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IN THIS ISSUE

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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

CATHOLIC MEDICAL ASSOCIATION (UK)

39 ECCLESTON SQUARE, LONDON SW1V 1BX
TELEPHONE NUMBER. +44 020 7901 4895
FAX NUMBER. +44 020 7901 4819

Registered Charity No. 1002374

CATHOLIC MEDICAL QUARTERLY

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Submitting articles to the CMQ

CMQ is an open access medical journal set up to discuss key issues in medicine as they relate to and support doctors, nurses and other health care professionals in their practice. It is the journal of the Catholic Medical Association (UK). Views expressed are those of the authors and do not necessarily reflect the views of the CMQ editor or those of the CMA(UK). The CMQ was originally published in 1947 as the Catholic Medical Gazette.

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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AUGUST 2019

For details of forthcoming branch meetings please contact your local branch Secretary or visit www.catholicmedicalassociation.org.uk.

HOC TEMPORE: CATHOLICS ARE NEEDED IN HEALTHCARE!

DR ADRIAN TRELOAR FRCP

FORCED ABORTION IN THE UK

Many will have been deeply shocked in June by the case of a 22 week pregnant learning disabled woman whose doctors wanted to abort her child without her consent. But the girl did not want an abortion. The woman's mother, a Nigerian Catholic midwife, said that she would care for the baby. However, Justice Lieven dismissed that possibility, and said she thought the pregnant woman would suffer more distress if the baby was taken away than if pregnancy was terminated.

"I think (she) would suffer greater trauma from having a baby removed," said the judge. "It would at that stage be a real baby." The judge added: "Pregnancy, although real to her, doesn't have a baby outside her body she can touch." Justice Lieven even went onto say that "I think she would like to have a baby in the same way she would like to have a nice doll." [1]

The woman's social worker disagreed that an abortion was in her best interests, and her legal team said there was "no proper evidence" to show this. Despite those objections the judge (Justice Lieven) ordered that the woman should have an abortion in her "best interests". Thankfully, the decision was overturned by the Court of Appeal, but many questions need answering.

The ruling sparked outrage and within 48 hours 98,000 people had signed a petition asking the Secretary of State for Health to act. Right to Life organised an excellent demonstration is outside Parliament which was well attended and attracted real support from passers by. Chanting **"Say Hey, say Ho, say No to forced abortion"** a clear message was given. Speaking at the demonstration, Emmi Egbonou, said:

"What is shocking is that this was ever allowed to happen in the first place. The fact that the state can force a late-term abortion on a woman who did not want one is not the kind of state we want to live in. The fact that a judge could make a ruling to force an abortion on a vulnerable woman without her consent is a betrayal of the justice system and betrayal of the most vulnerable in our society.
A forced late-term abortion would have been an irreversible trauma on the mother and would have ended the life of the baby that had been growing inside her womb for almost six months and, at 22 weeks, could survived outside the womb.

We are here today to we stand with this woman. We stand with her baby. We stand with her family. We stand with every woman in the UK who has been forced by a hospital to abort their baby.

The Government must ensure no women and family will ever have to go through this again. We are here today to send a clear message to the Government. This must never happen again." [2]

We should note that in all 63 paragraphs of the ruling however, no consideration or weight is given to the rights of the 22-week-old unborn baby. [3]

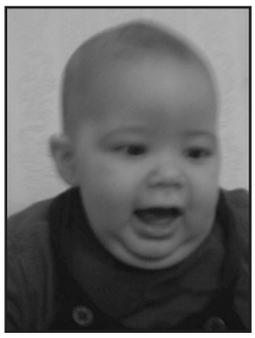
After the baby had been allowed to live by the Court of Appeal John Deighan, SPUC Deputy CEO said: *"The decision to perform an abortion on a disabled woman against her will, when her mother had promised to look after the child, caused shock and outrage around the world. A forced abortion is one of the worst things that can be done to a woman, and it is beggars belief that a judge of this land advocated this kind of cruelty and barbarity"* [4].

In all 63 paragraphs of the ruling however, no consideration or weight is given to the rights of the 22 week old unborn baby

But it is extraordinary that the UK has joined countries such as China and used legislation to force abortion upon women. In the face of a mother (who is also a midwife) pleading for the life of her grandchild, that is truly tyrannical state sponsored abortion.

The judge involved, Nathalie Lieven, has a long history of abortion advocacy. As a lawyer, she represented the British Pregnancy Advisory Service (BPAS) in 2011 in their crusade to allow home abortions. From 2015 to

2018, Judge Lieven represented the Northern Ireland Human Rights Commission as it launched legal action against Northern Ireland's government, arguing that their pro-life law violated the human rights of women and girls.[3]. She also represented the Family Planning Association in 2005 arguing against parental involvement with underage children in decisions about contraception, sexually transmitted infections and abortions.[5] Especially in the context of her judgement, we should be concerned about conflicts of interest.



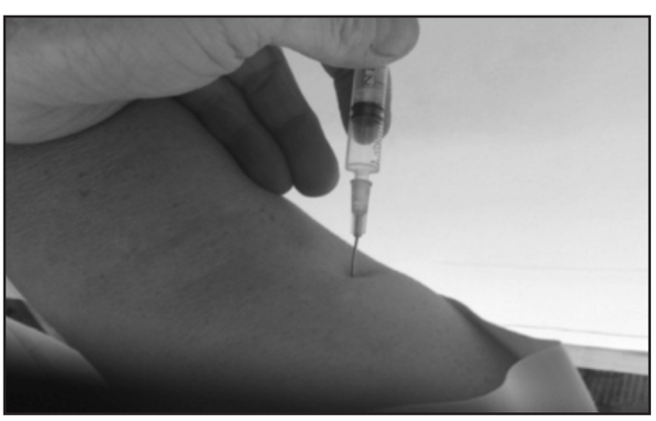
It is extraordinary that the UK has joined countries such as China and used legisslation to force abortion upon women.....that is truly tyrannical

Born and pre-born children are our greatest assets. President John F. Kennedy, himself one of nine children, once said: ***"Children are the world's most valuable resource and its best hope for the future."***

Moves towards assisted suicide despite coercion of Dutch GPs to perform euthanasia.

At the other end of life, Nick Boles MP was granted a debate in July on assisted dying. The BMA and RCGP are to poll their member on assisted dying. This is a time of great danger; and yet a paper in the Journal of Medical Ethics in May entitled ***"Pressure in dealing with requests for euthanasia or assisted suicide. Experiences of general practitioners"*** [6] found that the majority of Dutch physicians feel pressure when dealing with a request for euthanasia or physician-assisted suicide (EAS). The study explored the pressures experienced by general practitioners using semistructured in-depth interviews with 15 Dutch GPs, focusing on actual cases.

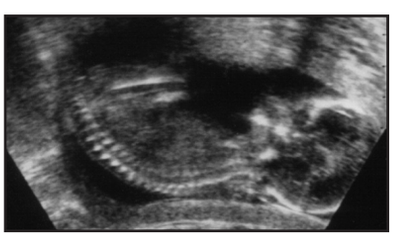
Six categories of pressure GPs experienced in dealing with EAS requests were revealed: (1) emotional black-mail, (2) control and direction by others, (3) doubts about fulfilling the criteria, (4) counterpressure by patient's relatives, (5) time pressure around referred patients and (6) organisational pressure.



The authors reported cases of emotional blackmail included patients threatening to commit suicide if the euthanasia request was not granted. Disturbingly, there were cases of the family threatening to kill the patient: 'Well, will I have to do it myself then, will I have to put a pillow over her head? And then you will be the guilty one' (Case 9.1)

The study also showed that doctors had to try to counteract pressure being exerted on a patient by their family. Case 4.1 states: "One GP counteracted this pressure by encouraging the patient to explicitly state to her partner: 'I am dying, not you, and I am the one making this decision'

De Boer et al concluded that "the pressure can be attributable to the patient–physician relationship and/or the relationship between the physician and the patient's relative(s), the inherent complexity of the decision itself and the circumstances under which the decision has to be made." We are familiar with the pressures applied to both mothers and professionals to cooperate with abortion, and should not doubt that in the NHS, pressure to cooperate with euthanasia will also be enormous. We cannot hope that the weak, sick and vulnerable will be protected and safeguarded under any laws that allow doctors to kill.



We cannot hope that the weak, sick and vulnerable will be protected and safeguarded under any laws that allow doctors to kill.

Aborted tissue cell line vaccines.

The failure of national and international vaccine programmes to meet "herd immunity" uptake targets has been repeatedly in the news recently. Therefore in this issue we publish a long awaited article on the ethics of using vaccines derived from aborted foetal tissue cell lines. It is an important issue: Catholic parents are refusing the rubella vaccine because, in conscience, many feel that they should not accept it. See page 13.

A double murder, the rights of the unborn child and the offence of Child Destruction

We looked on in horror recently at the brutal murder of Kelly Mary Fauvrelle: a pregnant woman who was stabbed to death in London [7]. Paramedics (heroically and very commendably) delivered her baby boy at the scene. Ms Fauvrelle, who worked at Croydon Delivery Office, was eight months' pregnant when she was killed at her home in the early hours of Saturday 29th June. Sadly, having fought for his life her baby son Riley died on the 3rd July. It appears almost certain that Riley was killed by the same attack that murdered his mother. We would expect therefore to see two counts of murder laid against the assailant. This was a double murder. Rightly, the Metropolitan Police recognised that and as a result stated that they were investigating a "double homicide". [8] We

are therefore surprised that when a man was charged with the murder of Kelly, he received the lesser charge of manslaughter with respect to baby Riley.

Very disturbingly, Anthony Porter points out in this issue [page 25] that intrauterine deaths caused by road traffic accidents are not being considered in prosecutions for Road Traffic Accidents. Mr Porter points out that in UK law, unborn children are being denied their rightful legal status as a person - which cannot be acceptable. Under the Infant Life (Preservation) Act 1929 [9] anyone who "acts with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to penal servitude for life:" Section 2 of the Act makes it clear that the offence of Child Destruction can be brought when a person is tried "for the murder or manslaughter of any child, or for infanticide". And yet charges are almost never brought under that Act. It is "'Too hard to convict people of harming unborn babies'" [10]. Only 16 people were convicted in 11 years between 2004 and 2015.

The simple solutions

In the face of all this there can be no doubt. We need our Bishops to speak out. And we, the laity must carry the arguments for life into the workplace. Our Annual conference in Hull was a great success [see page 19-21]. And we need to do all we can to make local meetings of like-minded doctors, nurses and others an ongoing g and frequent reality.

All that is required for evil to triumph is that good men remain silent [8]. We must pray for the grace and strength to follow Jesus in Healthcare.

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EDITORIAL

THIS IS THE AGE OF THE LAITY

DR PRAVIN THEVATHASAN

This is the age of the laity. The Church has reached a point in her history where the authority of the Clergy to speak and guide on matters of doctrine and morals has become very limited. There is a huge lack of respect for the clergy, and when they do speak out, clerics fear that speaking out may make things worse .

Many people were upset that so few Irish bishops spoke out against abortion prior to the recent abortion referendum. Why was this? It has been argued in some circles that bishops in many parts of the world have lost credibility. It is not surprising therefore that they prefer to stick to subjects that will be supported by the media: knife crimes, trafficking and the plight of migrants. They are unlikely to say much about abortion or euthanasia. Even inside the Vatican, there have been many financial and sexual scandals. The Pontifical Academy for Life is now largely irrelevant, filled with dissenting theologians. Membership is even open to those who are pro-abortion. In these areas relating to abortion and euthanasia, it is largely up to the laity.

But alongside the loss of authority caused by the horrific scandals and crimes with which the Church has greviously wounded people, there is another reason why it is argued we should not expect much support from our leaders. They do not appear, at all times to support key teachings of the Church.

It is now known that a group of liberal cardinals met annually from the late nineties at St. Gallen, Switzerland [1]. They wanted a reformist pope to succeed Pope St John Paul II. They did not get their man the first time. It is important to note that they did not want to be seen as pro-abortion or pro-euthanasia or pro-gay marriage. They simply did not want to focus too much on these issues. In the name of pastoral accompaniment, they wanted certain changes in the Church.

The spiritual head of the St. Gallen group was Cardinal Martini of Milan. In its obituary of Martini, the Daily Telegraph reports that Martini criticized the then-Vatican position on "embryo donation and euthanasia-calling for greater pastoral attention to the terminally ill." He even questioned the Church's teaching on abortion, suggesting that legalization had to be a positive development in that it could reduce or eliminate illegal procedures [2]. Martini was famous for his rejection of Humanae Vitae [3]. The spirit of Martini hovers over the Vatican.

And so it is concluded that we should not be surprised to read that Cardinal Parolin met LGBT activists working towards greater acceptance of homosexual activity throughout the world [4] . Or that Cardinal Joseph Tobin said in a nationally televised program that the teachings of the Catholic Catechism on homosexuality are "unfortunate" and "hurtful." [5]

Perhaps the most famous member of the St. Gallen group was Cardinal Danneels. I think that he is the personification of all that is currently problematic in the Church. He was caught on tape advising a man who had been sexually abused by a bishop to keep quiet about the crime [6](Lifesitenews, 19 March, 2019). It is also reported that Danneels told the king of Belgium that he could sign the abortion law in good conscience [7]. He regarded same sex "marriage" as a positive development. He cannot be entirely blamed for the demise of the Church in Belgium.

Although all of the above observations appear to be true, the Catholic Church as the Body of Christ has not lost its credibility. Good bishops have continued to teach with incredible courage. One thinks of American Bishop Thomas Tobin gently reminding parents that they ought not take their children to "gay pride" events. What an onslaught of verbal abuse he had to deal with for stating what would have been uncontroversial until recently.[8]

During crises, the Church has relied upon the laity to carry it through. At the UK March for Life in May 2019, there were 5000 prolife marchers, a few dozen clergy and one Bishop. But the unity of purpose was huge. And the message (life from conception, no exception) was made loud and clear. There is deep faith and authenticity among those who are remaining faithful to the Church. The bishops have a duty to teach us. We the laity have a duty to work in accordance with Catholic principles and natural law.

This is indeed the age of the laity. It appears to me that we must absolutely rely upon the faithful laity to rebuild the Church through this current crisis. And that is especially true in healthcare . If the Bishops cannot speak about abortion or if they cannot set out why the Church's teaching on marriage and family is right and true then we, the laity, must. Just as St Paul VI asked of us right back in 1968 [9] .There is much to do. We as laity, must "put out into the deep" (Luke 5; 4) and do that work.
That really is what Catholic Action is all about.

References on previous page

PAPERS

ABORTION IN THE U.S. AND THE QUESTION OF PERSONHOOD OF THE FOETUS

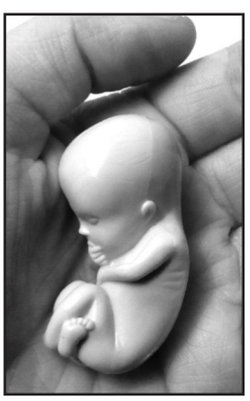
FR. WARD BIEMANS SJ

This year, very significant developments are taking place in the abortion legislation of several American states. In April, Ohio's Governor Mike DeWine signed a bill, referred to as 'heartbeat bill'. The bill bans abortion after the foetus's heartbeat can be heard, which is usually after about six weeks of pregnancy. In May, Georgia's Governor Brian Kemp signed a similar bill. A difference between the two bills is that Georgia's heartbeat bill includes exceptions in cases that involve rape or incest when the woman files a police report, whereas Ohio's bill does not include these exceptions. Earlier, the states of Mississippi and Kentucky passed laws that would ban most abortions after a heartbeat is detected. However, in March a Kentucky judge temporarily blocked the bill from being enforced. Abortion rights groups have already challenged Mississippi's law and have announced to do the same elsewhere. Nevertheless, in several other states lawmakers are still considering heartbeat bills.

The state of Alabama went even further in their restriction of abortion. The bill that passed in May makes all abortions a felony offense for a doctor who performs it except in cases of serious health risks to the unborn child's mother. Women who receive an abortion will not be held criminally culpable or civilly liable for receiving the abortion. When signing it, Governor Kay Ivey acknowledged that because of earlier jurisdiction, enforcing this bill would be difficult. However, she made her intentions clear: 'As citizens of this great country, we must always respect the authority of the U.S. Supreme Court even when we disagree with their decisions. Many Americans, myself included, disagreed when Roe v. Wade was handed down in 1973. The sponsors of this bill believe that it is time, once again, for the U.S. Supreme Court to revisit this important matter, and they believe this act may bring about the best opportunity for this to occur.'[1]

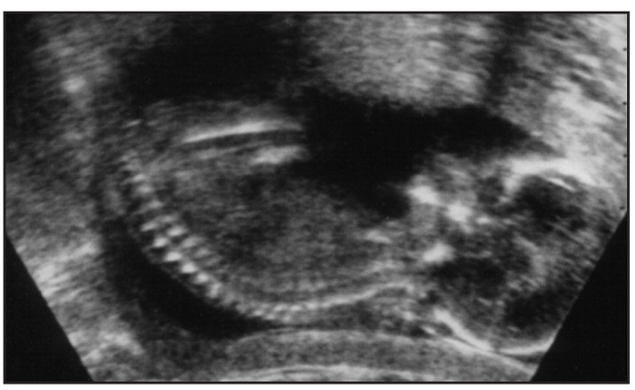
On the other hand, states like New York have recently passed legislation which extends legalized abortion even further than before. In New York State, abortions after 24 weeks have become legal 'when necessary to protect a woman's life or health'. Licensed midwives and nurse practitioners may perform nonsurgical abortions and physician assistants will be permitted to carry out surgical abortions. A similar bill, which would allow late term abortions in Virginia, failed. And in Massachusetts, abortion right advocates pushed through a bill called the NASTY Women Act (Negating Archaic Statutes Targeting Young Women), which formally repeals the state's 173-year-old law against 'procuring a miscarriage'. The bill aims to preserve abortion rights in the state in the event that the Supreme Court overturns Roe v. Wade.

The personhood of the foetus



Underneath all these legislative actions are very different views on the personhood of the foetus. Governor Ivey put it like this when she signed the Alabama bill: 'this legislation stands as a powerful testament to Alabamians' deeply held belief that every life is precious and that every life is a sacred gift from God.' Although opinions are diverging in relation to what is the best way to protect unborn human life and human dignity as such, there are strong biological arguments in support of the continuity of a child's development before and after birth, which could have implications for the recognition of the personhood of the foetus. In fact, embryonic development is guided by the DNA in the cell core, which is present and active in its specific combination from the moment of conception.[2] Also, the fact that a human embryo is dependent of the mother for its survival, is not fundamentally different from small children's dependency of their parents or other adults. Therefore, the unborn child's dependency has no implications for personhood, because it is clear that small children are persons.

Seen from a philosophical point of view, all limits to the acknowledgment of personhood before or after birth are artificial. As Don Marquis has already made clear in his famous essay on the immorality of abortion: abortion deprives the foetus of a future like ours, which is potentially valuable.[3] However, discussions on the morality of abortion often tend to focus on extreme and tragic cases like incest and rape. Often it is overlooked that other, much more frequent and also very painful cases of unintended pregnancy are at stake, for instance when the couple has financial problems, or when the male begetter just disappears from the woman's life, or when he or the woman's parents put her under pressure to have an abortion. In all these cases women deserve all the support they need from her family, her loved ones and from society to take care of her child, regardless the question if the pregnancy is intended or not.



The Catholic viewpoint has always been that human life, both before and after birth must be protected and deserves the utmost care. It is of great importance that the policy of restricting abortion is integrated with the provision of all needed support of expecting couples and families. In the U.S. and the U.K. this support is mostly privately financed by pro-life organisations, as well as charities that provide support in cases of adoption and foster care. With regard to the prevention of abortion, schools can do a lot in stimulating a pro-life mentality, for instance in their Relationships and Sex Education, by paying more attention to communication skills needed for building up long-lasting relationships and to virtues like fidelity and self-discipline, rather than a too narrow focus on issues like LGBT or artificial birth control.

If the new legislations on abortion do reach the U.S. Supreme Court, which is likely going to happen, it may provide a real opportunity for Roe v. Wade to be overturned. When Justice Brett Kavanaugh became a member of the Supreme Court, a branch of juridical interpretation known as 'originalism' got a fresh impetus. When the Senate confirmation hearings took place last year, Kavanaugh described himself as an originalist, seeking to identify the 'original public meaning of the constitutional text at issue'.[4] Remarkably, when in 1868 the Fourteenth Amendment of the U.S. Constitutions had been adopted, which aims at equal protection of the laws for all persons, nearly every American state had criminal legislation proscribing abortion, and most of these statutes were classified among 'offenses against the person'. Thus, as Joshua Craddock rightly remarks in the Harvard Journal of Law & Public Policy: 'The original public meaning of the term "person" thus incontestably included prenatal life.'[5] In this light, it will be most interesting to see what the Supreme Court will make of a revision of Roe v. Wade.

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NICE'S REPUTATION IS AT RISK AS A RESULT OF ITS NEW GUIDELINE ON ABORTION

From the President of the CMA(UK)

The recent NICE guidelines consultation on "Termination of Pregnancy" concluded on 31st May 2019. It was decided at the Catholic Medical Association (UK) Annual General Meeting in Hull on May 5th that a formal submission on behalf of the CMA (UK) would not be sent. It was feared that such a submission could be used by the consultation committee to grant respectability to the final published guidelines. Given the structure of the committee, it was suspected that any submission from the Catholic Medical Association (UK) or any other organisation opposing abortion would not receive a fair hearing or proper consideration. It was decided instead to send a letter of concern to the All-Party Parliamentary Pro-life group (via Ms Fiona Bruce MP) and to the current Health Secretary (Mr Nick Hancock), expressing our concerns. The essential content of those letters is reproduced here:

Reputation of NICE at serious risk

I write to you as a concerned citizen, a consultant medical physician and as President of the Catholic Medical Association (UK).

You may be aware that the National Institute for Health and Care Excellence (NICE) on 12 April 2019 published a draft consultation document relating to new proposed guidelines on "Termination of Pregnancy". Having read the document, I am particularly concerned that it is, in essence, a manifesto for the promotion of extremely liberal abortion practices. A spokesperson for the organisation Life Charity has accurately described it as "a dream business plan for the abortion industry at the expense of vulnerable women".

It is worth remembering that abortion remains a serious crime in this country, unless carried out according to the strict regulations laid down in the Abortion Act of 1967. The Chief Medical Officer, Dame Sally Davies, in 2012, reminded all doctors that "unless performed under the conditions set out in the 1967 Act, abortion remains a criminal offence under the Offences Against the Persons Act 1861". The regulations are there for good reasons, specifically to protect vulnerable women, and they are a recognition that recourse to abortion should only be considered in specific and rare circumstances.

I recognise that the attitudes of many towards abortion have greatly changed since 1967 and that abortion in the UK is now performed essentially on demand, with the law largely ignored in the vast majority of cases. I recognise also that there is a current movement aimed at the total decriminalisation of abortion but that has not yet been realised. The current draft guideline seems to presume that abortion is no longer a serious crime but is rather something to be encouraged and to be provided without restraints. There is a presumption throughout that decriminalisation has already been approved. It is not the role of any NICE committee or NICE document to dictate what the law should or should not allow.

The draft guideline strongly advocates prompt referral of women for abortion and a number of the proposals are made to ensure that abortions are carried out without any delay. It specifically recommends that there should be no compulsory delay for psychological assessment and no compulsory delay to allow women time for reflection before proceeding with abortion. In the UK, 98-99% of all abortions are carried out on the basis that continuing with the pregnancy poses a greater risk to the mental health of the woman than if she chooses to have an abortion. There is absolutely no evidence, anywhere in the world, to support a view that abortion is necessary for protecting mental health in pregnant women. In fact, there is evidence that women with pre-existing mental health problems are more likely to suffer a significant deterioration in their mental health if they have an abortion compared to women with pre-existing mental health problems who continue with their pregnancy to term. This fact alone supports the need for promoting a detailed psychological assessment prior to abortion.

A very serious consideration is the international evidence that up to 64% of all women presenting for abortion feel coerced or pressurised into making that decision. [1] This crucial safeguarding aspect of care is not acknowledged by the Committee promoting this draft guideline. Rushing women and healthcare professionals into abortion decisions and procedures is offering a great disservice to all concerned.

The draft guideline is clearly biased in many of the claims made about the safety of abortion. The references provided are totally from one side of the abortion debate and credible evidence presenting alternative opinions is ignored. In particular and specifically, there is evidence from many independent sources that abortion is associated with an increased future risk of premature births in subsequent pregnancies.[2-5] There is strong evidence that many women suffer serious mental health problems following abortion.[6-11]

Several studies demonstrate a link between abortion and subsequent development of breast cancer.[12-16] It is true that some studies demonstrate no significant risks of mental health problems, later premature births or breast cancer but the draft guideline should present a more balanced argument and studies demonstrating different results should be recognised. Those using a guideline from NICE deserve to be informed of the existence of conflicting evidence.

While it might seem to be pedantic, the actual use of the wording "termination of pregnancy" in the context of this draft guideline document is scientifically, medically and possibly legally incorrect. Every pregnancy, in fact, results in termination. Sometimes the termination is induced such as in deliberately induced abortion, but also in Caesarean sections for obstetric reasons with the intention of delivering a healthy child and protecting the health of the mother or in the induction of labour by pharmacological means to precipitate delivery of a healthy child. The guideline should, at least, be scientifically accurate in its terminology. Furthermore, in such a document, terms that may be open to varying interpretations should be clearly defined. For example, following the recent popular referendum in Ireland, leading to the repeal of the Eighth Amendment acknowledging the equal right to life of the unborn and the subsequent introduction of legal abortion in that country, abortion was clearly defined in the Irish Constitution as "a medical procedure with the intention of ending the life of a foetus". The terms "medical procedure" and "foetus" were further defined to ensure that there be no doubt in any mind as to what is meant by the terminology used. Any document produced by NICE must contain clear and indisputable definitions so that the content is clearly understood by all who consult it.

Surprisingly, the words "foetus" or "embryo" do not appear in the draft guideline. Instead, the more abstract term "pregnancy" is used throughout when referring to what is actually removed from the wombs of mothers with each abortion procedure, whether by surgical or pharmacological means.

Nowhere in the draft document is there any consideration that the aborted foetus or "pregnancy" could be considered a living being. This is scientifically inaccurate and is potentially offensive to many mothers, especially to any mother who has lost a child through miscarriage. Regardless of the stage of pregnancy, women who suffer a miscarriage often grieve over the loss of their child. The language expressed in the draft guideline is totally insensitive to women (and men) who suffer such loss.

While the authors of the guideline go to great lengths to describe how abortions should be performed throughout all the stages of pregnancy, there is no recommendation as to what care should be considered for an aborted foetus who may be born alive (perhaps unintentionally if the abortion attempt has "failed") and may have reached the stage of viability, especially if born after twenty-four weeks gestation. Not to provide proper care to a baby in such situations could be considered negligent and bordering on infanticide.

Many other concerns with the draft guideline could be expressed, including the lack of any reference to "abortion pill reversal" therapy. This has actually been requested by several women in distress, in recent years, in the UK when they have withdrawn consent and changed their minds after taking the first abortion pill (Mifepristone) in "medical abortions". Evidence from around the world supports such "reversal" intervention to help them preserve their pregnancies.

I could also refer to the concerns over recommendations that abortion training should be considered an essential part of core training for more doctors. Such a policy would inevitably result in many doctors feeling pressurised to participate in procedures that they consider to be unethical and abhorrent.

I could refer to the recommendation to speed up the process of procuring abortion by allowing women to avoid having appropriate face-to face consultations with their doctors or midwives and allowing consultations to take place instead by video links or telephone calls.

Similarly, it is objectionable that the draft guideline should recommend that, if necessary, women should receive tax-payer funded financial support to cover travel and a ccommodation expenses to enable them to have abortions. Women, children and men who require more essential and life-saving treatments for genuine medical illnesses do not currently routinely receive such financial support from NICE or other healthcare bodies.

I recognise that an opportunity is provided for interested parties to register to enable them to make comments or suggestions to the Committee as this draft guideline is officially a "consultation" document. From experience, however, I have no doubt that the Committee in question will certainly not be influenced or persuaded by any of the arguments quoted in this address. The Committee is heavily biased towards promoting a very liberal abortion policy. Most, if not all, of the members of this Committee have a strong bias in favour of liberalising abortion availability and they have a vested interest in doing so. There is no possibility that any arguments that dispute the promotion of increasing abortion availability will be taken seriously. If I, as an individual, or if the Catholic Medical Association (UK), as an interested organisation, submit our concerns and suggestions as a registered participant in the consultation process, we will receive a response thanking us for our contribution with an assurance that our submission will be considered by the Committee. The final published guideline will not be influenced by our concerns and our name(s) will be included in the list of contributors, giving credence and a degree of respectability to the final document. There will be an acknowledgement that not all of the contributors necessarily agree with all of the content of the guideline but it will not be revealed which individuals or organisations disagree with specific points in the content. This would be unacceptable for me and for the Catholic Medical Association (UK) as our "contribution" could be interpreted by some as an endorsement of the entire content of the published guideline. That explains why I feel the need to report my concerns directly to you.

NICE is, on the whole, currently respected by the medical profession and by the public at large. Recommendations

from NICE are generally taken seriously by doctors and by commissioning health authorities. This draft document runs the serious risk of discrediting NICE. If the final document is similar to this draft proposal, as is very likely to be the case, the reputation of NICE will be seriously and irreparably damaged. Many hundreds, if not thousands, of doctors may never again consider anything published by NICE to be trustworthy. It is really that serious.

I ask you therefore, to please bring these concerns to the attention of Government personnel responsible for safeguarding the reputation of NICE and the Department of Health and Social Care.
Yours Sincerely

Dr Dermot Kearney

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PRACTICAL MEDICAL ETHICS

THE BRITISH MEDICAL ASSOCIATION AND ROYAL COLLEGE OF PHYSICIANS' GUIDANCE ON CLINICALLY ASSISTED NUTRITION AND HYDRATION

HELEN WATT

This is an edited letter Edited letter to a Specialist Palliative Care doctor on new BMA/RCP guidance on Clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent

Dear X

It was good to speak to you on Friday. Since then, I've read the BMA/RCP guidance on CANH properly and have done a bit of consulting with doctors and others who find the document very concerning (and who also pointed out the lack of consultation among health care professionals and the general public).

It's worth stressing that the BMA's own authority is limited: they are not of course the GMC, but more a doctors' trade union. Even the RCP (which is currently polling its members on assisted suicide) is not the GMC!

In short, the guidance is not GMC guidance, and although the GMC generally endorse it on the cover-page, they helpfully make a point of saying that this not about threshold fitness to practice and that the guidance is a tool not a rule-book. It's also worth remembering observations in the document itself eg on p.23 to the effect that the guidance doesn't replace existing (including GMC) guidance (I also hear that new GMC consent guidance is in the pipeline).

Even if the guidance were a GMC document, and even if the BMA/RCP's interpretation of the law is accepted completely (though clearly the very detailed guidance goes beyond the law) that doesn't mean it would be ethical - or even feasible for busy doctors - to do everything the guidance says.

The guidance massively sidelines patients' objective health interests in favour of hugely disproportionate stress on the patient's past views (and present experiences if any). It's already a serious problem that doctors are expected to withdraw basic care like CANH because it was rejected in the past by the patient (who often will not have been remotely adequately informed). Far worse if CANH is withdrawn because life itself wasn't wanted or 'would not have been' wanted in someone else's opinion - which seems overwhelmingly the kind of case considered by the guidance.

One of the most worrying things is the way decision-makers are expected to be unusually proactive (even if nothing for the patient has changed) in constantly reviewing 'best interests' understood in very subjective terms, questioning family members on their loved one's wishes and beliefs re life in certain conditions (p.32 etc), finding others who might testify to these wishes and beliefs etc. Beginning such a process unfortunately may well turn up some kind of evidence that the person would not have wanted to live in their current state - in fact, that's more likely than turning up evidence that the person would have wanted to live (particularly with conditions like PVS).

To me there are serious complicity problems raised by getting involved in prior discussions with family etc along the guidance lines - as opposed to 'doing one's own thing', acting like a doctor, tactfully making a case for CANH being in the patient's clinical interests (the guidance itself accepts that CANH is clinically indicated for these patients), tactfully pointing out things the patient/family may not have known about CANH etc - perhaps as part of some freestanding consultation.

The guidance asks doctors either to make or implement the decision to stop CANH, including on 'patient didn't want to live' grounds, or refer the patient to a colleague for the purpose of making/considering/implementing such a decision. Any referral made specifically so that a colleague can make or implement a decision to withdraw CANH if the patient didn't want to live is no solution morally: no patient should be referred specifically for something you think it's wrong to do. (Of course, simply mentioning the possibility of a second opinion or informing the family/some higher-up that you're unable to do something does not constitute referral - you're not saying someone else should do it or actually intending people look elsewhere.)

As I mentioned on the phone, it's important not to give relatives the impression that something morally reasonable is happening when it's not. For me, hospice people getting involved in initial discussions with relatives along the guidance lines has worrying echoes of the situation

where abortion staff make a point of acting as if women having late abortions for disability were losing/going to lose their babies naturally. It's about sending out wrong/harmful messages, as well as perhaps being closely implicated in the withdrawal decision itself. Even if the patient's relatives do not actually support withdrawal of CANH (though they may rashly let slip that the patient wanted that) it's not good for them to get the message that morally nothing is amiss, not least as this may affect future decisions - or merely expressions of opinion - they may make about their own lives. In any case, care needs to be taken that the consultation does not turn into a garnering and hazardous recording on the patient notes of 'patient didn't want to live' material.

Hospices are for people with existing health conditions requiring palliative care, not for people whose death is being planned for, perhaps deliberately on the grounds is what they wanted (some doctors as well as perhaps some families and patients in the past will be actually intending death as well as cessation of a form of basic care). I'm not convinced that hospices should be agreeing in advance to accept patients who could live for years but thought in the past or 'would have thought' in the opinion of someone else that they would be better off dead than tube-fed in their current condition. At any rate, I don't think hospices should get involved in planning for/managing the whole process of wrongful CANH withdrawal (as opposed perhaps to accepting a patient some point after any wrongful CANH withdrawal, without that acceptance being promised specifically in advance). It is one thing to say that a palliative care service is generically open to patients who need it; something else to assure decision-makers in advance of a wrongful CANH withdrawal decision for a specific patient that one has an end-of-life care plan ready for that patient. It's a serious problem that the court and the guidance ask for such a care plan (the guidance including a space for it on the proforma) given that specialist palliative care working in hospice, community and hospital are the only people who have the skills to provide this, whether directly or via consultation.

Do let me know any thoughts you have yourself - or let me know if you would prefer to discuss this by phone.

Best wishes,
Helen

Dr Helen Watt is Senior Research Fellow at Anscombe Bioethics Centre

MEASLES, MUMPS AND RUBELLA (MMR) VACCINES: THE ETHICS AND THE NEED FOR AN ALTERNATIVE VACCINE

DR ADRIAN TRELOAR FRCP, MRCGP, MRCPSYCH

Abstract

Rubella vaccines available in this country are all derived from an abortion carried out in the 1960's. As a result many Catholics are concerned about the use of the vaccines, and some have avoided the vaccination of their children. In the past others have sought alternative vaccines from abroad but these are no longer available.

Multiple ecclesial authorities have said that the use of the vaccine is "remote cooperation" with the abortion, and therefore not intrinsically evil. Therefore if alternatives are not available it is legitimate to accept the aborted cell line vaccine.

Failure to vaccinate against rubella risks causing cases of congenital rubella (severe learning disability) in unborn and yet to be conceived children. Parents may therefore be putting their children at risk of grave harm if they do not vaccinate.

Parents therefore have two conflicts in conscience.

- Firstly, many will wish to avoid a vaccine which is (remotely) linked to abortion.
- But secondly, in conscience, they should not be willing to put their (or other peoples) children at risk of grave harm.

The absence of any work by statutory authorities to create ethical vaccines leave parents alone in those conflicts of conscience.

Given that there is currently no alternative vaccine, the author therefore recommends vaccination. It is also noted that Public Health England appears unconcerned about the plight of those who feel they must reject vaccination on ethical grounds.

THE QUESTION

Dear Editor,

I have recently found out that a school student I organized work experience for at the hospital has not been signed off by occupational health because of not having been vaccinated against MMR. To work even as a work experience student, the student must be vaccinated against MMR.

Faithful Catholics are sometimes avoiding having the MMR vaccine because of it's having been derived from an aborted cell line. Whilst this seems to me to be a very reasonable position, there are three problems:

1) Should we be advising Catholics to avoid being vaccinated against MMR because of it being derived from an aborted cell line?
2) Those Catholics cannot go into healthcare without being vaccinated against MMR, and
3) not being vaccinated and being in a Catholic community of people with the same view who have not been vaccinated may reduce herd immunity and could contribute to an outbreak of one of these diseases.

I was vaccinated against MMR without knowing about this contentious issue.

Please could you advise me as to what we can suggest to these Catholics in future?

OUR REPLY

I have divided the reply to your question into four parts.

1. The ethics and acceptability of vaccination with a vaccine derived from an aborted child.
2. The right of employers to require employees to accept medical treatments as a condition of employment.
3. What you might say to the school student
4. The public health ramifications of this problem

The ethics and acceptability of vaccination with a vaccine derived from the an aborted child

Background

The Measles mumps and rubella vaccine (MMR) vaccinates children against three diseases in a single injection. It is given to children at age of 1 year of age with a repeat dose before school at age 3-4. Further doses are given to some teenagers depending upon their vaccination history.[1]

Vaccination is given to both boys and girls and that enables better "herd immunity". The key benefit of vaccinating everyone, (and of ensuring that health care workers are immune) has been a further reduction in cases of Congenital Rubella to very low levels. About 20 cases have been reported since 1997 with a small number of medical abortions. According to the British Paediatric Surveillance Unit [2] ***"about half of the recently reported [cases of rubella in] infants had mothers who acquired infection abroad in early pregnancy, generally in their country of origin. Most of the remaining cases were children with mothers who, though they acquired infection in the UK or Ireland, were born abroad"***. Therefore as well as enabling herd immunity, vaccination also protects the individual vaccinated mothers from getting infected with Rubella. That in turn means that their children are protected from acquiring Congenital Rubella. Figure 1 shows how the incidence of Rubella has fallen since the 1970's.[3]

Whilst for an infected pregnant woman rubella is a fairly mild illness, it is devastating to her unborn child, causing

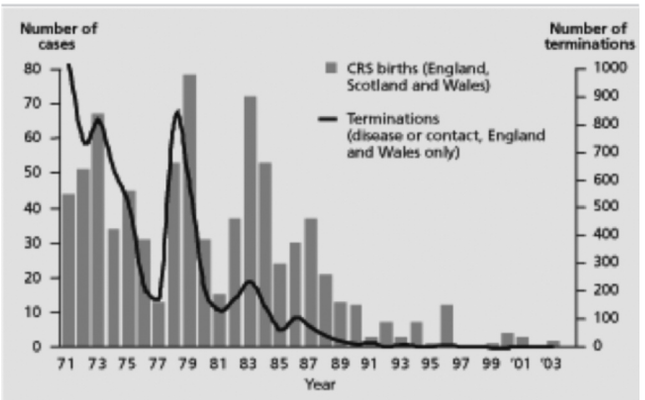

Figure 1. Congenital Rubella Syndrome

deafness as well as severe mental retardation. Rubella it is an illness which requires effective vaccination campaigns.

Those of us old enough to have seen children with congenital rubella know how dreadful an illness Congenital Rubella is.

Why the concerns about the vaccine?

The key concern with regard to the MMR vaccines is the fact that the Rubella component was grown by a Russian scientist (Plotkin) in the 1960's from lung cells taken from an aborted foetus. That vaccine was grown in lung tissue cells at 30^0 C with the result that the vaccine then only produces a limited infection (enough to immunise) when injected into humans. The vaccine worked well and was adopted because it is more effective than the other strains

Some strains of Mumps vaccine (though not all) are also grown on aborted cell lines. Table 1 shows a list of vaccines based upon the two aborted cell lines in use today. Researchers have estimated that vaccines made in WI-38 and its derivatives have prevented nearly 11 million deaths and prevented (or treated, in the example of rabies) 4.5 billion cases of disease.[4]

Table 1
Vaccines developed using either the WI-38 or the MRC-5 aborted cell strains.

- Hepatitis A vaccines [VAQTA/Merck, Havrix/Glaxo-SmithKline, and part of Twinrix/GlaxoSmithKline]
- Rubella vaccines [MERUVAX II/Merck, part of MMR II/Merck, and ProQuad/Merck]
- Varicella [chickenpox] vaccine [Varivax/Merck, and part of ProQuad/Merck]
- Zoster [shingles] vaccine [Zostavax/Merck]
- Adenovirus Type 4 and Type 7 oral vaccine [Barr Labs]*
- Rabies vaccine [IMOVAX/Sanofi Pasteur]*

**Vaccine not routinely given*

Alternatives to WI-38 Rubella vaccine

The Cendehill vaccine strain (Kitasato corporation) is based upon rabbit kidney cells. The author cannot find evidence that compares its efficacy with that of the aborted cell line strain based upon aborted foetal cells. But it is of note that ***"after testing, the aborted cell line vaccine was licensed in Europe in 1970 and was widely used***

there with a strong safety profile and high efficacy. In light of that data, and of larger side effect profiles with the other two rubella vaccines, it was licensed in the United States in 1979 and replaced the rubella vaccine component that had been previously been used for Merck's MMR (measles, mumps, rubella) combination vaccine". Therefore, there is at least some concern that the rabbit cell vaccine may be less effective.

The position of ecclesial authorities

People who value and understand the humanity of the unborn child frequently raise ethical questions about the use of aborted cells lines in vaccines. Some protect their children from being vaccinated as a result. The Vatican, as we describe below, has supported the used of aborted cell vaccines as the constitute remote cooperation with evil. Some members of the Catholic Church do not agree with the Vatican line and have asked for its moral guidance on the use of vaccines developed using cell strains started with foetal cells. As we have already said, this includes the vaccine against rubella as well as those against chickenpox and hepatitis A, and some of the rabies and mumps vaccines.

US National Catholic Bioethics Centre (NCBC), established in 1972, conducts research, consultation, publishing and education to promote human dignity in health care and the life sciences, and derives its message directly from the teachings of the Catholic Church. The (NCBC): states that in its view individuals should, when possible, use vaccines not developed with the use of these cell strains.[5] However, in the case where the only vaccine available against a particular disease was developed using this approach, the NCBC notes

"There are a number of vaccines that are made in descendent cells of aborted fetuses. Abortion is a grave crime against innocent human life. We should always ask our physician whether the product he proposes for our use has an historical association with abortion. We should use an alternative vaccine if one is available."

The NCBC then suggest that if a physician recommends one of these vaccines *"Sometimes alternative products, which are not associated with these cell lines, are available for immunization against certain diseases. For example, there is a rabies vaccine (RabAvert) and a single dose mumps vaccine (Mumpsvax) without any association with abortion that are equally safe and effective. If doing so is practical, you should ask your physician to use an alternative vaccine, but there is no moral obligation to use products that are less effective or inaccessible. Parents should check with their physician regarding the efficacy and availability of these and any other vaccine."*

But they go onto note that there are currently no alternatives for rubella (German Measles), Varicella (Chickenpox), and Hepatitis A.

In 2005 the Pontifical Academy for Life [6] , in a letter signed by Cardinal Sgreccia stated that

- *"there is a grave responsibility to use alternative vaccines and to make a conscientious objection with regard to those which have moral problems;*
- *as regards the vaccines without an alternative, the need to contest so that others may be prepared must be reaffirmed, as should be the lawfulness of using the former in the meantime insomuch as is necessary in order to avoid a serious risk not only for one's own children but also, and perhaps more specifically, for the health conditions of the population as a whole – especially for pregnant women;*
- *"the lawfulness of the use of these vaccines should not be misinterpreted as a declaration of the lawfulness of their production, marketing and use, but is to be understood as being a passive material cooperation and, in its mildest and remotest sense, also active, morally justified as an extrema ratio due to the necessity to provide for the good of one's children and of the people who come in contact with the children (pregnant women);*
- *"such cooperation occurs in a context of moral coercion of the conscience of parents, who are forced to choose to act against their conscience or otherwise, to put the health of their children and of the population as a whole at risk. This is an unjust alternative choice, which must be eliminated as soon as possible*

Thus Cardinal Sgreccia, on behalf of the Pontifical Academy for Life affirmed the use of vaccines derived from aborted cell lines as being remotely and not proximately partaking in the evil of abortion. An alternative example of this remote responsibility is paying one's taxes which in the UK fund the majority of abortion/ sterilizations etc.

Are we morally free to use vaccines based upon aborted cell lines if there is no suitable alternative?

The NCBC state that *"One is morally free to use the vaccine regardless of its historical association with abortion. The reason is that the risk to public health, if one chooses not to vaccinate, outweighs the legitimate concern about the origins of the vaccine. This is especially important for parents, who have a moral obligation to protect the life and health of their children and those around them."*

The Pontifical Academy for Life was founded by Pope John Paul II in 1994 to address contemporary bioethical issues. In the previously quoted Cardinal Sgreccia document, the Pontifical Academy for Life states that

- *"We find, in such a case, a proportional reason, in order to accept the use of these vaccines in the presence of the danger of favoring the spread of the pathological agent, due to the lack of vaccination of children. This is particularly true in the case of vaccination against German measles."*[6]

To sum up on the ethics of vaccines derived from aborted cell lines

It is absolutely understandable and right that those who value and respect human life will feel uneasy and many will be offended by the use of aborted cell line vaccines. The reality that the vaccines were derived from the killing of a can unborn child is neither trivial nor pleasant. And it must in no way be seen to justify or minimize the wrong of that abortion.

It is important to re emphasise that there are many devout Catholics who wish to faithfully serve God and His Church and after studying the issue have arrived to the view not to vaccinate themselves and their children using the MMR vaccine. This is because the rubella component is derived from an aborted cell line. The author wishes to acknowledge their desire to make the right decision and do the right thing for them and their children.

But the use of vaccine is remote cooperation and not proximate cooperation with abortion. Having the MMR vaccine neither causes nor justifies the abortion which was done in the 1960s. It is also important to acknowledge we live in a very broken world in which abortion is regarded as if not morally neutral even as a good act. It would seem that were the cells from a baby who had died and whose parents had left some of his organs for donation and medical science, it might be possible to have a cell line which does not have this association with abortion. We should therefore seek and ask for alternatives to these vaccines, which do not cause us to be remotely cooperating with evil, in the same way we pray for an end to abortion. Fr Hugh Thwaites once reminded us that "Good can come from the bad deeds of others". That does not justify or excuse the bad deeds but we should not reject the good that can be brought. Thus it is true that the sacrifice of that child has helped many people. That child can also be remembered and prayed for by many.

Two conflicts of conscience

Parents therefore have two conflicts in conscience.

- Firstly, many will wish to avoid a vaccine which is (remotely) linked to abortion.
- But secondly, in conscience, they should not be willing to put their (or other peoples) children at risk of grave harm.

The absence of any work by statutory authorities to create ethical vaccines leave parents alone in those conflicts of conscience.

It follows therefore that,

With regard to the ethics of aborted cell line vaccines such as Rubella, I feel bound to agree with the Pontifical Academy for Life.

- It is clearly offensive to some to use aborted cell lines to create vaccines.
- And that offence is causing some people to avoid vaccination.
- We should therefore seek and ask for suitable alternatives to these vaccines.
- But, the use of the vaccine is not of itself, intrinsically evil. Using these vaccines neither causes nor justifies the abortion that was done in the 1960's.

But I also feel bound to go a little further.

- We must (and I do) respect the views of those who find aborted cell lines offensive and feel they cannot use them.
- The avoidance of vaccination risks grave harm to unborn (or yet to be conceived) children.
- One unnecessary case of congenital rubella as a result of failure to vaccinate is a serious and grave harm.
- It is therefore wrong to avoid using the current vaccine strain because that risks a grave harm to unborn and yet to be conceived children.

Sadly, despite such encouragement, until an alternative vaccine is produced, some parents who value life will find that conclusion hard and may still avoid vaccination. Which remains a significant problem.

By far the best solution to this problem would be ethical vaccines which do not use aborted cell lines.

2 The right of employers to require employees to accept medical treatments as a condition of employment.

Your original question involved the right of an organization to insist that one of their workers has a particular medical procedure (vaccination against measles, mumps and rubella).

Hospitals have good reason to require that people are immune to key illness as they are to protect the patients whom they serve. Therefore, there is a separate question about whether or not organizations can impose vaccination upon their staff. It is clear that to some degree they can. HIV positive surgeons may be unable to work, as may those who are acutely infected with Hepatitis B for example. The governance arrangement around practicing in any healthcare profession all require that the employee must be fit to perform their duties. There is, therefore, an entitlement for trusts to insist upon some tests and upon immunity to some infections. However, I am aware that many health Trusts have found themselves unable to require their staff to have an influenza vaccine.

The key duty of healthcare organizations is to ensure that those who work for them are immune.

3 Advice for your friend

It is wonderful that your friend wants to have a career in healthcare. To do that, he needs to be well and should be expected to be immune to Rubella as well as other infections such as Hepatitis B. It should be possible to demonstrate immunity with blood tests for hepatitis, rubella, mumps and measles. Sometimes, those tests might only be available privately, although that is of concern in itself because it would disadvantage poorer applicants to healthcare positions.

And if those blood tests are positive the he will not need immunization. If those blood tests are negative, it may be that if you share this reply with the person who is seeking work, he will feel able to accept the rubella vaccine. If he is not immune, he may put others at risk of a serious and devastating illness.

While we are bound to sympathize with the concerns about the origin of the vaccine, a deliberate decision to put others at risk is a serious matter when the remedy required (vaccination) is not, according to multiple ecclesial authorities, intrinsically evil.

4 The public health options

So what are the options for public health?

At the present time, both the originator of the question and the author are aware of families who have refused vaccination because of the aborted cell line issue. In the past, alternatives were available with difficulty.[7] Some people went to Ireland where the rabbit Cell line was available (personal communication). That decision to refuse vaccination is deeply understandable and it is to be expected that the arguments presented above will not persuade many or all of those families to change their view.

Public Health England's view is robust. Public Health England [8] states that single vaccines lack an evidence base, will lead to delayed protection and reduced uptake and will therefore lead to an increased incidence of measles mumps and rubella. Without quoting any evidence base to substantiate this claim they state that "Single vaccines imported into this country haven't been independently tested for potency and toxicity. We have evidence that some of the single vaccines are less effective or less safe than MMR."

Public health England concludes that "There's no reason to make single vaccines available and every reason not to. Exhaustive research has provided very strong evidence that MMR is not linked to conditions like autism."

Alarmingly, the entire document does not mention the issue of aborted cell lines at all. It is an issue simply ignored. That is despite the fact that we and others have previously corresponded on this issue with the Department of Health (and been dismissed).

Finally, as if to dismiss any concerns the document states that "Parents are free to choose whether to protect their children, as no vaccination is compulsory in the UK." This final statement puts parents into a difficult position. They can decide not to vaccinate their children, but that does leave them at risk of having a child with congenital rubella and it may also make them unemployable in the NHS and elsewhere.

As well as all that, the single rubella vaccine is no longer available and as far as the author is aware the Kitasato Rabbit Cell vaccine is no longer available. Even from private healthcare. There is therefore, no alternative to the aborted cell line vaccine.

Are we dealing with a special group of people?

People who value life and who object to the use of aborted cell lines often meet together as a group. They tend most often to do so in Church on Sundays and in Mosques etc., at other times. Given that they meet together, there is an increased risk of mini epidemics arising within that population. As a group of young Christians, pregnant women will often be part of that population. Therefore the risks of congenital rubella may be amplified. Religion is a protected characteristic under the Equalities Act and should lead to reasonable accommodation of people's views.

In 2016 the Bank of England produced a new, plastic £5 note. It turned out that the notes were made with small amounts of animal fat (Tallow). A petition with 100,000 signatures stated that tallow, "is unacceptable to millions of vegans & vegetarians, Hindus, Sikhs and Jains in the UK". The amount of Tallow is very small. The amount used is less than 100 parts per million which means that each note contains less than 0.07mg of Tallow. As a result of the controversy the Bank of England are exploring non-animal fats for when the £20 note is launched in 2020. [9] So the amounts of tallow, which is a by-product of cattle production for meat, is miniscule. And of course no cow was ever killed for tallow. Tallow is a by-product of the meat industry.

For those who see the humanity of each unborn foetus, the issues of animal tallow simply do not compare with the use of tissue products from a human child which was deliberately killed in the womb.

Therefore, the opportunity (which has previously failed and been rejected by the department of Health) is to ask that those who object to the use of aborted cell lines are offered an alternative. If the Bank of England can change, then so too should Public Health England. But we must note that at the present time the alternatives to Rubella, and Rabies vaccines are not available.

What that means is that Public Health England's rather glib statement that "Parents are free to choose whether to protect their children, as no vaccination is compulsory in the UK." leaves parents and their children in a very difficult position. If single vaccines were available, better off parents could pay for these vaccines. But poorer parents will struggle to pay for such vaccines. As I have already said, the single rubella vaccine is no longer available.

Their only options appear to be to accept the aborted cell vaccine or to put their children and others at risk. For Public Health England to put people in such a position appears (to the author) to be wrong.

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NEWS

AMERICAN MEDICAL ASSOCIATION AND WORLD MEDICAL ASSOCIATION RETAIN THEIR OPPOSITION TO EUTHANASIA

The AMA and WMA have retained their opposition to euthanasia recently.
I received the linked news on this tonight and thought I would share it in case you don't already receive these bulletins -
https://www.lifenews.com/2019/06/10/ama-votes-to-retain-longstanding-opposition-to-assisted-suicide/

This shows we can prevail if we make a stand. And perhaps even roll back the abortion horror we find ourselves in the UK.

JEREMY HUNT ATTACKED BY EXTREMISTS FOR "INCREDIBLY ALARMING" ABORTION VIEWS

Foreign Secretary Jeremy Hunt has stood by his "personal view" that the abortion limit should be lowered.

Jeremy Hunt, the Foreign Secretary supports lowering the abortion limit to 12 weeks.

When he launched his bid to become Prime Minister, he came under fire from abortion activists for repeating his view that the abortion limit should be lowered.

View hasn't changed

Mr Hunt said in a 2012 interview that after reviewing the evidence, he supported lowering the abortion limit to 12 weeks. Asked by Sky News' Sophy Ridge on Sunday 9th June if that was still his position, he said: "My view hasn't changed on that and I respect the fact that other people have very different views.

"That's why these matters are always matters for free votes in the House of Commons and when they come up people vote with their conscience."

But wouldn't be Govt policy

When pressed on whether or not hecould guarantee the legal limit would stay at 24 weeks if he became Prime Minister, Mr Hunt replied: "What I can guarantee is it will be a matter for the House of Commons, not a matter for government policy.

"The prime minister will have his view just like every other one of the 650 MPs and these will be decided as a matter of conscience.

"But it won't be government policy to change the law in that respect."

Mr Hunt confirmed today that it would not be Government policy to change the abortion limit, and he has the backing of abortion supporting Amber Rudd, who said he had reassured her on the point.

"Horror show"

However, this has not stopped him being attacked by extreme abortion advocates. Labour MP Jess Phillips, one of the key figures behind the push to decriminalise abortion and impose it on Northern Ireland, tweeted: "Jeremy Hunt how about we base this stuff on evidence and science and keep what you think is best based on no experience out of this."

Liberal Democrat MP Christine Jardine said the foreign secretary's personal views were "incredibly alarming", while Scottish First Minister Nicola Sturgeon described the leadership contest as a "horror show", which included " attacks on abortion rights".

The British Pregnancy Advisory Service, one of Britain's largest abortion providers, and whose chief executive Ann Furedi has promoted abortion up to birth and sex-selective abortion, posted a series of tweets slamming Mr Hunt's remarks. One said that his desire to lower the time limit means "that you are okay with the fact that victims of domestic violence for whom abuse escalates in pregnancy will find it even harder to escape a violent partner."

In fact, as is detailed in Abortion and Women's Health, intimate partner violence is a risk factor for abortion all over the world. Decriminalising abortion, as BPAS is campaigning for, would mean there would be no obligation to question a woman on why she was seeking an abortion, meaning the opportunity to detect abuse and coercion would be lost.

The Editors of this Journal find it truly shocking that in an age of diversity and tolerance, Mr Hunt's desire to protect the most vulnerable and dis-enfranchised members of our society could be used as a bar to the office of Prime Minister. Especially when several polls have shown that a majority opposes removing abortion from the criminal law, and that women in particular support more restrictions than there are at present.

We are indebted to the Society for the Protection of the Unborn child for the original version on this article.

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https://www.spuc.org.uk/latest-news/latest-news/jeremy-hunt-attacked-by-extremists-for-incredibly-alarming-abortion-views

REPORTS

THE ANNUAL CONFERENCE OF THE CATHOLIC MEDICAL ASSOCIATION

BEING DISCIPLES OF JESUS IN THE WORKPLACE – A PERSONAL REFLECTION ON THE CMA ANNUAL CONFERENCE

During a very stressful period of my career, I attended the CMA conference and AGM. I had a very blessed experience and would like to share a few of the things I took away from this:

Virtue

Repeatedly falling into negative attitudes and behaviors such as detraction at work, I was reminded in a talk given by a GP partner, about our call as Christians to live a life of virtue at work. He shared the story of St Philip Neri who asked God for patience during a period of trial in his life, and was granted this; as well as the story of a man who during a challenging time at work, chose the path of perseverance, after coming to the conclusion that either the job was going to break him or he could allow it to turn him into a saint. I was reminded that I too could seek the path of growing in virtue, during this period of trial.

Faith and Conscience in the Workplace

I was encouraged and inspired by the witness of a Consultant Cardiologist who found a way in his day to day work to encourage morality and spirituality amongst colleagues. For example, he gave the example of how at the end of his lectures to junior doctors, he reminded them of their right to conscientious objection. Another example was a survey he held in which he asked colleagues to think about when human life began – a method that stimulates people to think about the sanctity of human life from conception. Simple acts of witness such as wearing a small cross on his shirt were also shared.

Competence

It was helpful to be reminded of the fundamental call of the Christian doctor to be competent. A talk given by a Consultant Anaesthetist about volunteering in Lourdes and the talk by the Consultant Cardiologist, reminded me that there is no ignoring this call to competence if we are truly to be witnesses to Christ, beacons of light that attract people to our Christian Faith, and if we are to help others. As a priest once reminded me in the confessional, patients are trusting us with their lives. We have a duty to respond to that trust by being the best healthcare professional we can be for our patients.

Support and nourishment

In addition to the talks, there were informal opportunities to network and share experiences, especially at the conference dinner. During this time, I experienced others giving of their time to listen, share experiences and offer counsel, and (very importantly!) we were physically nourished by the food arranged by Dr Josephine Treloar.

Charity

I became more informed about the charitable works of the CMA during the AGM, as a retired GP shared information with members about the various missionary projects that the Catholic Medical Missionary Society (a branch of the CMA) supports overseas.

Final thoughts…

Attending this conference was one step on the lifelong journey of personal sanctification, an opportunity for which I am thankful.

By a doctor in Specialist training and CMA member

CMA ANNUAL CONFERENCE 2019: "FOLLOWING JESUS IN HEALTHCARE"

Sister Andrea Fraile of the Sisters of the Gospel of Life

This, the Association's flagship event, was held in Hull University Chaplaincy on Saturday 4th May. The focus was billed as aiming to help Catholic healthcare workers answer four important questions:

- How can we keep a strong faith in a busy career?
- How do we bring hope?
- What is the purpose of healing and healthcare?
- How can we "live our faith" at work?

The venue was ideal – comfortable and well equipped, with rooms ideal for the formal presentations as well as for the social parts of the conference. The audience of attendees – a group of 50 of diverse ages and backgrounds, including students, nurses, midwives, doctors from various specialties, members of the clergy and interested non-medical lay persons– was made very welcome by the Hull University chaplain, Fr Mansell, and was all well fed and watered thanks to the sterling efforts of Dr Mrs Josephine Treolar and her band of volunteers (especially other Treolar family members!). Local accommodation was organised, varying from simple but comfortable rooms in the chaplaincy to local hotels, allowing those on various budgets to attend.

Sessions started and ended with a prayer, and we were fortunate to have a daytime Saturday mass in the delightfully small and friendly chaplaincy chapel and later the opportunity to attend together the vigil mass of Sunday in the parish church next door.

David Quinn, Director of the Iona Institute and former editor of the "Irish Catholic", gave an excellent keynote address "Bringing faith into public life" expounding on how the Catholic voice had been lost in the public space in Ireland, and how efforts to make it heard once again are giving hope.

Sr Andrea Fraile, from Glasgow, gave an inspirational talk in her lovely accent on "Helping people in a crisis: the work of the Sisters of the Gospel of Life". The loving but no-nonsense approach of the sisters, both to helping those facing fear around pregnancy and considering abortion, and to healing those damaged by having had an abortion, was very affirming of Christ's message. Giving hope and offering Christian healing are at the heart of their mission.

The other speakers, too, gave moving personal testimony of how their faith has inspired the best elements of their work, and how reflections around "healing" as opposed to "curing" have helped identify best practice. Practical advice and sharing of experiences on how to overcome forces opposed to the Christian view of care and social justice through bravely living one's faith were very moving. These sessions were wide-ranging and included:

- **"Being made whole": the purpose of healing and the purpose of healthcare"** by Dr Adrian Treloar, which offered an understanding of how a prayerful and thoughtful professional life allows us to identify those most in need and what those needs might be, focussing on the needs of those with dementia and how their "personhood" demands that they are as worthy as anyone else of the best of care.
- **"Caring for the sick in Lourdes"** by Dr Joseph O'Dwyer, a stimulating review of the difficulties and need for attention to detail when organising and carrying out medical support for a large diocesan pilgrimage, taking many sick and disabled pilgrims and carers - away from their comfort zones, but showing how the benefits far outweigh the costs.
- **"Living our faith at work"** by Dr Dermot Kearney, our young and dynamic president, was a moving account of how a strong faith allows us to support each other in times of trial and pressure to go against our Christian principles, and, combined with powerful reflections on their own professional lives by two other inspiring doctors, Mike Delaney ("**Keeping a strong faith in a busy career**") and Rob Hardie ("**Bringing hope to the sick: A Christian General Practice Surgery**") made a strong impression on those attending.
- **"Faith at work"**, by Julia Herbertson, was a story of how, even in the field of obstetrics and gynaecology, where the forces of secularism and evil disregard for the sanctity of life hold particular sway, a midwife with a strong Catholic faith and a determination to hold to her convictions is able to do so with the help of prayer and of support from like-minded colleagues, often from other Christian denominations. This reporter was especially moved by this testimony – like many juniors

in the medical world, he had found the joy of being involved in and helping ensure the best outcomes for mother and child at the time of birth to be an uplifting aspect of medical practice, only to find he lacked the courage in his formative years (in the 1980s) to pursue this as an area of practice because of a lack of courage to face up to those with a different view of the sanctity of life. It is a joy to hear that Christian witness is possible in this area and humbling to hear about Julia's bravery in this.

All sessions generated discussion and contributions from the floor, and overall, attendees felt this was a stimulating, enjoyable and life- and faith-affirming day, well spent. The author, for one, feels much better prepared to "follow Jesus" in his work, and the conference as a whole really did provide answers and areas for further reflection in response to the four questions highlighted at the head of this report.

FAITH IN MEDICINE

A MORAL COMPASS TO GUIDE ME

DR DONNA ROPMAY

Abstract

This narrative is a true account of a 38 year old woman's efforts to cope with the ethical questions that crop up in her mind while pregnant with her second child. As she hails from a medical background, she can fully comprehend the advice and choices offered to her by her obstetrician. She is also aware of the consequences of various
screening and diagnostic tests for foetal anomalies. At the same time, the deep religious convictions that she shares with her husband are oft in conflict with current medical knowledge and practice. An analysis of the medical facts of the case and adherence to values of their inherent Christian faith enable the couple to decide the next course of action, in the best interests of the mother and child.

Key Words: ethical, screening tests, foetal anomalies, religious, Christian faith

"I call heaven and earth as witnesses today against you, that I have set before you life and death, blessing and cursing; therefore choose life that both you and your descendants may live;"
Deuteronomy 30:19 [1]

My story unfolds in the hill station of Shillong in north-east India. As a 38 year old woman in my second gravida, I was wondering whether to follow my obstetrician's advice of going for a triple test in the 18th week of my pregnancy. I was happily married and had a 7 year old daughter. I had recently undergone an anomaly scan which revealed no obvious foetal malformations on ultrasonogram. I was thinking that if the results of the triple test turned out to be positive, I would probably have to go ahead with an invasive procedure called amniocentesis to find out if the foetus has a chromosomal abnormality. These screening and diagnostic procedures would have to be performed before the 20th week of gestation, so that I would have a choice of either continuing the pregnancy or terminating it on eugenic grounds, as per Indian law.

Medical facts

The triple test is employed to screen for foetal anomalies during the second trimester of pregnancy in women over 35 years of age.[2] It measures levels of markers *a*-fetoprotein (AFP), unconjugated oestriol and human chorionic gonadotrophin (HCG) in maternal serum. There is a 5% chance of a false positive result, creating unnecessary alarm to the parents.[3] It is also not an end in itself, but rather the beginning of a series of procedures to confirm or rule out the risk of having a disabled child. If the triple test results fall in the high risk category, the patient is usually advised diagnostic amniocentesis or chorionic villus biopsy to study the foetal karyotype. Amniocentesis involves extraction of fluid from the amniotic cavity through the abdominal route under ultrasonic guidance. It is associated with a 0.5-1% risk of foetal loss.[4] At the same time, because of the 5% false positive nature of the screening test, there are possibilities of losing a perfectly normal baby during this invasive procedure. The risk of foetal aneuploidy, primarily trisomies, increases with maternal age.[5,6] The additional age-related risk of non-chromosomal malformations is approximately 1% in women 35 years of age or older.[7]

This hard evidence justifies and supports my obstetrician's well-founded advice for me to undergo the screening test.

Legal aspects

The Medical Termination of Pregnancy (MTP) Act was passed in India in the year 1971,[8] with a view to curbing unsafe abortion practices performed in unsanitary conditions by unskilled personnel. It legalises abortion by a qualified doctor at a recognised centre on therapeutic, eugenic, humanitarian and social grounds. However, medical and surgical procedures cannot be performed after the 20th week of gestation, which is the legal cut-off for termination. A woman can obtain an abortion on her own consent if she is a mentally sound adult over 18 years of age. ***As far as my case is concerned, if the foetal karyotype indicates a chromosomal abnormality such as Trisomy 21, which could result in the birth of a seriously disabled child, it would not be illegal for me to terminate the pregnancy on eugenic grounds.***

Ethical considerations

I examined the morality of my possible choices in the light of the core principles of biomedical ethics described by Beauchamp and Childress.[9] Firstly, I had the right to determine what would be done to my own body *(principle of autonomy)*. I could make an informed decision after understanding the risks, benefits and consequences of the proposed investigation. Secondly, would the triple test be in my best interests? (principle of beneficence). Thirdly, would the results of the test harm me psychologically? How would the subsequent invasive procedure affect my baby? *(principle of non-maleficence)*. Fourthly, the triple test is neither free of cost nor readily available in local hospitals and laboratories. A pregnant woman who opts for it has to give her blood sample at a specified collection centre in Shillong, from where it is sent to another location for testing. These may not have been issues for me personally, but surely would have influenced the choices of a poor patient hailing from a remote area of northeast India *(principle of distributive justice)*. The most important ethical consideration is the sanctity of life which must be respected at all costs. This is one of the basic tenets of medical ethics enshrined in the Hippocratic Oath.[10] Its importance in my situation applies to two precious lives – my life and that of the child I am carrying. Often, conflicts may arise between the individual autonomy of the woman and the rights of the child in the womb. In a sense, promoting the mother's wellbeing may be at the cost of harming her child. ***These thoughts only served to deepen the moral dilemma I was facing.***

The dilemma – To screen or not to screen

I pondered on the fact that screening was just the initial step. If the odds were against me, I would have to go through a sequence of events whose end result may not be to my liking or approval *(Refer to Figure 1)*. Should I just do it anyway on the presumption that no untoward event would occur; that the screen would just be a routine procedure with normal results? Or should I choose not to go ahead with it, hoping against hope that pregnancy would continue to term? At that point of time, I was mentally prepared to accept the possibility and consequences of having a disabled child by virtue of my late maternal age. The silver lining behind the clouds was the chance of having a completely normal child, free from disabilities, because even the best screening and diagnostic tests have their shortcomings. Medical procedures are not always decisive or foolproof. Moreover, I would rather not know what the future holds but trust God who holds the future.

"Your eyes saw my substance, being yet unformed.
And in Your book they all were written,
The days fashioned for me,
When as yet there were none of them."

Psalm 139:16 [1]

A Moral Compass

I spent some time mulling over my situation but realised I would have to decide whether to take the test or not sooner rather than later. I discussed the matter intensively with my husband, my closest confidante, as I found solace in sharing my problem and getting it off my chest. It also helped us to re-focus on what was really important to us as a married couple. We then took a joint decision in the best interests of both mother and child based on the following considerations:-

- A false positive triple test result would make us needlessly anxious with the erroneous anticipation of having an abnormal child.
- Screening was not the end, but rather the beginning of a chain of events whose final result might have been in conflict with our deepest convictions.
- Abnormal tests could have ended up in abortion, which we were not considering, because of our religious beliefs.
- Amniocentesis, the invasive diagnostic procedure recommended after an abnormal triple test, is associated with a 0.5-1% chance of foetal loss.
- My conscience, that deep inner voice inside me, told me that I must continue my pregnancy against all odds.

  "Trust in the Lord with all your heart,
  And lean not on your own understanding;
  In all your ways acknowledge Him,
  And He shall direct your paths."

  Proverbs 3:5,6 [1]
- There were possibilities that the baby may not be deformed at all; it was too soon to give up on him/her.
- Even if I gave birth to a disabled child, my husband and I would accept him/her just as he/she is because he/she is a gift from God.

Finally, my moral compass guided me to exercise my autonomy and make an informed choice to opt out of the triple test.

"Your word is a lamp to my feet and a light to my path."

Psalm 119:105 [1]

Footnotes

[1]Four years later, we have no regrets regarding our decision, for our little baby is today an active andintelligent little girl, attends school and has a great sense of humour.

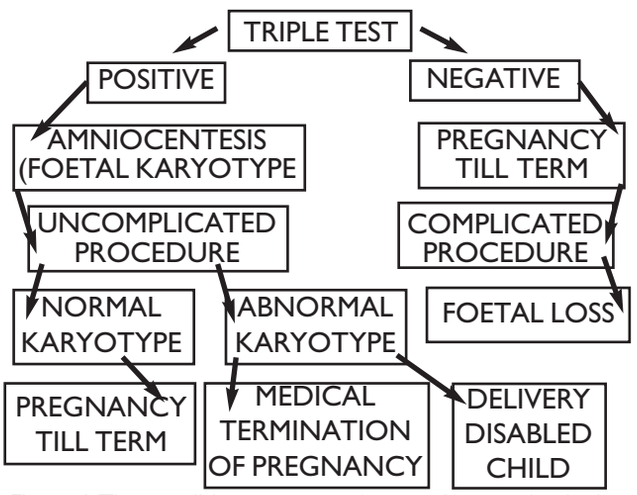

Figure 1: The possible sequence of events if screening is done

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Dr Donna Ropmay is Associate Professor, Department of Forensic Medicine, North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences, Shillong –Meghalaya, India.

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EVENTS

The Annual Conference of the Catholic Medical Association, Hull, 25th April 2020

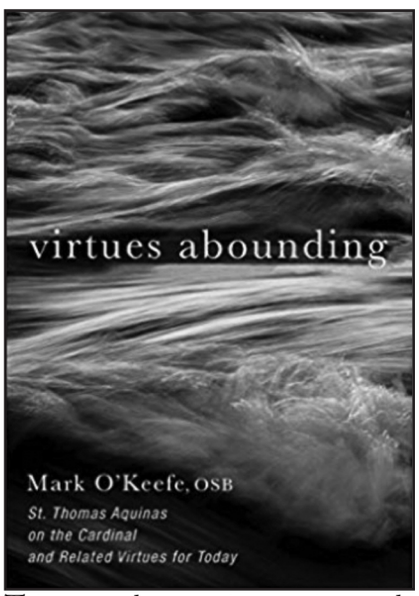
What Healthcare needs of refugees and the dispossessed
Where St Mary's University Twickenham
When 25 April 2020

Talks to include
The place of the Catholic Church in providing care, the travails of the refugee, the moral and legal framework, the physical, mental and social needs.

BOOK REVIEWS

Virtues Abounding St Thomas Aquinas on the Cardinal and Related Virtues for Today

Mark O'Keefe, OSB Cascade Books



Reviewed by Dr Pravin Thevathasan

This proved a very interesting and straightforward read. The author does not dwell on specific moral issues. Rather, this is a general comment on the virtues as understood by Aquinas.If we want to live happy lives, we are called to practice the virtues.

Prudence, says the author, is the virtue that enables us to make decisions well. All other virtues must be guided by prudence. It inclines us to the good. However, if we do not possess the other virtues, we cannot be prudent. Justice is grounded in the recognition that we are related to each other. It is the disposition to give to people what is owed to them. Types of justice include distributive and commutative justice. All this is explained clearly. This chapter also contains an interesting commentary of the doctrine of epikeia: what is the original intention of the law and how does it apply in a particular situation.It is never intended as a sneaky repudiation of natural law. A person can generously refuse to accept what is financially owed to him. He cannot under particular situations engage in adultery. That is situation ethics and was clearly condemned by the Church for 2013 years.

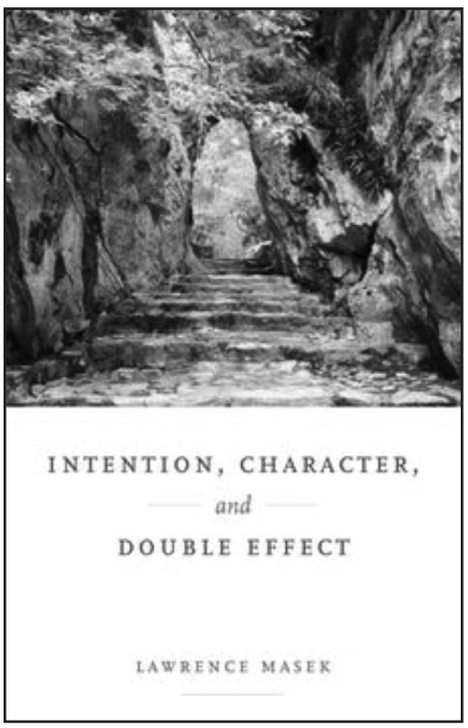
Fortitude is the abiding inclination to overcome obstacles. It moderates fear. Aquinas notes that fortitude is often accompanied by a kind of justified anger. The courageous patient with cancer who fights it, for example.

Temperance is the virtue that disposes us to moderation especially in our desires for food and sex. It directs us to a life worthy of a mature human person. The last excellent chapter examines the theological virtues, the infused moral virtues and the gifts of the Holy Spirit.

This is an ideal read for someone who wants to know what Aquinas has to say about the virtues. In about a hundred pages, the author has succeeded in showing us how the virtues form the human person.

Intention, Character and Double Effect

by Lawrence Masek University of Notre Dame Press



Reviewed by Dr Pravin Thevathasan

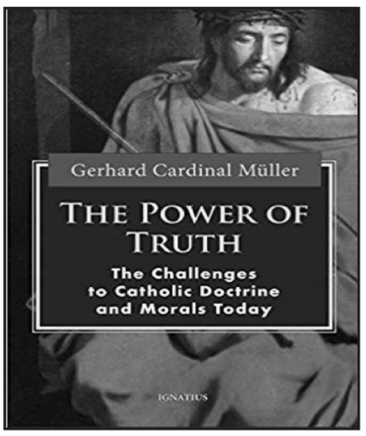
There is much to like in this work. Masek puts forward an agent-centred account of double effect reasoning. Intention really matters. When I intend evil, I commit evil, thereby corrupting my character. When I intend an act that is not evil in itself even though it has evil side-effects, I do not do evil. It goes without saying that the double effect rule needs to be followed, and this is discussed in detail. What is of great interest is the discussion of intention and double effect as understood by some of the great philosophers of our age, including Philippa Foot and Elizabeth Anscombe.

Masek is against abortion in most cases. However, he believes it is justified in cases of craniotomy, salpingotomy and in the Phoenix abortion case. He believes that these are cases of indirect abortion. I do not. In the Phoenix abortion case, a 27 year old pregnant woman developed serious complications caused by pulmonary hypertension. This led to the abortion of a 11 week old foetus. The nun who agreed to the procedure was excommunicated. While information regarding this case is scarce, I have no doubt that a direct abortion was carried out. Double effect reasoning does not apply because the doctor intended to terminate the life of a foetus by means of dilation and curettage.

I have no doubt that Masek as well as the new natural law theorists are pro-life in almost all cases. Unfortunately, they appear to use double effect reasoning to justify acts where evil is intended. In turn, this suggests a suspect understanding of the principles of double effect. Clinicians are best advised to follow the traditional teachings on the matter as proposed in the Catholic tradition. That said, I recommend this work for its nuanced discussion of a complex and important subject in medical ethics.

The Power of Truth: The Challenges to Catholic Doctrine and Morals Today

By Gerhard Cardinal Muller. Published by Ignatius Press



Reviewed by Dr Pravin Thevathasan

"It would be difficult to overstate the importance of this book." So writes Edward Feser and I tend to agree. More than ever, Catholics need an understanding of the strengths and limitations of the papal magisterium.

Is Humanae Vitae infallible? Yes, says Cardinal Muller. The wording of the document is such that it dispels any doubt about the possibility of a future revision. It is an infallible expression of the ordinary magisterium. I was particularly interested to learn that Monsignor Lambruschini, who was charged to present the document to the press, did say that there was no ex cathedra definition in the text. But he went on to say that the teaching was "non-reformable." By ignoring that, so many Catholics followed a path of confusion. With this encyclical, the Church has raised her prophetic voice, says Muller. It is a call to a renewal of marital spirituality.

In the chapter on who may receive Holy Communion, Muller notes a current tendency towards a view that the decision should be left to the feelings of the people. In reality, this exhibits a "contempt for the faith." Again and again, Muller returns to his central theme: the magisterium is not above the word of God but serves it, teaching only what has been handed down. There is only one magisterium. Bishops' conferences cannot have their individual magisteria! Something has gone dreadfully wrong when what is morally okay in Germany is a mortal sin in Poland. That is not a synodal Church. That is the Tower of Babel.

What about couples whose marriages have broken down and who are in their second civil marriage? Can they receive Holy Communion if objectively in a state of adultery? Muller quotes from the Congregation for the Doctrine of the Faith's 1994 statement that the Church's practice "cannot be modified because of different situations." Pope Benedict, while noting that they cannot be admitted to the sacraments, urged pastors to devote special concern to those affected. Given the widespread secularism that impacts on us, it is certainly possible that many marriages were not valid to begin with. Whatever the outcome, such people need to be treated with great pastoral sensitivity.

This is a splendid work and is much needed especially now.

CORRESPONDENCE

From: Fr Hugh Mackenzie

Many thanks for the helpful article on the significant weaknesses of the Mental Capacity Act (MCA, "Would you refuse a dying man water? (May, p.13). It was perhaps written before the 2018 BMA Guidance on Clinically Assisted Nutrition and Hydration and Adults who lack consent. While this does not allay the articles' key worries, its definition of "best interests" may allay one or two fears. For instance Best interests is defined as having a "strong presumption" in favour life prolonging treatment. This presumably would apply in the cases of uncertain diagnosis and prognosis you describe in section 3. And Appendix 1 uses case law to show that the will of the patient is only "almost invariably" the determining criteria for best interests (calming your conclusions in sections 2 and 6 a bit). However this also seems to permit doctors to make "better off dead" judgments even out of tune with the patient's desires..

Moreover, you have well pointed out that the tenor of the MCA strongly encourages the idea that treatments and care, which are morally and medically crucial, are just options.

What I understand to be the key point of the piece still clearly remains. The MCA has removed objective criteria concerning the duty to keep alive where practicable and to "do no harm". It is indeed worrying and I hope the piece's call to send in examples of worrying application of the MCA.

From: Antony Porter, London, W9

Sirs,

The sentencing of dangerous drivers who have killed pregnant women in road crashes presents an interesting area for future study, especially from a Catholic point of view. The topic seems so far to have been given scant attention and is often not known about until experienced.

According to my enquiries, under current British motoring laws a baby is not classed as a person until actually born. Consequently an unborn child's death in a road crash cannot be taken as a separate offence. Victim families are often shocked and infuriated when they discover that their child's life meant nothing.

Sometimes the babe is posthumously given a name. Past examples include Byron, Connor, Jamie, Sullivan and Thomas. Nevertheless, the situation raises questions about birth and death certificates. Furthermore, can there be salvation for children who have died so violently and without baptism?

In one case, the death of a baby could not be legally taken into account even though he had died at 31 weeks, two weeks more than the surviving mother when she herself was born. Indeed, such deaths are not included in official government statistics as they are not considered important.

All these themes are clearly "pro-motorist" legal loop holes that exemplify the motoring industry's influences upon the sentencing of dangerous drivers, enabling them to get back on the roads as soon as possible.

Meanwhile, motorisation issues remain the largest area of everyday life to be ignored by the Christian Churches and even the Catholic press prefers to focus upon speedy new cars and their performances.

Sincerely,

Antony Porter. London, W9

Editorial comment

We absolutely agree with the author that it is wrong not to count, record or consider unborn fatalities occurring as a result of Road Traffic Accidents. But we would also point out that that injustice is not really related to road injuries. UK law denies the legal rights and status status of all unborn children, which is not considered to be a person. With the result that unborn children are not considered to have the legal status of a person until they are born. That in turn means that, in a crisis pregnancy where a foetus requires urgent medical care, a refusal of that care by the mother cannot be over-ridden as a result of the rights of the child.

A situation which is, we believe, fundamentally wrong and merits changes in UK law.

As well as that with regard to the baptism of those children who die before birth and before baptism can be administered, we commend the reader to this quote " It can be asked whether the infant who dies without Baptism, but for whom the Church in its prayer expresses the desire for salvation, can be deprived of the vision of God even without his or her cooperation[1]" from Vatican teaching

Reference

[1] The Hope Of Salvation For Infants Who Die Without Being Baptised. International Theological Commission. Promulgated by Cardinal Levada upon receiving the approval of the Holy Father Benedict XVI January 19 2007. http://www.vatican.va/roman_curia/congregations/cfaith/cti_documents/rc_con_cfaith_doc_20070419_un-baptised-infants_en.html

You may have missed from Dr Steve Brennan FRCP

Dear Sir,

Clearly we need mature dialogue on the complex issue of "gender ideology" and I don't see that the Vatican's recent document, stating the obvious, disturbs this in any way. Almost everybody is born with either male or female anatomy and ends up following that identity for the rest of their lives. The simple clothing experiments of the pre-school years soon pass, but the tumultuous times of puberty are more difficult. One of the problems we face as parents is that we are all "amateurs", at least with our first child, and we need help from others, our own parents

and other relatives and friends, teachers and doctors. Most people will know that it is very common during puberty to go through periods of strong homosexual and heterosexual feeling, as well as all sorts of problems about body image. Most pass through this, in a year or two, without the need of a "gender dysphoria" clinic. It must surely be wrong, during this time, to let doctors alter anatomy and physiology irrevocably, with surgery and hormones. What happens with adults is different, but children must be protected from these experimental procedures. Your editorial of 15th June mentions suicide which has happened before anything is done, but it has also happened afterwards.

Yours truly,

Dr. Steve Brennan.

This letter was published in the Tablet on 29th June 2019.

References

Linked to this letter see also
Michelle Cretella (2017) The American College of Pediaticians: Statement on "Gender Ideology": A note of caution. Catholic Medical Quarterly, Volume 67(4) November 2017. http://www.cmq.org.uk/CMQ/2017/Nov/letters-gender-identity.html
Treloar A, (2017) The American College of Pediatricians Statement on "Gender Ideology". A Note Of Caution. Catholic Medical Quarterly, Volume 67(4) November 2017 http://www.cmq.org.uk/CMQ/2017/Nov/letters_gender_identity2.html

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