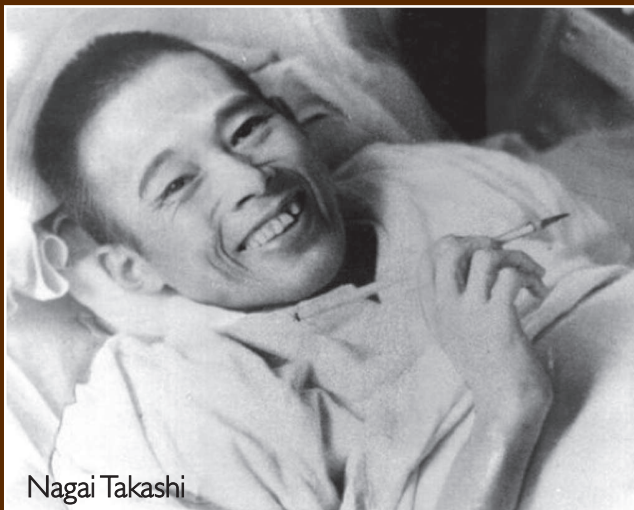


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Nagai Takashi

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*"when affectionate and genital feelings enter homosexual friendship, one should recognize and accept their presence. This does not mean the relationship is unhealthy."* The book became the reference book on sexuality in seminaries in the seventies. Much worse was Father Anthony Kosnik's book *Sexuality: New Directions in Catholic Thought* [10]. This came out in 1977 and made excuses for masturbation, cohabitation, swinging, adultery, homosexuality and even bestiality [11]. Amazingly enough, Kosnik remained a priest for a few more decades before finally leaving. The book also claims that *"the objective moral evaluation of a person's action must take into consideration the context of the person's moral stance, the circumstances of the action and the effects that issue from it."* If this is what is meant by accompaniment and discernment, it might mean many things, but it is not Catholic.

After the Second Vatican Council, the Church opened her windows. Sadly, at least some of what got into the Church was not fresh but filthy. Those great Gothic architects knew a thing or two when they made beautiful, soaring stained glass windows that let in the light of heaven while keeping the pollution at bay. Apologies and letters are well and good but not enough. What is needed is action. A great Carmelite priest once summed up the message of Fatima in three words: reparation, reparation and reparation.

True reparation, MUST include proper investigation of claims of abuse as well as a proper and robust response to each and every case of abuse. The Church must never tolerate, let alone protect abusers.

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*See also the article by Dr Ian Jessiman on page 14 of this issue*

## THE SUPREME COURT AND DEATH FROM DEHYDRATION

DR ANTHONY COLE

The Supreme Court delivered its judgement in the case of "Y" on 30th July 2018 [1]. Mr Y was an active man in his fifties when, in June 2017, he suffered a cardiac arrest which resulted in severe cerebral hypoxia and extensive brain damage. He never regained consciousness following the cardiac arrest. He required Clinically Assisted Nutrition and Hydration (CANH), provided by means of a percutaneous endoscopic gastrostomy, to keep him alive. In late September, his treating physician concluded that he was suffering from Prolonged Disorder Of Consciousness (PDOC) and that even if he were to regain consciousness, he would have profound cognitive and physical disability, remaining dependent on others to care for him for the rest of his life. A second opinion was obtained in October, from a consultant and professor in Neurological Rehabilitation, who considered that Mr Y was in a vegetative state and that there was no prospect of improvement. Mrs Y and their children believed that he would not wish to be kept alive given the doctors' views about his prognosis. The clinical team and the family agreed that it would be in Mr Y's best interests for



CANH to be withdrawn, which would result in his death within two to three weeks.

In November 2017 the Court of Protection advised that *"It is not mandatory to bring before the court the withdrawal of CANH from Mr Y who has a prolonged disorder of consciousness in circumstances where the clinical team and Mr Y's family are agreed that it is not in his best interests that he continues to receive that treatment"*

But because this represented a change in the law the official solicitor was given leave to appeal to the Supreme Court. In fact Mr Y died from sepsis in December 2017.

Chaired by Lady Hale, the Supreme Court concluded that "If the provisions of the Mental Capacity Act 2005 are followed and the relevant guidance observed, and if there is agreement upon what is in the best interests of the patient, the patient may be treated in accordance with that agreement without application to the court." The judgement does admit that *"It is important to acknowledge that CANH is more readily perceived as basic care than, say, artificial ventilation or the administration of antibiotics, and withholding or withdrawing it can therefore cause some people a greater unease."* But then goes on to say *"However, it was decided as far back as the Bland case that CANH is in fact to be seen as medical treatment. It is not easy to explain, therefore, why it should be treated differently from other forms of life-sustaining treatment..."*



In expectation of the Supreme Court's decision the General Medical Council along with the British Medical Association and Royal College of Physicians had already consulted on new guidelines to support the expected a change in the law. What the British Medical Association (BMA) and Royal College of Physicians (RCP) subsequently advised doctors caring for patients with the persistent vegetative state or minimally conscious state [2] Their interim guidance states that *"On 30 July 2018 the Supreme Court handed down its judgment in the case of Mr Y. This confirms that there is no need to go to court to seek approval for the withdrawal of CANH, providing:*

- the provisions of the Mental Capacity Act 2005 have been followed;
- the relevant guidance has been observed; and
- the family and the treating team are in agreement as to what is in the best interests of the patient."

They then state that "We continue to work with the Royal College of Physicians and the General Medical Council to develop updated and in-depth guidance on good professional practice for making decisions about CANH. We aim to publish in October 2018.

The rest of the principles set out in the interim guidance still stand and should continue to be followed."

As with the Supreme Court they use the term "Clinically Assisted Nutrition and Hydration" (CANH), which in most cases just means food and fluid by feeding tube. So there it is. CANH is medical treatment and the law of the UK is that patient's lives can be ended by removal of food and fluid administered by tube. The Bland judgment turned CANH into "medical treatment", and thus it could be withheld or withdrawn.

The recent judgment merely removes the final safeguards that cases should at least be considered by the Court of Protection, as doctors and families are in agreement.

The scene is now set for a slow death from dehydration, which is one of the worst deaths possible. The guidance from the BMA and RCP is silent about the suffering involved and, furthermore, they say that death from dehydration should not be mentioned on the death certificate. Doctors unwilling to follow this guidance should hand over care to those who will. It is hard to think of anything more divisive to the harmony of critical care teams. The new guidance will affect thousands of doctors with conscientious objections.

But in fact, tube feeding (CANH) is basic care in Catholic teaching. In 1994 St John Paul II described the administration of food and water, even provided by artificial means "as natural means of preserving life" therefore St John Paul said, withdrawal of them in the knowledge that death is the only possible outcome is "true and proper euthanasia by omission". [3]

In the minimal conscious state the RCP admitted that suffering can be experienced from dehydration so a regime of sedation is recommended by another RCP working party. It recommends i. v. and s.c. infusions of up to 100 mg Morphine / 24 hrs, plus Midazolam up to 200 mg / 24 hrs, plus Levomepromazine up to 150 mg / 24 hrs, and in some cases Phenobarbital up to 200 mg / 24hrs. If necessary i.v. anaesthetic agents can be used [4]. They claim this is not euthanasia, but many of us would disagree.

How is one to protect one's self from such a terrible death? The only remedy open to a future patient is make one's objection known in advance. If you have a welfare attorney, make sure they know your view on this. It is best to put it in writing and have a signed and witnessed advance statement such as "I forbid death by dehydration".

Dr Anthony Cole,  
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A shorter version of this article was first published as a letter in the Catholic Herald.

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