FEBRUARY 2019 Vol 69 No 1

catholic medical QUARTERLY

cmq

www.cmq.org.uk
Price £5.25 (free to CMA members)

IN THIS ISSUE

JOURNAL OF THE CATHOLIC MEDICAL ASSOCIATION (UK)

CATHOLIC MEDICAL ASSOCIATION (UK)

PRAYERS BEFORE MEETINGS

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

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

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

PRAYERS AFTER MEETINGS

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

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

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CATHOLIC MEDICAL QUARTERLY

Subscribing to the CMQ.
The CMQ is free to all members.

Annual Subscription
for non-members £25 or $50
(Within Europe postage paid:
Outside Europe add £5 or $10 for postage).

Single copies £5.25 + £1.75 postage in UK,
£5.25 plus £2.25 within Europe, or
£5.25/ $10 + £3.00/ $5 outside Europe.

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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FEBRUARY 2019

Erratum
We apologise for an error in the November Editorial [1]. The references were not quite right.
Ref [6] should read [1],
Ref [7] should read [6],
Ref [8] should read [7]
Ref [9] should read [8]
Refs [10] and [11] should read [9]

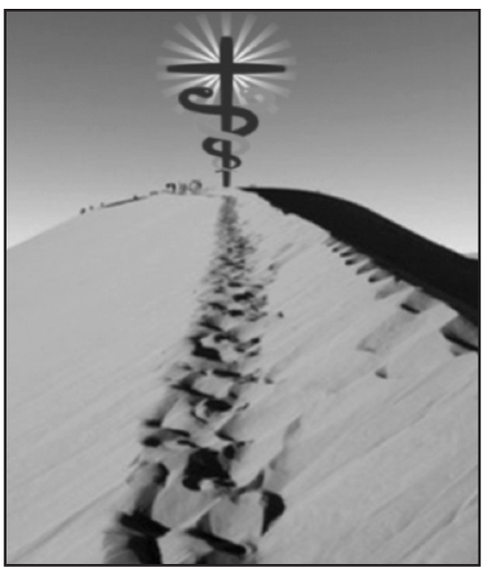
[1] The Catholic Church and the sex abuse crisis
Dr Pravin Thevathasan. Catholic Medical Quarterly, Volume 68(4) November 2018, page 3.

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

EDITORIAL

FOLLOWING JESUS IN HEALTHCARE

ADRIAN TRELOAR



How do we follow our faith in healthcare today?

The Annual Conference of the CMA will look at this question in Hull on the 4th May. We must recognise that it has always been a challenge to follow our faith at work but we should also, perhaps, admit that we may be approaching a time when it is especially hard.

At the centre of our faith are the great miracles of Jesus in the Holy Land. Often described and translated into English as "cures", older translations such as the Douay-Rheims and King James Versions used the phrase "being made whole" [Matthew 6, 55-56 and elsewhere in the Gospels]. So in fact, in his time on earth, Our Lord saw the healing that He did as a restoration to a physical and spiritual wholeness. Not merely a state of physical health. Happily for us, the World Health Organisation defines health as a state of physical, mental and spiritual wellbeing. And as health workers, we are asked to promote health which turns out to be "wholeness". Better still the Constitution of the World Health Organization still defines health as a ***"state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"***[1]. Making people whole is what healthcare workers do. Holistic medicine is where we are at.

> And running through that whole country, they began to carry about in beds those that were sick, where they heard he was. And whithersoever he entered, into towns or into villages or cities, they laid the sick in the streets, and besought him that they might touch but the hem of his garment: and as many as touched him were made whole. Mark 6, 55-56.

As Bishop Davies said during advent [2] *"Our renewal in holiness is the only renewal of the Church that will ever matter"*. Bishop Davies quotes Pope Francis who says *"The Lord wants us to be saints and not to settle for a bland and mediocre existence"*, for it is only by being holy that we can be truly happy. The Holy Father writes, *"Do not be afraid to set your sights higher, to allow yourself to be loved and liberated by God"*. For holiness, he writes, is *"the extent that, by the power of the Holy Spirit, we model our life on Christ's" …."Let us ask the Holy Spirit to pour out on us a fervent longing to be saints for God's greater glory, and let us encourage one another in this effort".*

Bishop Davies continued *"We can never reach this goal by our own unaided efforts. By the grace of God we can!"* That need for Grace must be even greater for Doctors, nurses and other healthcare workers who find themselves so deeply challenged on matters of faith, morals and ethics. To enable that grace to live within us, we need to sort a few things out for ourselves. I would suggest that there are several key themes that each of us need to explore.

1. **We must always aim to provide excellent, caring and compassionate healthcare.** We cannot be good clinicians merely because we are Christians. Our Christian faith must drive us to be excellent, to go the extra mile and always to do excellent medicine, delivered humbly and compassionately

2. **We must never think that we are better doctors or better nurses simply because we are Christian.** I have seen many fall into that trap and in their failings they bring great scandal upon Jesus Christ and upon His Church.

3. **We must pray, deepen our faith and continue to see our vocation in healthcare as an expression of Christ's love for us.**
   a. Attending Mass regularly
   b. Praying regularly (I was strongly and helpfully guided toward the Rosary by Fr Hugh Thwaites while he was Chaplain to Guys Hospital when I was a student there).
   c. Attending confession and including our work as a part of our examination of conscience

4. **We must seek to understand medical ethics and to be able to discern what is right and wrong**

5. **We must be willing to say no when things are wrong and to speak out**

6. **But far more often we must be willing to gently, and humbly, encourage others towards what is right**

7. **We must engage in public policy development, promoting what is good and what is right.**

8. **We must do all of that with love and a smile.**

David Quinn the Director of the Iona Institute will be one of our keynote speakers in Hull and will share his thoughts on how we can and should do this.

In every setting we will greatly help by seeing the humanity of the people whom we serve. Not unlike many

medical colleagues Fr Hugh Thwaites once told me that several women had been to see him shocked at being pregnant. Fr Thwaites told me that upon hearing the news he would always respond with a smile;- a clear but gentle welcome for the child within, who was immediately humanised by the smile.

I have found his observation very helpful in General Practice and also in care of the elderly. To see the humanity in an unborn child, or in a dying elderly person can be truly transformative. As St Catherine Labouré said ***"I saw the face of Christ in each one."***[3]

As Fr Gerard Toman tells us in this edition of the CMQ [page 8], work is prayer. And yet we need a prayerful foundation to allow that to become true.

There will be much to discuss and explore in Hull on the 4th May. The CMA will be the guests of Hull University Catholic Chaplaincy. Do please book your place and come along.

REFERENCES

[1] World Health Organization (1946).Constitution https://www.who.int/about/mission/en/
[2] Shrewsbury: Bishop Davies dedicates 2019 as Year of Holiness. Dec 3rd, 2018 Independent Catholic News www.indcatholicnews.com/news/36113
[3] Great Medical Lives. St Catherine Labouré: Seeing the face of Christ in the sick and suffering. Catholic Medical Quarterly Volume 66(3) Aug 2016. www.cmq.org.uk/CMQ/2016/Aug/st_catherine_laboure.html

Adrian Treloar FRCP, MRCPsych, MRCGP is a Consultant and Former Senior Lecturer in Old Age Psychiatry. He is also Assistant Editor of the Catholic Medical Quarterly.

NEWS

DOCTORS WITH AFRICA CUAMM

Founded in 1950 by the Bishop of Padua, Doctors with Africa CUAMM (Collegio Universitario Aspiranti Medici Missionari) was the first Italian NGO focused on healthcare. It is now the country's leading organization working to protect and improve the wellbeing and health of vulnerable communities in Sub-Saharan Africa. CUAMM's Mission is to advocate the universal right to health and promote the values of international solidarity, justice and peace. CUAMM believes in driving development through strengthening African Health Systems. This strategy is consistent with the ideals and experiences of over 60 years of fieldwork in Africa in both emergency and development-oriented settings with the perspective to contribute to make communities more resilient and autonomous. Today, CUAMM works in Angola, Ethiopia, Central African Republic, Mozambique, Sierra Leone, South Sudan, Tanzania and Uganda.

It operates in 23 hospitals, 64 districts, 3 nursing and midwifery schools and 1 University. Ninety per-cent of 2.233 staff is African. CUAMM's priority areas of intervention are maternal and child health, infectious diseases, nutrition, Non-communicable diseases and Universal Health Coverage. CUAMM is also active in the field of operational research collaborating with African institutions, research centres, academies and other non-profit organizations to inform the public and raise awareness on the value of health as a fundamental human right and essential component for the full development of human potential. CUAMM's headquarter is Italy with an affiliated branch in UK (CUAMM UK) and in the USA (CUAMM USA).

Doctors with Africa CUAMM offers the opportunity to doctors to work in one of the hospitals targeted by its projects.

CATHOLIC MEDICAL ASSOCIATION
ANNUAL CONFERENCE 2019

FOLLOWING JESUS IN HEALTHCARE

4th-5th May
Hull University Catholic Chaplaincy
£10-£30

KEYNOTE SPEAKERS

David Quinn,
Director of the Iona Institute

Sr Andrea Fraile
Sisters of the Gospel of Life

Conference timetable
Saturday 4th May
10am- 6pm with Mass at 6.30pm
Conference supper at 8pm

Sunday 5th May
9am- Annual General Meeting of the Catholic Medical Missionary Society
11am- Annual General Meeting of the CMA
1pm- Close with lunch

Bringing faith into public life
David Quinn, Director of the Iona Institute and former editor of the "Irish Catholic"
Helping people in a crisis: the work of the Sisters of the Gospel of Life
Sr Andrea Fraile,
Sisters of the Gospel of Life
"Being made whole": the purpose of healing and the purpose of healthcare
Dr Adrian Treloar, Consultant in Old Age Psychiatry
Caring for the sick in Lourdes
Dr Joseph O'Dwyer,
Consultant Anaesthetist
Living our faith at work
Dr Dermot Kearney,
Consultant Cardiologist
Keeping a strong faith in a busy career
Dr Mike Delaney, Retired GP
Bringing hope to the sick: A Christian General Practice Surgery
Dr Rob Hardie, GP
Faith at work
Miss Julia Herbertson, Midwife

Panel discussion

How can we follow Jesus in our daily work?
How do we keep our faith at work?
Can you be a Catholic in public life?

Meet fellow Catholic healthcare workers
Reflect upon your vocation
Share your experience of living your faith through work

Start 9.45am for 10am Saturday 4th May
AGM's (for CMA members only) of the CMA and Catholic Medical Missionary Society are held on Sunday 5th May

ALL YOU NEED TO KNOW

Who should attend?
Members of the Catholic Medical Association and all healthcare workers (including doctors, nurses, social workers, OTs, physios, pharmacists), and students of all healthcare professions who have an interest in a Catholic view of healthcare today.

How to get there
By Rail the nearest station is Hull Paragon. Take a bus routes 103 or 105 to Cottingham Road
Full address: University Chaplaincy 113-115 Cottingham Road HU5 2DH

How do I book my place at the conference and for the conference supper?
Please email kentcma@gmail or phone 07831 577 371. If you can't join us for the whole day, you are very welcome to join us for part of the day..Provide details of:
Name, address, email, mobile number, dietary requirements
The conference supper must be booked in advance. The cost is expected to be £20-£25

How much will it cost?
Members of the CMA £20.00, Non-members of the CMA £30.00.
Concessions (students and chaplains etc): minimum donation of £10.00.
Conference supper additionally £20-£25.
Annual CMA Membership with benefits of the Catholic Medical Quarterly and all other CMA activities will be available on the day for £30.

Lunch
Lunch will be provided. Contributions welcome

Accommodation
There is a limited amount of very low cost accommodation for students.

Ask when you book please.
As well as that we have a limited number of twin rooms booked in the local Premier Inn, Ashcombe Road, Hull HU7 3DD at a cost of £45 per night per person. **Please discuss this when you book to attend.** If you prefer you can also book for yourself online or on 0871 527 8536

Mass details
Hull University Chaplaincy Masses: 6.30pm Saturday , 10am Sunday

You are welcome to join us for part or all of the conference as you are able

www.catholicmedicalassociation.org.uk/www.cmq.org.uk kentcma@gmail.com

BUILDING A CULTURE OF LIFE!

Semper Idem is the newsletter of the Catholic Medical Association's Committee for the New Evangelization. The Committee for the New Evangelization aims to support young Catholics in healthcare. Semper Idem is one way in which we hope to do this.

HOLINESS

"And the peace of God, which surpasseth all understanding, keep your hearts and minds in Christ Jesus".

The fruit of holiness as mentioned by St Paul above is a foretaste of paradise, the very end that God has lovingly planned for all of us from the beginning of time. We have only to stick to the path and not mess up ie be holy.

The Right Reverend Bishop Mark Davies of Shrewsbury has this past advent written a beautiful letter on our universal call to holiness. [2] He points out that everyone no matter their state in life is called to holiness and that holiness is the only answer to the scandals and challenges facing us today. Let us heed the call of this good bishop, even if we are not of his diocese, to strive to holiness and be saints.

Holiness is something to which we are all called. It is simply being always connected to God, who is the source of all Holiness. Being healthcare professionals, one may say that our line of work is especially oriented towards holiness, that we have almost no excuse for not being holy! Our profession puts us in daily contact with people in their most vulnerable moments and in need of support. Furthermore, it pushes us out of ourselves to care for others. Perhaps it is neither wise nor lawful to go full out preaching in the workplace but holiness has a way of radiating through our being and touching whoever comes into contact with it.

Another good thing about being healthcare professionals is that it lessens the danger of holiness being an abstract idea. Holiness is about caring and loving even the most difficult patients, it is about giving everything we have to save a life, and then some more. It is about coming home to our families after a long day at work and serving them with joy. Let us not forget also that it is about fasting, praying and penance. It is about carving out time from our busy schedules for the rosary, the sacraments especially confession, and most of all for the Holy Sacrifice of the Mass.

Venerable Fulton Sheen once remarked that ***"we have tried all ways of changing the world but one: holiness. It is easier to wear slippers than to carpet than the whole earth"***. Let us then put on our Gospel shoes and change the world!

"Wherefore having the loins of your mind girt up, being sober, trust perfectly in the grace which is offered you in the revelation of Jesus Christ,
As children of obedience, not fashioned according to the former desires of your ignorance:
But according to him that hath called you, who is holy, be you also in all manner of conversation holy:
Because it is written: ***"You shall be holy, for I am holy."***[3]

I would like to know more about the defects of Saints and what they did to correct those defects. That would help us much more than hearing about the miracles and ecstasies.

St Bernadette

REFERENCES

[1] Philippians 4:7
[2] Bishop Mark Davies (2018) Advent Pastoral Letter On Our Call to Holiness, the First Sunday of Advent 2nd December 2018 www.dioceseofshrewsbury.org/about-us/advent-pastoral-letter-on-our-call-to-holiness-the-first-sunday-of-advent-2nd-december-2018
[3] 1 Peter 13-16

THE BIOETHICS COLUMN

TWO TOOLS FOR DECISION MAKING
BY THADDEUS, A YOUNG CATHOLIC
BIOETHICIST

Having introduced the concept of health and how Catholic clinicians should relate to it, we can proceed to reflect on some of the principles governing ethical reasoning, or, so to say, conscientious [1] decision-making. In this issue we will look briefly at the Principle of Double Effect and issues relating to the cooperation with evil, and then highlight some important points that come from these. Hence, we will look more at whether we are allowed to do something, rather than whether we should do it.

The Principle of Double Effect can be applied when an act has both a positive effect and a negative side effect to decide if the bad effect can be tolerated, and hence the action performed. The seminal case that introduced this principle to the wider debate is Aquinas' self-defence case (Summa Theologica, II-II Q64, 7), though neither did Aquinas formulate the classical conditions used in the application of this principle, nor was it the first instance in Christian literature to which such reasoning could be attributed (see 1 Maccabees 6:43-47) [2]. Currently, the four commonly accepted conditions of the Principle of Double Effect [3] are:

1: The act itself cannot be intrinsically evil
2: The good effect cannot be realized through the bad effect
3: Only the good effect is willed
4: There must be a proportionate reason for accepting the bad effect

Cooperation with evil.

In his accessible book 'Catholic Bioethics for a New Millennium' Archbishop Fisher[4] discusses various aspects of cooperation with evil. These range from considerations of how remotely the cooperation occurred in time and space, how necessary it was for the evil act, as well as whether the bad intentions were shared or not. These are important considerations, for we can never remove ourselves from all association with evil. Our colleagues might be involved in illicit procedures, and working for the benefit of our NHS Trust might also benefit some illicit services provided by the Trust. As an example medical discoveries such as Dr. Jerome Lejeune's work establishing the chromosomal basis of Downs Syndrome were clearly and primarily intended for righteous use. But their misuse to screen and eliminate children with Downs syndrome are not the responsibility of Prof Lejeune.

We can never share in the bad intentions of others or directly assist others in their bad deeds, e.g. by helping an abortionist with an abortion; but we might accept that the surgical tools we sterilise or the doctor we help to train might one day be used in or assist in such procedures. We should never will the bad, such as the death of a child, but we might accept that an unborn child will die during a lifesaving procedure aimed at treating the mother's cancer. While we must not as Catholics cooperate directly with evil and we must be careful about what we get involved in, we must also not become paralysed by fear.

END NOTES

[1] It is worth noting that the term 'conscience' means with-knowledge, and implies that we need the knowledge of Catholic moral principles to make good decisions. If you are interested in the topic of conscience I recommend Fr Chalmers' book 'Conscience in Context: Historical and Existential Perspectives' Peter Lang, 2013.
[2] If you are interested in the history of Double Effect see Mangan 'An historical analysis of the principle of double effect' Theological Studies 1949.
[3] See e.g. Eijk CWJ, Hendriks LJM, Raymakers JA 'Manual of Catholic Medical Ethics' Connor Court Publishing Pty Ltd, 2014, for more details.
[4] Fisher A. Catholic Bioethics for a New Millennium. Cambridge University Press; 2012.

Further reading from past issues of the Catholic Medical Quarterly

These issues have also been discussed in the following papers, which you might like to read.

Crean Fr Thomas OP(2017) What is an intrinsically evil action? Catholic Medical Quarterly Volume 67(3) August. www.cmq.org.uk/CMQ/2017/Aug/what_is_intrinsically_evil_act.html

Thevathasan P, (2003) Moral Absolutes and the Principle of Double Effect. Catholic Medical Quarterly 53(4) November. www.cmq.org.uk/CMQ/2003/moral_absolutes_double_effect.htm

Shaw Joseph (2013) Double effect in Beauchamp and Childress. Catholic Medical Quarterly Volume 62 (1) February 2012, p20-26. www.cmq.org.uk/CMQ/2012/Feb/01-double_effect.html

THE BOOK REVIEW

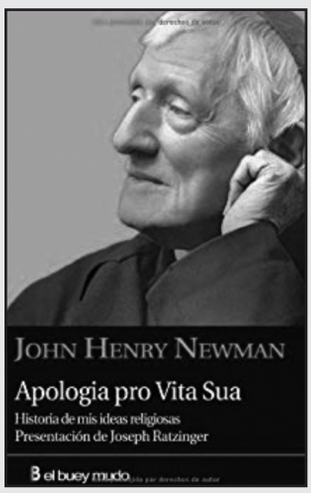
THE BOOK REVIEW IS A NEW REGULAR COLUMN IN SEMPER IDEM
WRITTEN BY A JUNIOR DOCTOR (PEN NAME): GREGORY SCRIPTORUM

APOLOGIA PRO VITA SUA

by John Henry Newman. Printed in Great Britain by Amazon.co.uk, Ltd., Marston Gate. Paperback, 174 pages

Whilst at university I attended mass at the Birmingham Oratory, the home of the national shrine of Blessed John Henry Newman (1801-1890), an Anglican clergyman who would later convert to Catholicism. I started to read about Newman's life and his contributions to theological thought especially the development of doctrine and the authority of conscience. Therefore it seemed fitting to read his famous autobiography 'Apologia Pro Vita Sua'.

SEMPER IDEM



Apologia Pro Vita Sua is a defence of Newman's religious belief. It details how his theological thought developed but is also immensely personal and honest. Newman's relationship with Jesus Christ is always apparent; as highlighted by his motto ***cor ad cor loquitor*** or heart speaks to heart. Above all I was most touched by Newman's search for the Truth. This search, which led to his reception into the Catholic Church in 1845, was slow and methodical. Apologia Pro Vita Sua is a genuine account of someone wanting to know God more fully. I was amazed at how Newman's faith in God persisted amid his questions and doubts: "Of all points of faith, the being of a God is, to my own apprehension, encompassed with most difficulty, and borne in upon our minds with most power." (Part VII: page 150)

There is much confusion in today's society and the secular world has influenced medical practice in many ways. Today's young doctors and healthcare professionals ought to take much encouragement from Newman's resolve to choose the Truth above all else simply because it is the Truth. After all "truth cannot contradict truth" (Pope Leo XIII).

FAITH IN MEDICINE

WORK AS PRAYER

FR. GERARD MARY TOMAN

I am a Franciscan Conventual priest – a Greyfriar, and I was ordained to the Sacred Priesthood in July of this year. I now live in our recently erected Friary in Walsingham – where I minister as a priest at The National Shrine of Our Lady, for Roman Catholics in England. As part of the regeneration and renewal of the Shrine, the current rector, Mgr. John Armitage, recently invited our friars back to Walsingham, 480 years after our original friary – much of which still stands – had been dissolved on Henry VIII's orders, in 1538.

St. Maximilian Mary Kolbe was also a Conventual Franciscan. As well as having been honoured by the now Pope St. John Paul II as, 'the Patron saint of our difficult times', St. Maximilian Mary is also one of the patron saints of families and the pro-life movement, and given the manner of his martyrdom, namely, having been killed by lethal injection, administered by a doctor, after having first been starved for ten days, St. Maximilian Kolbe is also venerated as the patron saint of those suffering from drug addictions. We should certainly call upon the intercession of St. Maximilian Mary Kolbe in our fight against assisted suicide and in the Godly work of ending the culture of death. Following the example left to us by St. Maximilian Kolbe, I dedicate this reflection to Mary Immaculate, the-Mother-of-God-and-our-Mother, and to St. Joseph, her spouse most chaste, faithful patron of workers and Guardian Protector of the Universal Church.

My name is Fr. Gerard Mary Toman, and it is a real privilege for me to be here today; it is wonderful to see so many of Christ's faithful seeking excellence in their professional lives by seeking first the Kingdom of God and cultivating the sanctity proper to His Holy People. An especial thank you to Dr. Joseph Nunan for the kind invitation he extended to me, so that I might be here with you today and give a reflection on ***Work as Prayer***.

To begin my reflection on Work as Prayer, I would like to say that, as part of my preparation for Holy Orders, over a number of summers, I worked as a volunteer hospital chaplain in Guys and St. Thomas', undertaking the necessary training required for that role. Although not yet a priest, I found myself, at times, on both day and night duty; the idea being that patients and their families could at least be prayed with and comforted, while a Catholic priest was found. The many experiences I had over those long weeks left a lasting impression on me, and I look back on those days with much gratitude to God, Who, in His goodness, placed me under the guidance of a faithful, generous and loving Catholic chaplain, Fr. Jake Dicto.

Very early on in my hospital volunteering, it became quite apparent – both in my own life and in the life of the doctors and nurses I spoke with – just how thin the line can become, in a healthcare environment, between one's life and one's work; it was as if the hospital – and all the things associated with it – had become, in a manner, part of who I was. In almost every other job I had ever done, there were certain boundaries that helped delineate: work from rest, activity from prayer, yet in the hospital, these

parameters often crumbled away. My days were no longer 9 to 5, weekends were no longer for resting, my evenings no longer went undisturbed, and whenever I closed my laptop at the end of the day, the urgent needs of people remained.

Developing a nourishing, fulfilling and grace-filled life of prayer always requires attentiveness, patience and care. However, given the heavy responsibilities placed upon those working in healthcare, given the long and varied hours, and very the nature of the work itself, living a life of prayer as a doctor or nurse can prove especially challenging. However, a challenge, and an impossibility are two very different things – and even the busiest of medics can, by placing simple things in the right order, come to live a devout life of intimacy with God, turning everything they do – including their work – into prayer.

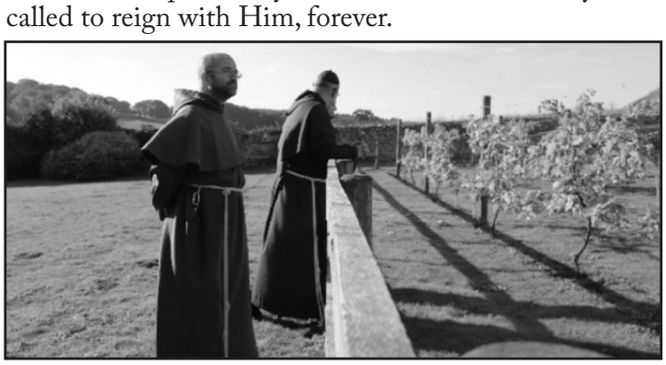
Seeing as the subject of prayer in the Judeo-Christian tradition is enormous, in preparation for giving this talk, I decided that, for today, I would not focus upon the many ***types*** of prayer witnessed to in Sacred Scripture and Tradition: for example, the prayer of thanksgiving, the prayer of intercession, the prayer of petition, the prayer of worship etc. Our Lord even taught His disciples the Perfect Prayer – the Our Father, which would merit a talk in its own right. Instead, it is my hope that this talk will help to bring a little light to the subject of prayer, by setting the context in which one can begin to see ***work as prayer***; simple teachings that will help to ensure that all of you, no matter what role you have in healthcare, are able to stay close to God, allowing your lives to reverberate with His love. When you enjoy this unceasing intimacy with God, both the people you work alongside and those you minister to, will really glimpse and experience the healing and joyful presence of God in everything you do. Today, therefore, we will look at prayer, not in its more narrow sense of asking seemly things from God,[1] but in its wider theological sense, as an act of religion – namely, the life of prayer.

One of the most helpful Scriptural texts on how we Christians should live, comes from St. Paul's ***First Letter to the Thessalonians***[2] Here, the Apostle urges us to ***'Rejoice always, pray constantly, give thanks in all circumstances; for this is the will of God in Christ Jesus for you'***. So, how is it possible for us to pray constantly? How can something such as work, become prayer?

In the Fathers of the Church, we find two helpful definitions of prayer in its broadest significance. Here, prayer is, according to St. Augustine, the soul's affectionate quest of God,[3] and in a similar vein, St. John Damascene, holds that prayer is 'an elevation of the soul to God'[4]. Using these definitions of prayer in its broader sense, let us look again at the life that St. Paul proclaims should be ours as Christians: 'Rejoice always, allow your souls to seek and rise to God, and give thanks in all circumstances'. This is the Godly perspective that allows us to see ***work as prayer***. Rejoicing for all the many wonders God has done, seeking God throughout the day, having a purposeful awareness that you are in His presence at all times and, giving Him thanks for His abundant blessings.

However, all too often in life, we find ourselves with many noble ambitions concerning living a prayerful and graced life, but we struggle when translating these holy sentiments into practice. More often than not, this is because we haven't first put down the right foundations, foundations which will then allow the Lord's grace to help us to build the house. So here is a short list of things that must be in place for us to begin to see ***work as prayer.***

Firstly: know who it is you are. This is essential if you are to live a peace-filled, ordered and prayerful life. You are a child of a loving, gentle, heavenly Father. Through your baptism, you were truly adopted by Him and were incorporated into the Body of Christ. Your soul became a dwelling place for the Triune God Himself, and when you are in a state of grace, God can live and work in you; your good actions subsequently take on a meritorious character, allowing all the good you do, through the generosity of God, to store up treasure for yourself in heaven. Through the shedding of His Most Precious Blood, the gates of heaven were opened to you, and as a child of God, you are called to reign with Him, forever.



No job, no promotion or award, and no failure or mistake can ever define you otherwise. You must never allow your profession to either establish or determine your essential worth – you are already of inestimable value in the eyes of our Merciful Father, and although we must always strive for excellence in our professional lives, there will come a time when old age or poor health or some other circumstance signals the end of your working days. If you don't really believe that it was God Who loved you into existence, and Who, through this same love, has kept you in existence, you won't be able to truly love your colleagues, or to bring God's peace and comfort to those you are caring for. So, the first ***key*** to seeing ***work as prayer,*** is knowing and loving God for Who He is, and knowing and loving yourself in that true light.

Secondly, as Christians, we are called to live holy and grace-filled lives; and by living thus, we are, in effect, praying at all times because we are honouring the will of Our Father in Heaven. There are the three principals, upon which, the Godly work of the sanctification of our lives is founded.

- The first of these principles is this: we believe our ultimate end is God Himself, meaning that, in all our actions, we must direct ourselves towards God and give Him glory. As St. Paul would write, in his First Letter to the Corinthians, 'so...whatever you do, do all to the glory of God'.[5] Clearly, it is not necessary for us to expressly and explicitly intend the glory of God in all of our actions. Rather, it is sufficient that we elicit an act of charity when we do things, and thus, we virtually direct our actions towards God. When we take prayer in its wider sense, as any pious movement of the soul towards God, to elicit an act of faith, hope or charity is to pray. So, when, in our homes or places of work, we do ordinary, everyday things that are inspired by true love for neighbour, such hidden acts of charity are done for the glory of God. This is what St Therese of Lisieux, meant when she said: 'To pick up a pin for love, can convert a soul.' And, Blessed Mother Teresa of Calcutta, who was profoundly inspired by the little flower and her little way, was known to say likewise: 'Do ordinary things with extraordinary love.' To do this, is to turn work into prayer.

- The second principle of sanctifying our lives is this: that we find our happiness in the attainment of God, our ultimate end, and that the more perfectly we attain this end, the greater the happiness that will be ours – for we do not, and cannot, find happiness in anything else. For work to become prayer, requires that we do not see work as an end in itself, but as a means of leading us to Heaven. In short, work must become for us, part of what sanctifies us; work becomes the arena in which we proclaim, principally through our chaste words and example, the Good News of Jesus Christ to others.

  This is precisely why, what sort of work we do, is of critical importance in determining our spiritual and moral health. If we are ever involved in procedures which are intrinsically evil or if we undertake an action with an evil intent, clearly, such work can never have a role in sanctifying us, and such work can never been seen as prayer. Indeed, the doing of such evil things will only serve to expel the Divine life within us. So, the second principle of sanctifying our lives, is that our true happiness is found in God alone, and we can only really be happy in our work if we are able to find God in our work. Working in a healthcare environment provides no shortage of opportunities to find God in other people, and to love God precisely through caring for others. When we do this, work becomes prayer.

- The third and final principle of sanctifying our lives is this: that our ultimate end – perfect happiness with God – cannot be attained without supernatural grace, which is given in sufficient degree to every person through the redemption of Christ. My dear brothers and sisters, if our work is to be prayer, and if this prayer is to convert hearts and minds to Christ, we all must live truly sacramental lives.

  Our Lord instituted the seven sacraments precisely to be instruments...to be channels of His grace: the Sacraments sanctify every stage of human life. If we are to bring God into our workplace, He first has to be in our hearts and souls, and He is only in our heart and soul when we are in a state of grace. Never become so busy that you can't receive the grace and mercy and forgiveness of our Lord in the Sacraments. In the confessional, the Good Shepherd not only forgives and cleanses, but He gives each of us the grace we need to be faithful and strong in love – allowing fidelity, chastity and charity to be the hallmarks of our lives: turning all we do, work included, into prayer.

  Our Lord also waits for us in the Most Holy Eucharist, where He work wonders in the soul who receives Him in a state of grace, and where He pours all His Goodness – the very Goodness of God – into the hearts and lives of those who adore Him in this Blessed Sacrament. Further, private prayer, the reading of Sacred Scripture, the praying of the Most Holy Rosary are all ways in which we can daily receive the grace of God, once our souls have first been sanctified through the Sacraments. We should try to consecrate the stages of each day to God, through such things. Although life on the ward may be non-stop, never underestimate the power of sending up to Heaven: heartfelt short prayers: *'Loving Father give me patience'*, or 'Jesus, be my Strength', or *'Mary and Joseph, pray for me this very moment!'* Here, work becomes prayer thorough prayer itself.

So, to bring all these together then. To allow our work to become prayer, we first need to get God right. We need to know that He is our Father and that He loves us, and that our worth, in His eyes, comes not from anything we might do, but from who we are to Him – we have been purchased and redeemed by the Precious Blood of His Only Begotten Son.

Once we have come to accept this beautiful and foundational Christian truth, we can then move onwards to the sanctification of our lives, thorough God's grace. We must understand, in first place, that everything we do must be done for the glory of God, and that one of the surest ways that we can give God glory, is to elicit an act of charity. Love, is what we are called to, and love must be our life, for nothing passes the eyes of God unseen, and even the smallest act of love, as we have heard from the lips of the saints, can convert hearts and lives. Never give up on love, and never give up loving.

Then, we must remember that our happiness lies in God alone, and that our work must never become an end in itself, but rather, it must be something which, through God's grace, helps to sanctity and ennoble us. Finally, we must come to understand the profound truth that we will never make it to Heaven if God's grace isn't working in us, so, we must stay close to Our Lord in the Sacraments, and then beautify and sustain our lives of faith through prayer, the reading of Scripture and through the praying of the Rosary and other devotions which foster the love

of God and neighbour in our hearts.

There is one final thing that I would like to say, and I will end my reflection on this point. In the Garden of Eden, the Sacred Writer recalls that, even before Adam had sinned, *'The LORD God took the man and put him in the garden of Eden to till it and keep it.* [6] This short verse is of profound importance, for it reveals to us, that work is not a result of the Fall, but is something entirely in keeping with the dignity and vocation of humanity. Indeed, by undertaking work, Adam was ennobled because he was responding faithfully, obediently, to the voice of God. After the Fall, undertaking work became difficult, frustrating and tiresome. However, work itself never lost its power to contribute to our sanctification and our growth in virtue. After all, St. Joseph and our Lord were carpenters, and Jesus chose men as Apostles who were already engaged in their various professions.

Have courage and confidence therefore, that by staying close to Our Lord in the Sacraments, by remaining in a state of grace through daily heartfelt prayer and a life of devotion, and by undertaking honest work faithfully and dutifully, all you do, can and will, become prayer. And you will be living the blessed life of the Gospels, exactly where God has placed you. After all, we Christians are called to live in the truth of Christ, and to love, faithfully, exactly in the situation and in the vocation in which we find ourselves. Everyone can give glory to God by doing the simplest things entrusted to us, ***with*** love, and ***in*** truth. God, Who stands in need of nothing, asks no more of us than that: and to do so, is to truly live the life St. Paul teaches us to lead, 'to Rejoice always, to pray constantly, and to give thanks in all circumstances'.

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A JOURNEY THROUGH FAITH

DR DONNA ROPMAY, ASSOCIATE PROFESSOR OF FORENSIC MEDICINE

"Now faith is the substance of things hoped for, the evidence of things not seen." Hebrews 11:1

In the wee hours of February 12th 2014, I went into a prolonged labour for the birth of our second child after a gap of eight long years. I experienced a normal delivery but the little baby girl did not cry at birth. She was resuscitated and closely monitored in the Neonatal Intensive Care Unit (NICU) of the mission hospital where I was admitted. She was put on oxygen and intravenous fluids to support her frail existence. One day, a junior doctor walked into my room on ward rounds and announced, "Your baby's collar bone is broken." I was too stunned to respond! When I got the chance to visit my little girl during her feed, I noticed that her right arm had been placed in a soft gauze sling on the advice of the orthopaedician who had seen her.

A week later, when my husband and I had hoped she would be discharged from NICU, we were devastated to learn from the treating paediatrician that she had developed neonatal sepsis with fever, abdominal distension and raised levels of C-reactive protein (CRP). She received combinations of antibiotics for about two weeks to treat her condition. On one occasion, when I had just breastfed her, I looked at the needles which pierced her tiny hands and feet and couldn't hold back the tears. Fortunately, my husband was by my side, sustaining me all along and assuring me that things would be alright. He read a verse from Psalm 139 [1] which says,

"For You formed my inward parts;
You have covered me in my mother's womb.
I will praise You, for I am fearfully and wonderfully made."

These words gave me hope as I realized that life and all its circumstances are in God's hands. All we need to do is trust Him to take care of our concerns.

As days went by, our little girl improved, but we were in for another shock when the paediatrician said, "I'd like to evaluate her cardiovascular system (CVS) and get an Echocardiogram (ECHO) done." The investigation was arranged and carried out by a cardiologist at the government hospital where I served as Faculty. Sure enough, the scan revealed a 3mm Atrial Septal Defect (ASD), Ostium secundum type, which is a less serious form of what is commonly known as a 'hole in the heart'. The specialist was of the opinion that it had a 95% chance of closing on its own in due course of time. Meanwhile, follow up visits would be required to observe the defect and its possible implications.

Our baby's oxygen saturation had picked up, and within a couple of days after the investigations she was fit to be discharged on the 28th of February.

The homecoming was special, more so for our elder daughter, ***Wyona Grace***, as she welcomed her new sibling to the family. We had several visitors, including friends and relations we hadn't met for years. There were questions about what we were going to name our child. One day, as my sister-in-law and I were looking affectionately at the baby sleeping in her cot, she said, "How about naming her ***Azania***, which in Hebrew means ***God listens*** or ***The Lord hears?***" I instantly agreed – it was so touching. My husband and I mutually consented to naming her ***Azania Faith***.

I had taken maternity leave for six months and during that period our baby's milestones developed normally. Her

right shoulder had healed completely. She received regular shots of vaccines as per the national immunization schedule. Her appetite was good and she was very sociable. On December 15th 2014, my husband and I took her to the hospital for her measles vaccination at the age of 10 months. We also got an appointment with the cardiologist for an Echocardiogram (ECHO) to check the status of her ASD. I held my breath as the scan was performed and heaved a sigh of relief when we were told that the defect had closed! Praise God!

Grace in Retrospect

When I look back at the diagnoses that were made soon after our baby was born, I thank God for seeing her through all of them. Although not life threatening with prompt medical attention, they are pretty grave conditions which I cannot take for granted – birth asphyxia, fracture right clavicle, neonatal septicaemia and atrial septal defect. Birth asphyxia, if severe or prolonged, could lead to irreversible brain damage and long-term motor, sensory, cognitive, behavioral, neuropsychiatric and developmental disorders.[2]

A fractured clavicle in the newborn is an unavoidable event in spontaneous vaginal delivery. There are studies which show an association with prolonged second stage labour, oxytocin use, forceps delivery and low Apgar scores. It usually heals without any permanent sequelae. Rarely, it can lead to Erb's palsy or brachial plexus nerve injury.[3-5]

Neonatal septicaemia of late onset, acquired from the nosocomial environment, is a serious condition with increased morbidity, mortality and extended length of hospital stay.[6]

Recent evidence shows that 100% of atrial septal defects <3mm close spontaneously by the age of 18 months, while >80% of those measuring 3-5mm in diameter are usually closed by 12-15 months. Surgical correction is an option in holes which do not mend on their own.[7]

But for the Grace of God, I don't think I could have taken so much in one go. Not only did He restore healing to our child, but also gave us parents the strength to carry on through those moments of great anxiety.

Thanksgiving and Reflection

"In everything give thanks for this is the will of God in Christ Jesus for you." I Thessalonians 5:18

Praise the Lord that in spite of the problems she had at birth, she is doing well today.

I'm thankful for His mercies, great and small. I'm glad I saw how hard the nurses in hospital work round the clock to ensure its smooth functioning. Their dedication and tireless energy really inspire me. The care, compassion and concern that they show to their patients surely makes the world a better place. It reminds me that the spirit of Florence Nightingale, the Lady with the Lamp lives on. Thank you matrons and sisters – may your hard work done with love for the little ones be duly rewarded!

"All things work together for good to those who love God, to those who are the called according to His purpose." Romans 8:28

In the autumn of 2015 we had a housewarming service at our new home to which we had invited our local pastor and close relations. My husband welcomed all the guests and reflected on God's blessings upon our family and especially His healing touch on Baby Azania. When it was the pastor's turn to speak, he made a reference to Psalm 103 whose words never fail to encourage me:

"Bless the Lord, O my soul;
And all that is within me, bless His holy name!
Bless the Lord, O my soul,
And forget not all His benefits;
Who forgives all your iniquities,
Who heals all your diseases,
Who redeems your life from destruction,
Who crowns you with lovingkindness and tender mercies,
Who satisfies your mouth with good things,
So that your youth is renewed like the eagle's."

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Conflict of interest: None to declare. Source of funding: Nil

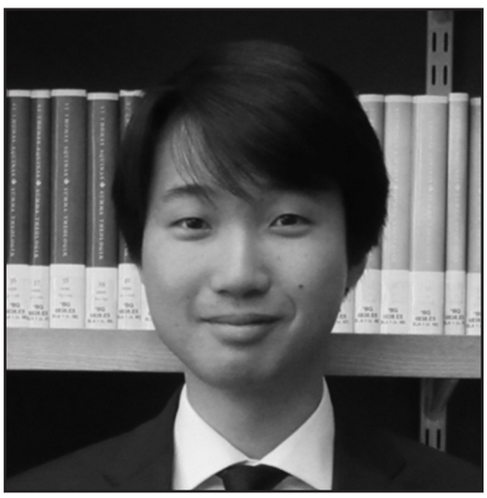
Disclaimer: The views expressed in this article are the author's own and do not reflect the official position of the institution.

PAPERS

THE ALFIE EVANS CASE: HOW NOT TO APPLY CATHOLIC TEACHING ON WITHDRAWING LIFE-SUSTAINING TREATMENT

MICHAEL WEE

A version of this paper was delivered at 'A Panel Discussion on the Alfie Evans case and its Implications', hosted by the Catholic Union at Notre Dame University, London on 11th September 2018.



Beginning with the Person

When we come to consider the tragic events of the Alfie Evans case, it is imperative that we begin by remembering that we are dealing not with a subject in the abstract, but a real-life human person: Alfie Evans, who died in April this year following the removal of his ventilator by court order.

There is much to be said about the merits of the various court judgements dealing with Alfie Evans's medical treatment, but I want to begin by asking you to consider the image of a young child on life support, in contrast with the image of an adult on life support. How, and why, do they seem so different – if indeed they do? Why is it that the subject of withdrawing life-sustaining treatment, which is never an easy one, seems particularly difficult when it comes to children and infants?

One reason may be that we have a more instinctive tendency to protect the youngest members of our society. But in my opinion, there is something else at work: With adults, we are easily struck by the horror of autonomy that is lost, especially if the patient is also unconscious. With children and babies, however, they are in general more obviously dependent on the help and support of others anyway, and so life-sustaining treatment appears less unnatural or invasive. Somehow, it is their dependence, in fact, that accentuates our sense of their humanity, and we are better able to see them as whole persons, compared with adults on life support. And therefore the language language that has been known to be applied to adults in a persistent vegetative state (PVS) in the context of removing nutrition and hydration – 'a passive prisoner of medical technology' (from a justice of the US Supreme Court), 'the shell of his body' (in relation to Tony Bland in this country)[1] – would have been met with great repugnance if applied to Alfie Evans, who was said to be in a 'semi-vegetative state'.[2] Children, it seems, awake in us moral sensibilities that we more easily let slide with adults.

To be clear, I am not saying that we should never withdraw or withhold life-sustaining medical treatment. Even assisted nutrition and hydration, which is in Catholic teaching is not medical treatment but ordinary care, can be withdrawn in extreme circumstances – though the fact of PVS alone does not suffice.[3] The Catholic moral tradition does not tell us that we are obliged to do everything we can to preserve life whatever the cost. But decisions about withdrawing treatment must be made in view of the whole person – their whole humanity, their intrinsic dignity and worth – rather than by focusing on what seems like 'mere bodily existence', as may be the temptation when we come face-to-face with an adult on life support, compared with a child. We can make judgements about the worthwhileness of a particular treatment, but what we must never do is make such a judgement about the worthwhileness of someone's life itself, including our own. This, however, was a problem in the way the Alfie Evans case was decided.

Ordinary and Extraordinary Means

But first of all, when might life-sustaining treatment cease to be worthwhile?

Catholic medical ethics has long made a distinction between ordinary and extraordinary means in medicine. Ordinary means are those which are not futile and not overly burdensome; we therefore have a moral duty to undertake them as part of our more general duty to protect and preserve our own lives, which have inherent worth. Extraordinary means by contrast are those which are futile, or excessively burdensome, or which promise little benefit in relation to the burdens they entail. They are, therefore, not obligatory. These burdens could include physical, emotional, psychological and even financial burdens. And why are we not obliged to undertake these, even though they might extend our lives? It is because medicine must serve the whole human person, and medical means become extraordinary when they become disproportionate for the person to bear, taking into account their whole life.

Indeed, medicine must not just serve the whole person but also the whole community. And that is why even resource allocation, a lack of resources, can be a reason for a hospital or a patient to refuse life-sustaining treatment, if it has been carefully assessed that the limited resources available are needed more urgently elsewhere and will be of greater benefit there. This justification must not, of course, be abused and turned into an evaluation of patients' lives by cost and cost savings. It would not be respectful of some

one's dignity to judge them primarily or solely in terms of their cost to the taxpayer; at the same time, the reality of the limited resources and an overstretched NHS should not be forgotten.

It is worth clarifying two things here. Firstly, the question of whether a particular treatment is ordinary or extraordinary is, in general, relative to the patient and their context. It is a moral and not a medical judgement. [4] The same course of antibiotics can be ordinary for one person and extraordinary for another. Secondly, although our moral judgement must have the treatment as its object, and not our own life (or the patient's, if we are making a decision on their behalf), that it is not to say that one's underlying condition plays no role whatsoever in the judgement. Obviously, one's condition might affect how much benefit can be derived from the treatment in question, and this would have an impact on an assessment of its benefits and burdens.

But here, there is potential for confusion: The suffering that comes from a disease or condition is not the same thing as the suffering brought about by treatment. Yet the two are easily mixed up, as when a particular treatment is said to 'prolong the suffering' of a patient even when the treatment itself poses few or no burdens at all. The patient's suffering caused by their condition is not by itself a reason to withdraw or refuse treatment; otherwise we come very close to judging the worthwhileness of the person's life.

The Alfie Evans Case: Judging Life or Treatment?

It is clear, then, that making a judgement about ordinary and extraordinary means is not all that straightforward a matter. We might therefore ask whether this distinction was properly applied in the Alfie Evans case.

Interestingly enough, in the High Court judgement of 20 February 2018, the judge in the Alfie Evans case quoted a letter by Pope Francis precisely on the subject of withdrawing life-sustaining treatment. Personally, however, I would be cautious about making too much of that. The fact of the letter being cited may indicate, perhaps, that the judge was accepting of the distinction between ordinary and extraordinary means in medical treatment, and that of course is to be welcomed. But the letter itself does not do the work of telling us whether in this case, the treatment in question – continued ventilation – was indeed in the realm of extraordinary means. In fact, Pope Francis's letter contains these words of caution regarding making judgements about ordinary and extraordinary means:

> To determine whether a clinically appropriate medical intervention is actually proportionate, the mechanical application of a general rule is not sufficient. There needs to be a careful discernment of the moral object, the attending circumstances, and the intentions of those involved.[5]

It was precisely where the moral object was concerned that I think the High Court judge, Mr Justice Hayden, went wrong in this case. It seems to me that what he was judging was the worthwhileness of life, rather than the worthwhileness of continued treatment. It is true that at various points in his judgement, Hayden J refers to continued treatment as being 'futile', but it is when he cites guidance on withdrawing life-sustaining treatment produced by the Royal College of Paediatrics and Child Health (RCPCH) that he truly gives some conceptual clarification as to what he means by 'futile' and why exactly he thinks this is the case. (I should note that this piece of guidance was also referred to by the High Court judge in the Charlie Gard case.) The importance of this piece of guidance should not be understated, for the judge explicitly states, 'It is necessary here to root my own conclusions… within the available guidance' in relation to it.[6]

The portion of the RCPCH guidance that Hayden J quoted in particular reads:

> Lack of ability to benefit; the severity of the child's condition is such that it is difficult or impossible for them to derive benefit from continued life…[7]

This is no judgement about the futility or burdensomeness of treatment, properly understood. It is a judgement on the worthwhileness of Alfie's life, albeit rather circuitously phrased. The idea that life is something we can 'derive benefit' from or not suggests a rather utilitarian form of thinking – as if life is something we own, analogous with other possessions, rather than something constitutive of who we are as persons at a fundamental level. Human life becomes valued for its 'use' to its 'owner', rather than for its own sake. This thought was, sadly, also at work in the Bland judgement of 1993, when Lord Keith referred to a large body of medical opinion as holding that 'existence in a vegetative state with no prospect of recovery is… regarded as not being a benefit'.[8]

Simply put, what is being said here in the Alfie Evans judgement is, 'This is a life no longer worth living'. This is dangerous, slippery territory for medical ethics, and in particular for those who live with profound disabilities, for life is no longer regarded as having intrinsic worth by this judgement. [9]

Valuing Life as Intrinsically Good

The idea that life is something we own, rather than a constitutive part of who we are, is popular with advocates of euthanasia. But if there is anything that disabuses us of this notion, it is reflection on the level of dependence so inherent in infancy and childhood, as mentioned earlier. We do not own life, and that is why dependence is nothing contrary to our humanity but in some ways a fulfilment of it, since we are by nature interpersonal beings and dependence is part of the fabric of our social life. This applies equally to adults, even those in PVS. Children such as Alfie Evans help us understand that even being in a state of near-complete dependence on medical technology, with limited conscious experience, does not render a life meaningless or worthless. Life always remains an intrinsic good.

But in all fairness to the judge in the Alfie Evans case, I would like to add that, where criticisms of 'euthanasia' or 'court-sanctioned killing' are concerned, I do not think it is indisputably the case that those charges are true. The ruling may have been made based on a judgement on the worth of Alfie's life, and this is deeply problematic, but this does not necessarily translate into an intention to deliberately end life. A charitable interpretation of the judge's ruling might hold that its fault lies, rather, in an

insufficient appreciation of the obligation to preserve life. It is analogous to a patient with advanced cancer who decides to stop chemotherapy because he thinks, 'I want the suffering from my cancer to end quickly'. I am not saying this is a legitimate way of reasoning about withdrawing treatment, but we would not be hasty about calling such an intention 'suicidal' either. While it is clear to me that there is something deeply wrong with the way the Alfie Evans case was decided, we should be cautious about criticising anyone as intending euthanasia or suicide unless such an intention is demonstrably present.

Yet it is not difficult, of course, to see why such criticisms were made. If Hayden J was cautious in his choice of words in the High Court, sticking largely to the language of the futility of treatment (though he justified that futility incorrectly), Lord Justice McFarlane in the Court of Appeal was more explicit about his characterisation of the case, saying that the judge has concluded 'it is not in the best interests of the individual to carry on living'.[10] That is polite-speak for 'better off dead'.

Hence, in summary, one of the key questions we must consider when looking back at this case is this: Was this a rightful application of the ordinary-extraordinary means distinction in medical ethics? I have suggested that it was not. Life-sustaining treatment can, no doubt, be legitimately withdrawn in some cases – it may well have been a legitimate conclusion to come to with Alfie Evans's situation, leaving aside the question of whether the courts should have given the parents' views more weight, which was another problematic aspect of the case. Cases of this kind are precisely those where reasonable people can come to different conclusions, and there should be a high bar to be cleared before parental decisions are overruled. But in any case, even the right thing or the permissible thing must still be done for the right reasons, and this excludes judging the worth of someone's life, as unfortunately the High Court judge in this case did.

Even as we go about the often difficult task of weighing up burdens and benefits, we must remember that prolonging life should always be regarded as a benefit in itself. And we can look to children to reawaken our sense of the preciousness of each life which goes beyond utilitarian calculations, and how there need be no shame in dependence.

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[9] I note that Hayden J, in an earlier part of the judgement, also quoted a doctor's report as saying, 'I believe that given Alfie's very poor prognosis with no possible curative treatment and no prospect of recovery the continuation of active intensive care treatment is futile…' (Alder Hey [2018] EWHC Fam 308 [25]). While this does not go so far as to make a judgement about a life not worth living, it is clear that such an idea of ventilation being 'futile' fails to take into account that it is still prolonging life, and that is not a futile thing to do, but an intrinsic benefit of such treatment. Ventilation was not going to cure Alfie in terms of his underlying neurodegenerative condition, but this fact alone does not make it futile.
[10] Thomas Evans v Alder Hey Trust [2018] EWCA Civ 964 [32].

NEW TECHNOLOGIES: NATURAL CYCLES APP FOR NATURAL FAMILY PLANNING

CHRISTINE BERGESS

This article first appeared in the NFP Teachers Association newsletter

The NFP Teachers Association received an email request to their website from Jack Pearson, a clinical embryologist employed by Natural Cycles as a Medical Science Liaison based in the UK

On behalf of the Association I contacted Jack and scheduled a telephone call for 1.10.18.

Resume:

Jack's original email stated:

"I noticed on your website that you are currently unaware of any applications that are more accurate than charting and wanted to offer you more information about Natural Cycles. This would include the published peer review data supporting its effectiveness and our current EU and FDA approval for use as a contraceptive device".

NC app uses temperature only and predicts fertile/non fertile days on this indicator alone, with the potential, says Jack, to use LH test as an additional aid.

Jack asked if we, as an Association, had heard of NC and the published data. I confirmed that we had but stressed the Association view/belief and insistence on women being aware of fundamental knowledge of their fertility. I also stressed at the outset that we teach clients the four fertile signs and are SMT based, believing thedouble check method to be the most reliable and efficient. Jack was undeterred and replied quoting the pearl index perfect failure rate of 1.0 following a study of 22K women over 9 months for NC.

Jack explained that NC like to educate as much as possible and have an in-service App function explaining more and a large support team for those requiring this level of information. Jack says, NC use a " smart" algorithm that updates following data input to build a pattern for the user, giving more green days as it builds this knowledge (Green = non fertile; Red = fertile). The algorithm accounts for deviations such as alcohol, drugs etc.

The feedback from users suggests women are fascinated with learning how their bodies work!!

I asked about drop-out rates: currently around 50%, which is a point for them to address.

I said the first three months can be difficult for our clients; we allow no pre-ov infertility as women get used to how their bodies work and then are able to build in confidence with the system and their bodies. During this time we offer, as teachers, extensive support and encouragement, but user motivation is the key.

Jack explained that in 2015 NC had a large marketing campaignon social media – social media – and recognised that this captured those that may not have been suitable. They are aiming to pin point the most suitable to market: Their current mean age is 30 and they come from Europe, Africa and the Americas. Their algorithm predicts best on 5 day recordings per week; they believe weekends are usually out of user's routine and therefore are not concerned if users do not record on these days! Jack thought those with irregular cycles may not be suitable, nor according to their literature: those with cycles less than 21 days or more than 35.

They have some issues with alerting users to the correct method of temperature taking: 4 hours sleep, before getting or sitting up; approximate time +/- 2 hours. As their key requirement is temperature only, BBT is vital. Users can elect to set parameters for plan/prevent at the start of their use and pregnancy is an area they are interested in pushing in the future.

Users can switch and Jack explained that interestingly, some users elect prevent when wanting to conceive – Jack considers maybe as additional security?

Their data shows that users demographic are educated, professional women.

NC and Jack's own experience of working in an IVF clinic, is the lack of knowledge women have of their own bodies. On rating their App, users comment regularly that they have never been taught this basic information.

Jack stressed that NC was the only app with EU/FDA approval; they started with a small study and now have 1 million users globally and 200K in the UK. Biggest markets: UK, Sweden, Australia, Canada and Germany. They are setting up an office in the US and will be marketing forcefully there.
Jack's role is to provide medics with data, publications and educating healthcare professionals.

We spoke about younger generations drawn to technology and therefore giving them a choice of healthier options than pharmaceutical based contraceptives. As we know, GPs do not have the time necessary to provide information on NFP. Technology is a route for millennials, but we must ensure responsibility and reliability and as NFP teachers, we feel no App can replace personal awareness and basic knowledge.

I was particularly interested in the drop-out rate - first 3 months and reiterated that this is the time, as teachers, that our support is invaluable for clients to gain in confidence and trust in their unique pattern enabling them to continue with the method.

I enquired about their targets for the future – waiting to hear…..

It was an interesting conversation - NC intend to establish a UK office, potentially London. I expressed an interest in visiting. Jack will keep us informed and send us data as published.
NC have received bad press concerning unintended pregnancies but are not deterred in the promotion of their method.

www.naturalcycles.com. Natural Cycles website states ***"Our mission at Natural Cycles is to pioneer women's health with research and passion – by empowering every woman with the knowledge that she needs to take charge of her health."***

Advice for readers
The CMQ notes that there are a wide variety of apps for NFP. We recommend that any potential user be advised to check with the NFPTA or Billings OM for advice. Some are excellent. Others are very poorly desgined and take us back to the sort of technologies and knowledge of the 1950's before NFP was developed as a science.

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GREAT MEDICAL LIVES

ROBERT E. HAVARD: THE MEDICAL INKLING

SARAH O'DELL, M.A., B.S.

Many are familiar with the Inklings, the Oxford writing group who met throughout the 1930s and 1940s and whose members included C.S. Lewis, J.R.R. Tolkien, Owen Barfield, and Charles Williams. The group's shared interest in mythopoetic literature and Christian thought has attracted a wide variety of scholars, with many academic journals dedicated to the group or its respective members. Nonetheless, a large number of Inklings remain woefully under-studied, including Robert E. Havard, a Catholic physician, scholar, and poet.

Robert Emlyn Havard was born in 1901 in South Kyme, Lincolnshire. After receiving undergraduate training in chemistry at Oxford, he went on to study medicine at Cambridge and Guy's Hospital in London. Over his career, he held a number of research posts and co-authored over twenty scientific publications in a wide variety of journals: **The Lancet, Nature,** and the ***Annals of Tropical Medicine and Parasitology,*** among others. While Havard's scientific training primed him for a career in academic medicine, his yearning for a more clinically-oriented position eventually lead him to accept a general practice in Oxford.

Dr. Havard's association with the Inklings, and notably his friendship with C.S. Lewis, began around 1934 when he made a house call to treat Lewis's influenza. In Havard's reminiscence "Philia: Jack at Ease," he recounts that the pair spent "some five minutes discussing his influenza … and then half an hour or more in a discussion of ethics and philosophy" [1]. The men's common interests—philosophy, theology, and poetry—set the groundwork for a friendship that would last until Lewis's death, almost thirty years later.

Havard also enjoyed a long-standing friendship with J.R.R. Tolkien, likely aided by their shared Catholic faith. Just as with Lewis, Havard's relationship with Tolkien persisted even once the Inklings had dissolved as a writing group. In "Professor J.R.R. Tolkien: A Personal Memoir," Havard recounts that the two men were neighbors from 1953 to 1968. They attended the same church, and Havard "often drove him home and [the pair] sat in the car chatting for half an hour or so outside [Tolkien's] house" [2]. Indeed, it was not uncommon for Havard to drive both Lewis and Tolkien throughout the course of their long friendships, as while both claimed to hate the automobile, each would call on Dr. Havard whenever they needed a ride [3]!

Surprisingly, scholarship has largely neglected Dr. Havard's contribution to the Inklings—despite the fact that he was one of the group's most regular members—as well as his published writings. While not as prolific as his compatriots, Havard's his own literary accomplishments include an appendix to Lewis's first apologetic work ***The Problem of Pain***, his own apologetic for the importance of beauty,[4] a sizeable number of poems,[5] and a variety of book reviews on theological and medical topics. Crucially, Havard's Catholic faith—inclusive of his integrated view of medicine, spirituality, and human persons—shines through and unites this body of work.

Of special importance to Dr. Havard was the role of medicine among those of religious vocation. As a Catholic physician in Oxford, he was often called upon to offer medical care and advice to the religious houses in the area, and such work required an acute understanding of the qualities of religious life. Colin Havard (son to Robert Havard) has remarked on his father's sensitivity to the context of such medical cases, noting that he "had a good sense of psychology as well as of pure physical medicine" [3]. Dr. Havard's attentiveness to human psychology, as well as his compassion for those suffering mental illness, exists as a common thread throughout his work.

Indeed, a glimpse into Dr. Havard's service in religious houses and his care for those suffering psychiatric illness is provided by a 1956 book review published in this very journal. Titled "The Religious Life: The Role of the Medical Adviser,"[6] the article reviews Medical Guide to Vocations by René Biot, MD., and Pierre Galimard, M.D. Praising its authors, Havard's review largely focuses on the book's treatment of mental health.

Havard begins his review by affirming the "essential unity of human nature" 6], stressing a Thomistic understanding of human persons: "For it is clear that if body and soul are one "thing," then any activity of the soul, as in prayer, will be reflected in some way in the body, and vice versa" [6]. It is in this intersection between body and soul that medicine "comes into contact with such spiritual questions … [such as the] difficulties met with in the religious life" (26). Havard eloquently recognizes both the limitations of medicine—noting the "ill-defined borderland between body and mind" [6] and that "medicine is not an exact science, still less so psychological medicine" [6]—as well as its relevance to religious life. While he notes that mental illness is not "fundamentally altered" [4] by the religious life, the duty of the physician is tripartite: to recognize an individual's mental suffering, to understand their illness, and "wherever possible, to help them" [6. Near the conclusion of his review, Havard calls for a collaboration between a doctor and a priest to explore the "relation between the life of the spirit and the life of the emotions" [6] Such work remains relevant and necessary today.

The fundamentally Catholic view of human persons so emphasized by Dr. Havard continues to inform the way that Christians practice medicine. In today's medical landscape, with frequent burnout among health providers and the perceived lack of empathy in the provider-patient encounter, Dr. Havard's humanitarian and intellectual work remains important. As I work on a book-length consideration of Dr. Havard's life and writings, I hope to not only unveil a physician-scholar nearly forgotten by history, but also enrich how we consider our own work in medicine.

references on page 16

REPORTS

"FUTILE TREATMENT? FUTILE LIVES?"

A JOINT MEETING OF THE MEDICAL ETHICS ALLIANCE AND THE MIDLANDS BRANCH OF THE CMA IN BIRMINGHAM 20TH OCT.

A joint meeting between the Medical Ethics Alliance and the Catholic Medical Association was held in Birmingham on 20th October at Newman House. It was well attended by members of both associations and other interested parties.

Under the chairmanship of the M E A attendees contributed under Chatham House rules on the topic "Futile treatment? Futile Lives?"

It began with a brief presentation of some patients who may have thought to have futile lives. These included a child with persistent vegetative state who was part of a ward community where he was greatly loved by the staff and "when all he had to offer was his humanity, it was very appealing". Another child who was almost an organ donor, made an unexpected and complete recovery from post cardiac arrest cerebral oedema.

A nurse also mentioned a case they had cared for who was thought to be dying and denied fluids, but who made a rapid recovery. Nurses, in general, were troubled that patients for whom they regarded themselves as advocates, were being denied the essentials of life such as food and water.

A participant described her own experience of being in a virtual locked in state, unable to communicate other than by winking. She too made a considerable recovery and is now campaigning for life, especially in the latest climate of withholding or withdrawing food and fluids. She also had experience of poor nursing which led to a wide discussion of nurse training and selection. It was accepted that there will always be nurses with character faults and there was a further discussion of society`s attitude towards the disabled and the way that that could influence the attitude of healthcare staff towards the profoundly disabled patients whose life might be characterised as "futile".

There followed a detailed discussion of recent high profile cases of children with incurable diseases and recent judgements including the Supreme Court judgement in the case of "Y" which removed the necessity of the Court of Protection involvement in decisions concerning the withdrawing of food and fluids if provided by tube. This was, in any event contrary, to Catholic teaching. The Royal College of Physicians working party on the palliation of thirst was considered to be a regime that was incompatible with survival and therefore, euthanasia in all but name.

There was a discussion on the working of the Mental Capacity Act (2005) which made "best interests" the criterion for clinical decision making. It was pointed out that this construct was eminently corruptible and in any event based on uncertainties in diagnosis and prognosis. Yet it would become determinative in matters of life and death. The Mental Capacity Act did not define "best interests" but only how to approach making a "best interests" decision. It was an attempt to inform how clinical decisions should be made in those who lack capacity. In effect it could make clinical decisions more difficult and in an extreme case, the administration of artificially give food and fluids, illegal.

The meeting closed with a comparison between Scottish law and the Mental Capacity Act. The former making the ultimate criterion not "best interests" but treatment justified if it was deemed "beneficial".

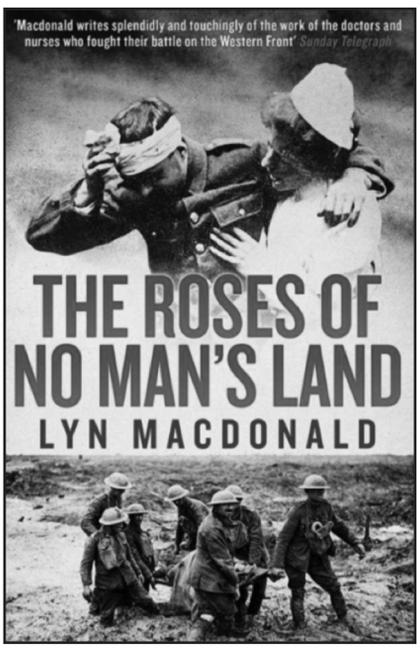
It was hoped that a more informed public awareness, publicity and case histories, especially from the viewpoint of relatives, could lead to improvements in medical practice and ultimately the law.

In the wake of the meeting a new public appeal for feedback on the working of the mental Capacity Act has been launched.

CORRESPONDENCE

FIRST WORLD WAR MEDICS

DR STEPHEN BRENNAN FRCP



I came across a book review in the BMJ 1980[1], as you do when retired; it set off some thoughts about how things have changed. It was written by Ronald Gibson, a colleague of my father, Edward Bernard Brennan, both in the RAMC in the WW2 and who both became radiologists after that war. The book was "The Roses of No Man's Land" by Lyn MacDonald[2] about medical services in WW1. It spoke of the initial enthusiasm and hopes, gradually moving to anxiety and weariness at the endless mutilation and destruction. I have yet to obtain a copy of this extraordinary book, but it is thoroughly researched and full of letters from doctors, sisters, and members of the Voluntary Aid Detachment at the front-line. They didn't have time to be novices, quickly getting used to improvisation, inadequate equipment and accommodation, as they dealt with thousands of casualties, many of whom who had only left the safety of home days before. Wards were soon in chaos with "mud and cold, hunger and fatigue". Casualties of gas attacks, gunshot wounds, shrapnel, gas gangrene, blindness, suffocation, pneumonia, enteric fever and shell shock. Sometimes two surgeons would be working six operating tables "with only a Padre to give the anaesthetics". "Filthy dressings had to be torn off screaming soldiers by gentle girls who had never seen suffering before, let alone chronic agony and death".

Without antibiotics, the complications of wounds were unimaginable; lives depended on antiseptics like Eusol, Dakin's Solution and more surgery. Later in the war, blood transfusion became useful in cases of chronic infection as well as blood loss. Loading casualties on to lorries and trains to move them back from the front after the battles to varied accommodation, maybe open-air muddy shelters, local homes, hotels, or even stately homes, must have been the final straw; everyone cold, wet, hungry, dirty and lice-ridden, but trying not to let it all rub off on the patients. "If you couldn't laugh you were finished".

Could we health workers of today cope like that now, "spoilt" as we are by our splendid NHS? I think the computer says "no"! However, we of faith have other resources, and could, as always, rely on God's help to keep us going from day to day, provided we asked for it. We must pray that our NHS can keep going.

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CARE OF DYING CHILDREN WITHDRAWAL OF TREATMENT IN CHILDREN.

DR ANTHONY COLE J P, F R C P (EDIN). F R C P C H,

I write as a paediatrician with forty years experience in general paediatrics and neonatology in the N H S. Here are two m points that I think important

1 The insights of parents

It is not uncommon for disagreements to arise between parents and healthcare professionals over small signs of consciousness or other responses in very sick children. Parents have a natural empathy with their child and are often in nearly continuous contact . Professional, on the other hand, may attach great importance to relatively small X-ray findings or other investigations which parents may not appreciate. Communication is of the essence to maintain confidence with the clinical team. Images as such, may not be synonymous with a diagnosis. The observations of parents should be treated with the utmost seriousness and documented. The comment that is sometimes made that "the response is just reflex " may be unhelpful or even mistaken.

2 The withdrawal of life supporting treatment

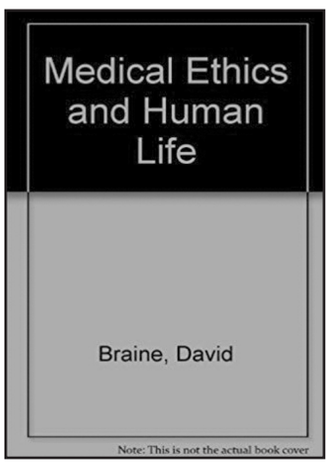
This is a very sensitive matter and a good relationship between clinical decision makers and the parents is of paramount importance. This will take time and the issue is not only the survival of the child, but the long term emotional and spiritual well being of the parents and the wider family. As Dame Cicely Saunders reminds us, the manner of death lives on with the survivors. I have been humbled and great full to parents that I have known and, in particular, a willingness to accept the inevitable, but clinicians must be prepared to wait for the right moment.

Dr Anthony Cole. Is Chairman of the Medical Ethics Alliance

BOOK REVIEWS

WHY READ THE WORKS OF BRAINE

MICHAL PRUSKI PHD, MA, AFHEA



This article serves a dual purpose. Firstly, it is a personal tribute to David Braine, secondly it hopes to promote Braine's work as a philosopher. Braine died quite recently, in February 2017, [1] and while his work is not the easiest to read, it should continue to influence bioethicist. This is not only because his prestige as a scholar, who had some training under Anscombe'[2] but also because he suffered from severe disability for many years, and hence also lived out a life of Catholic bioethics.

His obituary testifies that he was an important, if insufficiently known, philosopher[1]. Finnis acknowledged Braine in his work [3] and Cardinal Eijk references him in one of his recent papers [4]. Braine's work was rather varied and not all of it was related to Bioethics, but below are three examples that should be of interest to CMQ readers.

Though slightly obscure, probably one of Braine's most important contributions to bioethics is his testimony to the Scottish parliament on the End of Life Assistance (Scotland) Bill [5].[5] It is a highly personal piece as it relates to his own experience as a disabled, wheelchair bound person (the accident that caused his disability also prevented him from entering the Dominican order) [1]. In it Braine describes his personal experience with disability and outlines the reason why society should object to physician assisted death. He also states clearly why physicians should object to such procedures. As such, this short document provides a personal testimony with an expert philosophical touch to it.

Braine authored a short booklet on bioethics [6]. It is not so much a manual for clinical practice, rather it is a general guide to the attitude a Christian should have to bioethical matters. It is very concise and refers to a lot of early Christian texts, as such it is a great starting point for any Catholic beginning their venture into Bioethics.

The last piece of Braine's writing that I want to mention here is 'The Human Person: Animal & Spirit' [7]. This book is not specifically oriented towards bioethics, but it concerns human ontology - a crucial matter for bioethics. Braine presents a holistic vision of the human being, deeply rooted in the Thomistic tradition and phenomenology. It is definitively not an easy read, especially since Braine uses a lot of example from linguistics, with which a lot of the readers might not be familiar. Nevertheless, the book does a good job at tackling both materialism and dualism, and though it has been published about a quarter of a century ago, it is still relevant to the present bioethics debate'[4].

This is only a brief selection of Braine's work. Yet, it is hoped that this account presented Braine's writing as worthwhile to Catholics involved in healthcare and bioethics, and as a potential source of intellectual weaponry necessary to fight the good fight.

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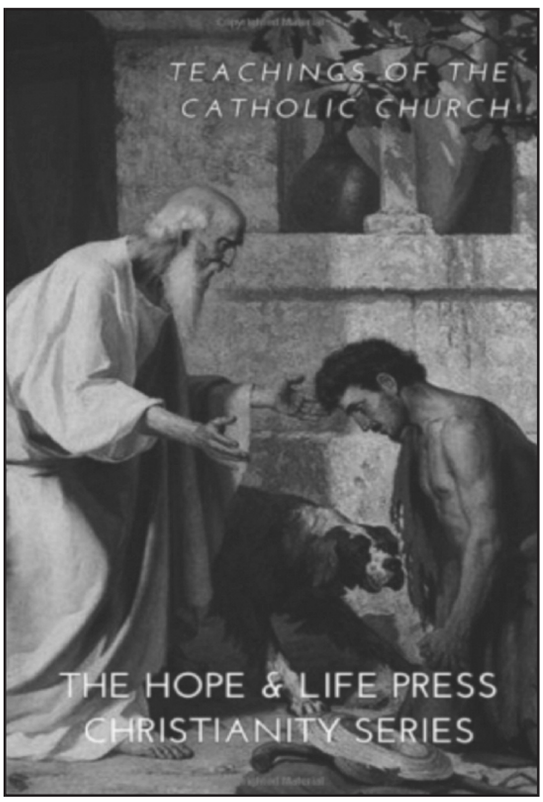
TEACHINGS OF THE CATHOLIC CHURCH. PUBLISHED AS PART OF THE HOPE AND LIFE PRESS CHRISTIANITY SERIES

REVIEWED BY PRAVIN THEVATHASAN



This proved to be a very interesting read. The chapter on the magisterium was especially helpful. We are reminded that "not everything contained in the statements of the ordinary magisterium is infallible." Thus when the pope discussed employment issues or matters pertaining to economics, there need be no charism of infallibility. In contrast, when he "teaches and judges of faith and morals for the universal Church" the teachings must be "adhered to with submission of faith."

Thus submission must be given on matters of faith and morals. Pope John Paul wrote very clearly that women cannot be ordained to the priesthood. This is not a matter to be discussed. It pertains to faith. On the other hand, he upset many people by inviting leaders of different religions to come together to pray. Note that he did not want them to pray together. Nevertheless, there was a resultant temptation towards religious indifferentism, the idea that one religion is as good as another. The pope was trying to be a good pastor when he asked that all people of good will pray for peace. He was clearly not invoking his ordinary magisterium. In the case of Pope Francis, this pastoral approach has indeed been numerous. It goes without saying that a pastoral approach can never contradict a matter of doctrine.

What about the death penalty? Like most Catholics, I am opposed to it. However, there can be nothing "intrinsically evil" about capital punishment. Otherwise we would have to condemn all popes up to Pius XII. I would have preferred Pope Francis to have reiterated the teachings of John Paul: that practically speaking, there is no need for it.

There is always a danger that justice and peace issues are to be seen as "liberal" and pro-life issues are for "conservative" Catholics. But the Church is neither left nor right. I was delighted to read the following : " The natural law itself, no less than devotion to humanity, urges that ways of migration be opened" to people who have good reasons to leave their homeland. This quote comes from the great "conservative" pope, Pius XII.

In summary, this is a very helpful overview of the important teachings of the Church.

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ISSN 0008-8226
Tudor Printing: 10 Marsh Drive, Freckleton, Preston, Lancashire PR4 1HJ
Telephone: 01772 633098