[1]

Our Lady Help of the Sick. Lourdes

After Dr Dunot de Saint-Maclou's death in 1891, it was the Bishop of Tarbes who appointed the new permanent

doctor, and thus President of the Bureau des Constatations, Dr Prospère Gustave Boissarie (1892). In 1904, on the occasion of the coming celebrations for the 50th anniversary of the Dogma of the Immaculate Conception, Mgr François-Xavier Schoepfer, Bishop of Tarbes, travelled to Rome with an official delegation including Dr Boissarie. During their stay, different issues were discussed with the Holy See in view of the celebration of the 50th anniversary of the Apparitions and one year later (1905), the Holy See confirmed to the Bishop of Tarbes — in his capacity as Guardian of the Grotto — the right to use the procedures of the Bureau des Constatations Médicales to investigate any declared cure. This right is still valid today.

The term " Bureau des Constatations Médicales" has two meanings. (1) In the first place, it means an office in the Sanctuary with a permanent practising doctor who receives the declaration and starts a critical examination thereof and his Secretariat. The author is the 15th President and he assumed office in 2009. (2) If an alleged cure appears to be serious, the permanent physician convenes, and chairs, a " Bureau", i.e. a collegiate meeting for "discussion of a clinical case" . All doctors and healthcare workers present in Lourdes at that time can attend the meeting, regardless of their religious belief. In one or more meetings the professionals answer three main questions: (1) Was the person really sick? (For us a cure must take place for a described diagnosis with severe prognosis); (2) Is the person really cured? (For us the cure must have been unexpected, instantaneous, complete and lasting); and (3) finally was there for this cure a possible explanation? In thousands of cases we have reached the conclusion that a cure was « unexplained according to current medical knowledge ». The Bishop of Tarbes and Lourdes informs at this stage his fellow Bishop of the Diocese where the cured person lives of the medical conclusion of a case. 62 Bishops have declared – after the 7 of 1862 - a cure as being <<Miraculous >>, for a total of 69 miraculous cures. The latest in 2013.

Today, most of the doctors and healthcare professionals coming to Lourdes are members of the Association Médicale Internationale de Notre-Dame de Lourdes. On 6 September 1925, the Journal de la Grotte, the official organ of the Pilgrimage and of the Bureau des Constatations Médicales, announced the establishment of an "Association Médicale de Notre-Dame de Lourdes" at the suggestion of the Bishop of Tarbes, Mgr François-Xavier Schœpfer, and of Dr M. Petitpierre, interim President of the Bureau des Constatations Médicales. With the acronym AML, "an Association has been established among all Catholic doctors participating in Pilgrimages to Lourdes or directly interested in the Lourdes cures. The goal of this Association is to strengthen the relations among all these colleagues and thus facilitate the investigation of the ethos of Lourdes. (……) The existence of the Association will not produce any change in the way the Bureau des Constatations Médicales operates, remaining open to all doctors wishing to participate, whether Catholic or not" . Dr Auguste Vallet, President of the Bureau from 1927 to 1947, "shortly after his arrival took the initiative of ... transforming the Association Médicale de Notre-Dame de Lourdes into an international body. It thus became the Association Médicale Internationale de Lourdes — better known under the acronym A.M.I.L.- in order to keep in touch all doctors from all continents wishing to maintain a lasting relationship with Lourdes after their visit to the Sanctuary. This development was compulsory for a very simple reason: it was (and, no doubt, it is) necessary that one could evaluate the qualifications the candidates may show or have, in view of their admission, and listen to their clear explicit will. The creation of the new institution immediately required putting in place a Bulletin, a quarterly organ, the first issue of which was published in February 1928 and the publication of which was basically never discontinued since".[2]

The AMIL comprises: APIL (International Pharmacists' Association of Notre Dame de Lourdes, established in 1935), ADIL (International Dentists" Association of Notre Dame de Lourdes, established in 1991), AILACS (International Healthcare Workers Association of Notre Dame de Lourdes, established in 1993), and AIIL (International Nurses' Association of Notre Dame de Lourdes, established in 2014). The sitting President of the Bureau des Constatations Médicales is also the President of the AMIL, the headquarters of which are located at the Bureau des Constatations Médicales.

A Lourdes « Medical Committee » was set up in 1947 by Mgr Pierre-Marie Théas, Bishop of Tarbes and Lourdes, and by Dr François Leuret, President of the Bureau des Constatations, coopting some doctors and professors with excellent scientific reputation in their respective scientific fields with the task of assessing and, as may be the case, "certifying" that a cure, which has been declared "unexplained" by the Bureau des Constatations Médicales of Lourdes, is indeed "unexplained" on the basis of current medical knowledge". [3]In 1954, the Bishop wanted this Committee to acquire an international dimension becoming the International Medical Committee of Lourdes -CMIL.

The International Medical Committee of Lourdes has about thirty members from different Countries (France, Italy, Spain, Germany, Switzerland, Belgium, England, Wales, Scotland, Ireland, USA and Haiti) and it is jointly co-chaired by the Bishop of Tarbes and Lourdes, Mgr Nicolas Brouwet, and by one of its members, Prof Marie-Christine Mouren, appointed by the Bishop for a renewable mandate. The President of the Bureau des Constatations Médicales is the Secretary of the Committee.

All physicians, and other health-care professionals, coming to Lourdes are warmly invited to stop at the Bureau (Building Accueil Jean Paul II) to sign the Register showing their availability to work on a declared case. Signing makes that professional a member « pro tempore » of the Bureau. The same professionals can also consider applying for membership in our prestigious Lourdes International Medical Association-AMIL.

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SUBMISSIONS

RESPONSE TO THE UNITED NATIONS CONSULTATION ON THE GENERAL COMMENT NO 36 ON ARTICLE 6 OF THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS (ICCPR) , ON THE RIGHT TO LIFE .

This is an excellent and long submission which we plan to publish in the print edition of the CMQ in August. Space did not allow that in this issue. You can access it on the website at www.cmq.org.uk and use the Submissions tab. We print just the conclusion of the submission here.

Overall Conclusion

René Cassin, one of the principal drafters of the Universal Declaration, declared that the UDHR was based on *"the fundamental principle of the unity of the human race."*[1] All human beings are members of the human family and as such are human persons and the subjects of rights for which Society has corresponding obligations. "The child is not a generic, anonymous foetus. We can identify the child's father, and whether the child is a son or a daughter. We can ascertain long before birth that the child is a unique member of the human family, biologically, genetically, and genealogically."

The draft General Comment No 36 fails to fully recognise unborn children as having human rights as human beings, members of the human family and as human persons. Unborn children must not be reclassified as individuals who are less than human and therefore expendable in favour of the rights of others, Science or Society. The right to life must remain central to our understanding of human rights and international law. Medicalised killing in the form of abortion, assisted suicide and euthanasia are logically inconsistent with the fundamental principles and philosophy of the UN Declaration and Covenants and the Hippocratic tradition.

The six underlying foundational principles within the Declaration of Human Rights and subsequent Conventions are inclusion, inherency, equality, inalienability, indivisibility and universality.

Inclusivity means that the rights refer to "everyone" and "every person" without discrimination. The rights are inherent to all living human beings by virtue of their humanity and membership of the human family. They are not conferred rights that are granted by external government. Inalienability refers to rights that cannot be removed, destroyed, transferred or renounced even by the individuals themselves, their parents or Society. Equality means that no human beings are "more equal" than others but that everyone has equal rights as members of the human family. "The notion of equality springs from the oneness of the human family and is linked to the essential dignity of the individual." Human rights cannot be predicated on the view that certain individuals are either superior or inferior to others nor are they premised on the child being born. The act of being born does not confer rights, but rather the fact of being human. The rights are indivisible and cannot be sacrificed or denied in order to enhance the rights of others. Finally, human rights are universal to be upheld everywhere and at all times irrespective of culture.

The inalienable rights of all human beings, both before and after birth, must continue to be respected by the United Nations and Article 6 of the International Covenant on Civil and Political Rights. These fundamental human rights are inherent and derive from our human nature and membership of the human family and must be recognised and protected through the rule of law.

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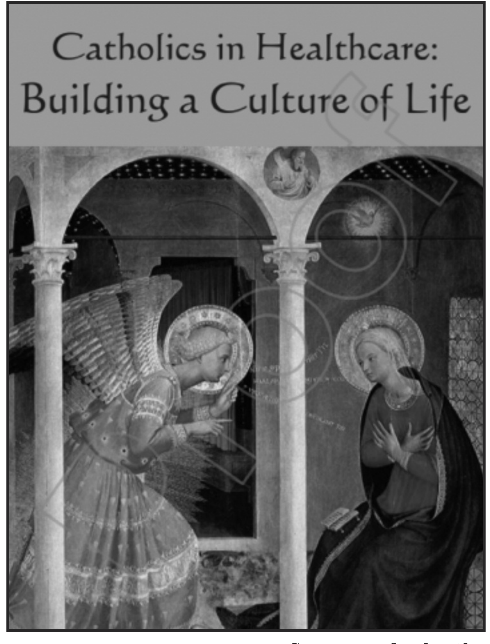
The Third Annual CMA Youth Conference



See page 9 for details

REPORTS

JOINT ETHICO-MEDICAL COMMITTEE REPORT 05.11.17

DR PHILIP HOWARD. PRESIDENT OF THE CATHOLIC MEDICAL ASSOCIATION.

General Pharmaceutical Council Consultation (Conscientious objection).

The General Pharmaceutical Council sought to change the Ethical Code for Pharmacists. This would have moved the Ethical Code away from an objective ethic which seeks to ensure the health, wellbeing and safety of patients and to maintain the trust and confidence of the public. Instead, it is now promoting patient-centred care with a subjective ethic which seeks to satisfy the wishes of the client requesting Pharmacy services. This proposed that Pharmacists *"recognise their own values and beliefs but do not impose them on other people [and] take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs."* The Council recognised that this would be a significant change from the current position and goes on to state that *"a referral to another service provider might not be the right option, or enough, to ensure that person-centred care is not compromised."*

The Council published its Guidance on 22nd June. It makes it clear that referral is still an option, except where a service is not accessible or available elsewhere. This means that in the overwhelming majority of cases Pharmacists can still exercise their right of conscientious objection. This will have favourable repercussions for other healthcare professionals.

UN Human Rights Committee consultation on Human Rights (Article 6 of ICCPR: Right to Life).

The UN Human Rights Committee has recently consulted on Article 6 ('Right to Life') of the International Covenant on Civil and Political Rights.

The six underlying foundational principles within the Declaration of Human Rights and subsequent Conventions are inclusion, inherency, equality, inalienability, indivisibility and universality.

Inclusivity means that the rights refer to "everyone" and "every person" without discrimination.

Inherent means that all living beings by virtue of their humanity and membership of the human family. They are not conferred rights that are granted by external government.

Inalienability refers to rights that cannot be removed, destroyed, transferred or renounced even by the individuals themselves, their parents or Society.

Equality means that no human beings are "more equal" than others but that everyone has equal rights as members of the human family.

The inalienable rights of all human beings, both before and after birth, must continue to be respected by the United Nations and Article 6 of the ICCPR. There is a definite move to regard abortion, assisted suicide and euthanasia and other forms of mediatised killing as human rights. If Article 6 were to be changed, this would require both a two thirds majority at the UN and endorsement by individual Member States. Nevertheless, there is a concern that the UN is also pushing the agenda of "safe abortion" as a means of population control and there is a growing move towards "eugenic" abortions in the case of Down's syndrome and other congenital conditions. There is also a persistent move towards assisted suicide and euthanasia.

Dr Philip Howard MA, LLM, MA, MD, FRCP

REPORT ON THE 13TH MATERCARE INTERNATIONAL CONFERENCE, "CATHOLIC HEALTH PROFESSIONALS CAN STILL DELIVER: CONFRONTING TODAY'S MORAL AND ETHICAL CHALLENGE", ROME SEPTEMBER 2017.

DR DERMOT KEARNEY

Matercare International is an organisation of Catholic obstetricians and gynaecologists primarily dedicated to the care of mothers and babies. Its mission is "to carry out the work of Evangelium Vitae (the Gospel of Life) by improving the lives and health of mothers and babies, both born and unborn, through new initiatives of service, training, research, and advocacy designed to reduce the tragic levels of abortion world-wide and maternal and perinatal mortality, morbidity in developing countries" [Matercare International website mission statement]. It is officially recognised as the obstetrics and gynaecology wing of

FIAMC (the International Federation of Catholic Medical Associations).

The organisation was formally founded in 1995 with an international gathering of obstetricians and gynaecologists in Liverpool, England and was largely an initiative responding to calls from Pope John Paul II in his Evangelium Vitae encyclical. Dr Robert Walley, a founding member, remains very much a driving force and an inspiration. Originally training in Obstetrics and Gynaecology in his home country, England, he felt that he had to emigrate in the early 1970s as he was not prepared to compromise his conscience and participate in abortion provision. He was told at that time that he basically had three career choices:

1. **abandon conscience and perform abortions;**
2. **change to a different speciality in medicine or surgery;** *or*
3. **emigrate. He chose the third option, settling in Newfoundland, Canada.**

The first Matercare International workshop took place in Rome in 2001 and the group of 120, mainly obstetricians / gynaecologists, were honoured by being granted a private audience with Pope John Paul II. He expressed his admiration for the organisation and for loyal Catholic healthcare personnel in general. "Your profession has become still more important and your responsibility still greater in today's cultural and social context, in which science and the practice of medicine risk losing sight of their inherent ethical dimension, [and] health-care professionals can be strongly tempted at times to become manipulators of life, or even agents of death.

It is my fervent hope that at the beginning of this new millennium, all [Catholic] medical and health care personnel, whether in research or practice, will commit themselves wholeheartedly to the service of human life. I trust that the local Churches will give due attention to the medical profession, promoting the ideal of unambiguous service to the great miracle of life, supporting obstetricians, gynaecologists and health workers who respect the right to life by helping to bring them together for mutual support and the exchange of ideas and experiences." [Pope John-Paul II to MaterCare International, 18th June 2001].

The 13th Matercare International Conference took place, once again in Rome, from 20th to 24th September 2017. The Conference was appropriately titled "Catholic Health Professionals Can Still Deliver: Confronting Today's Moral and Ethical Challenge". The location was ideal for any Catholic conference as it was held at the Istituto Maria SS Bambina, a convent situated literally metres from the Vatican City colonnade lining St Peter's Square. The rooftop of the Istituto overlooks the Square and is the familiar site used by a host of Tv companies whenever they need prime location for Vatican reports. Wakening each morning to the site of the dome of St Peter's Basilica overlooking your bedroom window is truly memorable.

Aside from the excellent location, the actual facilities at the Istituto were also ideal. Three meals were provided each day as part of the overall registration cost and this was a very welcome unexpected bonus. The bedrooms were simple but spacious, clean and very comfortable. The meeting room for each of the presentations was a very appropriate size with very good acoustics. The chapel in the convent was beautiful to behold and it was wonderful to have the opportunity to attend Mass and Rosary each morning before the conference sessions began. The rooftop facility gave a wonderful view over St Peter's square and also over the city of Rome on the other side of the Tiber. It proved a wonderful location for socialising with the other conference attendees each evening.

The impressive line-up of guest speakers included His Eminence Willem Cardinal Eijk, Archbishop of Utrecht. Prior to the calling to the Priesthood, Cardinal Eijk qualified as a medical doctor from the University of Amsterdam in his native Netherlands. He qualified with his initial medical degree in 1978. He continues to have a particular interest in Medical and Biological Ethics and successfully completed a dissertation on the subject of euthanasia in 1987 to obtain a PhD, two years after his ordination to the priesthood. At this Matercare conference he delivered an inspiring opening address on the first evening of the meeting and subsequently spoke about the ***The History of Euthanasia and Physician Assisted Suicide*** on the following morning. It should be noted that the Conference dealt not only with issues relating to the care of mothers and babies but also covered several other important ethical issues affecting healthcare personnel. In this respect, the conference was extremely helpful and supportive to all of us working in areas outside of Obstetrics and Gynaecology.

It was thrilling to be present to hear and meet the daughter of a canonised saint. Dr Gianna Emanuela Molla, daughter of St Gianna Molla spoke about ***My Mother the Saint: Dr Gianna Beretta Molla***. She spoke lovingly of her mother, whom she never knew, who gave her life heroically that she might live. She told us of the love that surrounded her from her widowed father and her brother and sisters as she grew up. Following the steps of her mother, she qualified as a medical doctor and later specialised in Care of the Elderly. She temporarily stopped working as a doctor so that she could provide total care for her aging father, returning some of the love and sacrifice that he had shown towards her throughout her life, especially during her childhood and developing years. Dr Molla brought prayer cards and relics relating to her mother for all of the conference attendees.

We were blessed to have a number of priests attending the entire conference. Fr Richard "Dixie" Taylor from Boarbank Hall in the Cumbrian Lake District is the Spiritual

Advisor for Matercare International. He delivered a number of presentations including a mini-retreat on Mary and the ***Theology of Motherhood*** and on ***Blessed John Henry Newman's address to medical students***. Fr Raymond de Souza is a priest for the Archdiocese of Kingston, Ontario in Canada and is a world-renowned correspondent, writing for several Catholic newspapers and periodicals, including our own Catholic Herald in the UK. His presentations on ***Religious Freedom, Law and Medical practice – What Future?*** and ***Hard Case made Canada's very bad Assisted Death Law*** were incisive, very well researched and expertly delivered.

The Canadian contribution to this Conference was quite remarkable. Robert Wally, the organisation and conference founder, was accompanied by his wife Susan and two of their seven children, Simon and Roisin, both of whom were instrumental in the whole organisation of the event. In total, fifteen delegates had travelled from Canada to Rome for the conference, contributing greatly to its success.

An even larger number travelled from Australia. Led by Dr Elvis Seman, the Chairman of Matercare Australia, seventeen Aussies represented their country. Dr Seman also played a major role in the conference organisation and the daily proceedings, ensuring that each session ran very smoothly. A total of 67 delegates from 14 countries and four continents attended the five day event.

As mentioned above, the conference dealt with a wide range of topics particularly relating to healthcare issues that provide ethical and moral challenges for Catholic healthcare professionals and students. Prof Bogdan Chazan and Dr Malina Swic informed us of particular challenges they have faced in their native Poland in relation to conscientious objections to carrying out abortions and the provision of pre-natal testing that might lead to abortions respectively. There was a separate presentation on the work of the Ordo Iuris Institute in Poland, dedicated to protecting the conscience rights of workers. There was also a wonderful presentation by Nik Nikas and Dorinda Bordlee from the American Bioethics Defense Fund on the current legal status in the USA for conscience rights in healthcare. These organisations defending conscience rights in the workplace operate on similar lines to the Thomas More Legal Centre in the UK.

In addition to the presentations already mentioned there were outstanding mini-seminars with entire sessions dedicated to the problems of Assisted Dying and Euthanasia with speakers giving personal experiences from Canada, USA, Belgium and the Netherlands and also on Natural Fertility Awareness programmes and NaPro technology. It was lovely to meet Dr Monique Risso, a CMA (UK) member based in Gibraltar. Dr Risso trained in Leeds before returning to her native Gibraltar and she has established a local NaPro technology service. She gave an inspiring account of how she managed to establish this service after an initial enlightening account of what NaPro technology involves.

Fr George Woodall, an English priest, is professor of moral theology and bioethics at Rome's Regina Apostolorum university. His presentations on ***Principal of Double Effect and The Object and Intention of Natural Family Planning*** were among the highlights of the entire conference. He took the opportunity in the latter presentation to re-visit the ***Humanae Vitae*** papal encyclical to illustrate the treasures of natural methods of family planning over the misguided tragedy of artificial contraception. Fr Woodall is the author of ***Humanae Vitae***; Forty Years on: A New Commentary published in 2008 on the 40th Anniversary of the encyclical. It remains one of the greatest commentaries on that pivotal work. The good news, we were told at the Matercare session, is that a new revised edition is set for release this year to commemorate the 50th anniversary of ***Humanae Vitae***.

The social programme was highly enjoyable. We were treated to a video recording of a remarkable premiere performance of a unique ***Cantata in Celebration of Motherhood: from Eve to Mary*** from the Basilica of St John the Baptist in St John's, Newfoundland. This new work was composed by the highly-acclaimed Newfoundlander Gerard Blackmore. There was also an opportunity for attendees to participate in a guided tour of the Vatican museum as it was on our doorstep. Each evening ended with a social gathering on the rooftop of the Istituto. Of course, we also managed to attend the general Papal audience with Pope Francis as a group in St Peter's square on the first day of the conference.

This Matercare International conference was highly educational. From a personal point of view, I learned so much about areas of medicine and medical ethics that I was previously unfamiliar with, particularly in relation to modern methods of fertility awareness and NaPro technology. The most enduring memory, however, is the experience of friendship and support from meeting so many good people from many different countries and many different backgrounds sharing their faith, their fears, their worries and their joy. That's really what makes attendance at such international conferences so worthwhile. The next Matercare International conference, once again in Rome, is planned for Autumn 2019. Try it. You won't regret it.

The University College for aspirants to the Medical Missions (CUAMM)

The CUAMM, 'University College for aspirants to the Medical Missions', [my translation] is based in Padua. (Founded by the Diocese in 1950)

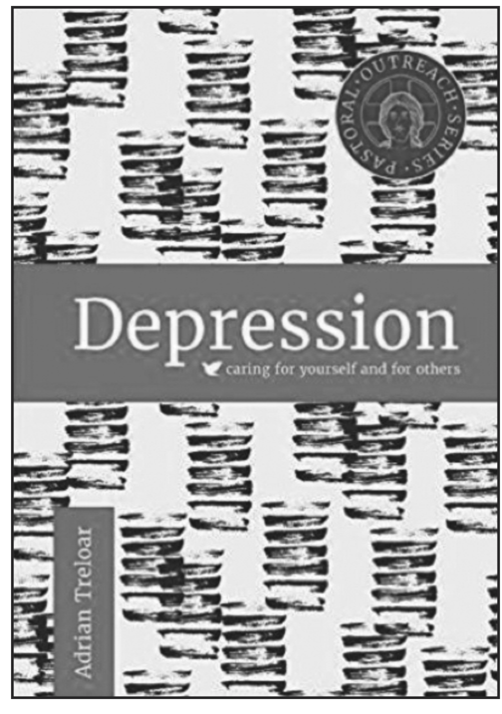
The College has some 70 resident members who study at the University. In addition they run an Anglophone Mission, to support missionary hospitals (19) largely in the Eastern side of Africa. They are now setting up CUAMM (UK) as a sister organisation and have sought our interest and cooperation. They are currently seeking an Office in London and another in USA. They plan to run courses to explain what they do. Meanwhile they are able to offer people a way to undertake missionary work in one of their hospitals. This could be for as little as 15 days, in which case the candidate would pay their own fare, or for a contract for a year with a small salary (fares and accommodation provided).

(www.mediciconlafrica.org/ <uk@cuamm.org>)

BOOK REVIEWS

DEPRESSION CARING FOR YOURSELF AND FOR OTHERS BY ADRIAN TRELOAR

REVIEWED BY PRAVIN THEVATHASAN



This is a very helpful and practical guide to helping those who suffer from depression. Sufficient facts are presented to help us understand this complex health condition. But the overwhelming thrust of the work is active care.

Depression, says the author, is quite different from sadness. It is a set of symptoms that are disabling in a way that sadness is not. Anyone can get depression and in many ways it is no different from many physical health conditions like hypertension. The features include persistent low mood, feelings of hopelessness, sleep disturbance and loss of appetite. Persons with depression can isolate themselves and this makes matters worse. As depression increases, people may develop ideas of self harm. Sadly, some act on these ideas.

The author looks at risk factors which include unemployment, homelessness, being older, being isolated and in chronic pain. Throughout the work, there are helpful case histories to illustrate what is being said. In the section about severe depression, for example, the author looks at people who have suicidal ideation and those who develop psychosis brought on by depression. Severely depressed people can develop delusions of damnation or a feeling that they have lost their faith. How valuable sound spiritual guidance is for those who are depressed.

The author examines bipolar disorder and depression after childbirth. He reminds us that the prognosis for depression is good when the right remedies are offered. Suicide prevention is critical and the Mental Health Act is used in appropriate instances.

The author notes the cultural variations in which depression presents. People from an Asian background are more likely to present with physical symptoms. Treatment needs to be holistic. Effective psychological and social support are essential. The author delicately reminds us that the depressed person needs to approach counselling with some care. Although counselling claims to be non-judgmental, the particular prejudices of the counsellor can surface. I am reminded of the counsellor who told a practicing Catholic that maybe her faith was leading to guilt feelings which in turn led to her depression. Rogerian therapy does not sit well alongside the Christian concept of virtue and sin. Freud's view that we are products of our biology does not fit well with the Christian concept of free will.

The author looks at the drug treatments on offer. The early antidepressants caused quite marked side-effects, unlike the newer ones. The author's examination of the role of faith in the treatment process is very helpful. Although prayer, which is always a challenge, may prove difficult, it is vital as is recourse to the sacraments. The wise sayings found in the Christian classic Abandonment to Divine Providence are an excellent remedy for those suffering from feelings of hopelessness.

Mistakes can also be made in our synthesis of faith and treatments. The idea that depression can be cured by recourse to faith alone is dangerous.

The author ends the book with some well known prayers. All in all, a very helpful resource

Publised by Redemptorist Publications 2017

Courses from the National Association of Natural Family Planning Teachers.

1. Learn to become a Teacher of Modern Methods of Natural Family Planning.
2. Natural avoidance or achieving of pregnancy.
3. The return of fertility after stopping hormonal contraception, after childbirth and while breastfeeding and also during the Menopause

The Online course consists of 12 sessions at weekly intervals and costs £600. Each student has their own Tutor.
The Attending Course is 3 weekends with Tutors in attendance.
Venue to be announced but in the Portsmouth area.
Proposed dates are May 12th and 13th, July 7th and 8th, September 8th and 9th .
All materials provided. Cost is £600.

CORRESPONDENCE

Sir

I read the excellent article on Transgender issues in the latest CMQ [1]

I just wondered where we stand if a patient asks us for a referral for a transgender clinic? I am certainly not happy with doing so and am dreading someone coming asking for this! (Obviously I would treat them with respect and explore all the underlying psychological issues etc)

Is there any guidance on conscientious objection?? I was appalled to see recent program on BBC where children as young as around 6 were living as opposite sex - and adults approving of this!!!!!

Thanks for any guidance

Author's reply

That's very kind of you to say so. Writing it was hard work.

When the GMC revised its document of personal beliefs they started out with a view that one protected group (religion) would not be able to impose its views on another protected group (Transgender). As a result they suggested that the trans group would trump the religious viewpoint and that to refuse services to them would be "***defacto***" discriminatory. We pointed out that that could not be so. If a thing is unethical it should not be done and the fact that a minority group member which has legal protection is asking for it cannot be a sufficient reason to be forced to provide it and to abandon ethical considerations. For example, if a Catholic mother insisted upon intensive care admission for an infant which had no chance of survival, the fact that this was a request from a minority group would not mean that the request could not be refused.

That view carried the day and it was concluded that if we think a procedure is unethical, then we can refuse to provide it. But the right of ethical and conscientious objection does require that we must refuse to provide it to all groups and not just the minority group.

That stipulation does not particularly matter for transgender issues as the things that are done are more or less entirely specific to that group. Although there is a real challenge for doctors and pharmacists who are asked to provide on-going prescriptions for sexual phenotype changing hormones.

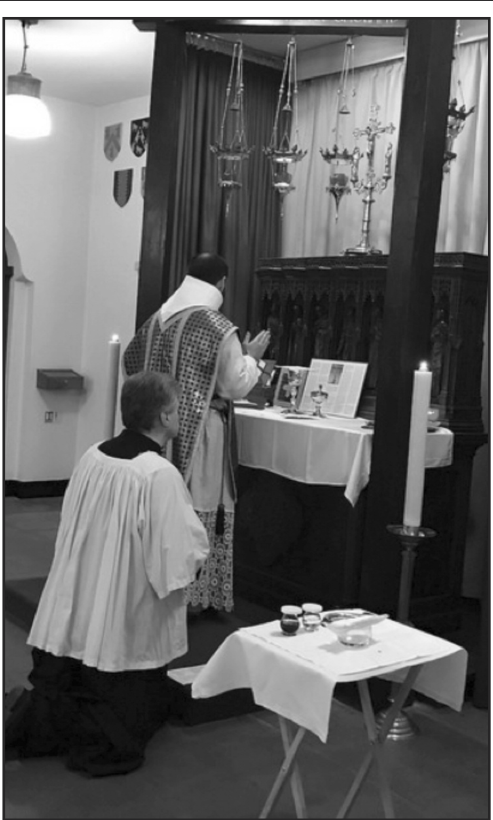
For contraception it works well for those (Catholics) who refuse to provide the pill to all women married or not, though it works less well for those Anglicans who only want to give the pill to married couples. For Viagra, and in other circumstances, there are some real challenges. Many are likely to think that Viagra to enable continued sexual intercourse between a husband and wife is different from giving Viagra to single men who are wanting to be able to have a one night stand. We hope to publish more on that soon.

So there is some real complexity. Would you prescribe Viagra for an unmarried man who wants a one night stand? Would the GMC respect your refusal to do so?

But with the transgender campaign there is, in fact a more complex issue which probably triggered the pharmacists' troubles earlier this year. I have heard that some Some pharmacists (and some GPs) are refusing to provide the oestrogens etc to transitioning and transitioned (to female phenotype) men. In men who are starting transition, we might well refuse to provide the hormones as we think that such treatment is mutilating. And therefore unethical. But for those who are established on female hormones, is continuation of those hormones a continuation of the mutilation, or has the water passed under the bridge and is this maintaining the (new) status quo the best remaining option? It might well be. I don't think we fully understand that issue yet. And it needs careful thought and discussion. The instinct is not to provide and not to cooperate. But although we should not cooperate in an unethical act, we will support people with ethical care once that unethical act has been completed. I am thinking of the very different situation of a woman undergoing an abortion.

Adrian Treloar

1. Treloar A. The American College of Pediatricians statement on Gender Ideology CMQ 2017 Volume 67 http://cmq.org.uk/CMQ/2017/Nov?letters_gender_identity2.html



Holy Mass for our Youth Conference at the Shrine of the English Martyrs