

cmq

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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.



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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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EDITORIAL

“SOLVING ETHICAL CONUNDRUMS BY PRESSING DELETE”



**DOCTORS IN
IRELAND
CHANGE
ETHICAL
CODE TO
INCORPORATE
NEW
ABORTION
LAWS**

As recently as 2 years ago, Irish doctors had very clear guidance on the care due pregnant women and their unborn babies. Doctors would need only consult their “Guide to Professional conduct and Ethics for registered medical practitioners” (which in 2016 was already on its 8th edition.)^[1] Reading for example paragraph 48:1 of this ethical Magna Carta for moral guidance in medical matters, they would find the following sound (and presumably well deliberated) ethical guideline: “You have an ethical duty to make every reasonable effort to protect the life and health of pregnant women and their unborn babies.”

Sound ethical principles such as these give a rock-solid foundation to a moral and humane medical practice. They also guide legislation and give consistency to the laws of the land, protecting them from the whims of time. Our Lord himself commands us to build on rock - *“Everyone who listens to these words of mine and acts on them will be like a wise man who built his house on rock. The rain fell, the floods came, and the winds blew and buffeted the house. But it did not collapse; it had been set solidly on rock”* (Matthew 7:24-25).

What are we doctors to make of it, when instead of moral principles informing laws, the reverse happens - new laws dictate the moral principle? Now with the abortion act in Ireland, abortion has suddenly become legalized. Doctors with a heart and conscience are left in a conundrum. What to do when a new law clashes with and contradicts the existing moral code? Is it not a danger when law dictates ethics rather than ethics informing law? Anyway, enough of those type of questions. Popular opinion is the new moral compass. Anyone who contradicts it must be some kind of “-phobic”. Hype and sloganeering can easily usurp any code of professional guidance and ethics. But *“the rain fell, the floods came, and the winds blew and buffeted the house. And it collapsed and was completely ruined”* (Matthew 7:27). The view of the majority? Why don’t more people stand up for what is right? Where is the voice of the Catholic doctor?

The new law contradicts the existing medical code. So what to do about the impasse? Simple - just delete the paragraphs! And this is what will happen - the paragraphs in the code will be deleted to force the ethical content of the medical code to be in line with the legislation. The Medical Council website announces it thus -

*“***Please note that from the commencement of the Health (Regulation of Termination of Pregnancy) Act 2018, paragraphs 48.1 to 48.4 of the Ethical Guide will be deleted, thus removing any conflict between the Ethical Guide and the Legislation.”*^[2] This is very confusing for all doctors, in Ireland or elsewhere, who have their patients’ best interests at heart, and who are gravely concerned when morality no longer informs legal frameworks but the exact opposite happens - the law hijacks ethics and dictates medical conduct. The terrible examples of this in recent history should make us all more cautious.

Legislators alone cannot be allowed to decide what is the new morality for doctors. Catholic doctors should be emboldened to speak out more. They would do well to remember the exhortation of St Paul: “I charge you in the presence of God and of Christ Jesus, who will judge the living and the dead, and by his appearing and his kingly power: proclaim the word; be persistent whether it is convenient or inconvenient; convince, reprimand, encourage through all patience and teaching. For the time will come when people will not tolerate sound doctrine but, following their own desires and insatiable curiosity, will accumulate teachers and will stop listening to the truth and will be diverted to myths. But you, be self-possessed in all circumstances; put up with hardship; perform the work of an evangelist; fulfil your ministry” (2 Timothy 4:1-5).

In speaking out against abortion they should feel fully supported by the Catholic moral tradition, with Pope Francis himself being a vocal advocate against the wrongs of abortion: “I feel it urgent to state that, if the family is the sanctuary of life, the place where life is conceived and cared for, it is a horrendous contradiction when it becomes a place where life is rejected and destroyed. So great is the value of a human life, and so inalienable the right to life of an innocent child growing in the mother’s womb, that no alleged right to one’s own body can justify a decision to terminate that life, which is an end in itself and which can never be considered the “property” of another human being.”^[3]

We Catholic doctors need to ask for the grace of courage, not to be passive, but to respond. “Go up onto a high mountain, Zion, herald of glad tidings; Cry out at the top of your voice, Jerusalem, herald of good news! Fear not to cry out” (Isaiah 40:9). There is a call and urgent mission to speak out knowing that, as St Catherine of Siena warned, it is silence that makes the world rotten.

Fr James McTavish, MA, FRCSEd, STL, FMVD
Provisional, Verbum Dei Manila, Philippines

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THE DEMISE OF THE ROYAL COLLEGE OF PHYSICIANS?

NEUTRALITY ON ASSISTED SUICIDE ACCEPTS THAT DOCTORS MAY LEGITIMATELY KILL THEIR PATIENTS

DR ADRIAN TRELOAR FRCP



The Royal College of Physicians celebrated its 500th anniversary last year. Simply to exist for half a millennium is an astounding achievement. But to develop into an international organisation that commands such respect is an even greater achievement.

For almost the whole of that half millennium, the College has been opposed to killing. The oath of Hippocrates and the Fifth Commandment found themselves enshrined in College policy, practice and writings.

But in January, at a Council meeting the College changed its position to one of neutrality to assisted dying. Ostensibly this change is described as enabling the College and members to enter the debate on Assisted Suicide. The College also changed its use of terminology. “*Assisted suicide*” is out, “*assisted dying*” is in.

The term ‘assisted dying’ is defined by the RCP as “*The supply by a doctor of a lethal dose of drugs to a patient who is terminally ill, meets certain criteria that will be defined by law, and requests those drugs in order that they might be used by the person concerned to end their life*”^[1]. So really, especially when the large majority of medications will be given with support and often intravenously by medics, this should of course be called “Killing”.

As a result of that a group of doctors (the author is one of them) have sought to take the College to Court. The reader may reasonably judge whether we are courageous, foolhardy, or both. We are concerned about the process that the College used to arrive at its decision and believe that the College has been unfair in the way it approached this. As well as that the College has adopted a “supermajority” method which means that moving policy away from neutrality can only be achieved if 60% of college members vote for the College to support or reject a change in UK law. The supermajority system is usually used to prevent a short term and slim majority in an electorate from changing policy on a matter. But in this case it is being used to prevent a reversion to policy that has been held for 500 years and to ensure that a new policy,

imposed by Council without consultation with members, cannot be changed back.

Neutrality on an ethical question means that you are not against something in all circumstances. Therefore neutrality in this case requires a willingness to accept that doctors may kill their patients. I cannot imagine the RCP adopting a position of neutrality on modern slavery, racism or other evils in our society. The RCP entirely fails to point out that neutrality, in essence therefore accepts the principle of assisted suicide. But to many of our colleagues neutrality will look like an attractive (though false) option. As the Canadian family physician Williard Johnston said when commenting upon the effect of the Canadian Medical Association adopting a neutral position on assisted suicide “*Few Canadian doctors foresaw that going neutral would guarantee the arrival of euthanasia . . . Learn from our mistakes.*”^[2]

And the College has put in place a mechanism which appears to have the sole intention of making it very hard to change the newly adopted position of neutrality back to one of opposition. As can be seen on page 9 of this issue the same switch towards neutrality is being proposed at the World Medical Association by doctors from Canada and the Netherlands.

The key point about neutrality on assisted suicide is that being neutral accepts that doctors can legitimately kill their patients. That will become a massive corruption deeply embedded within the profession of medicine. Assisted dying and killing cannot sit alongside good care and treatment of the weak and vulnerable. “*Every kingdom divided against itself shall be made desolate: and every city or house divided against itself shall not stand. And if Satan cast out Satan, he is divided against himself: how then shall his kingdom stand?*”^[3]

It is hard to believe that the College of Physicians can embrace killing as its Council has sought to do and continue to stand. Patients need a College where they can be confident that members will truly value and respect their lives

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[3] Matthew 12:22-28

See also the News section on page 7 for details of the press statement

THE END OF FREE SPEECH

DR PRAVIN THEVATHASAN



I disapprove of what Stephen Fry has to say about religion. But I will defend to the death his right to say it. That is the price we have to pay to live in nations that give us the right of free expression. There are always limits to this freedom and laws are already in place to ensure that such rights are not abused.

The pro-abortion MP Rupa Huq wants a ban on vigils outside abortion clinics. She is supported by Jeremy Corbyn. We are talking here about peaceful vigils that lovingly give witness to the value of human life, both born and unborn. Pregnant mothers have turned away from abortion thanks to the support they have received from these pro-life witnesses. The "buffer zones" favoured by Ms Huq are intended to restrict the rights of freedom of assembly and freedom of expression. There are already public order laws in place to prevent any form of threats directed at women entering or leaving these clinics.

The Catholic Herald reports (January 18, 2019, p11) that John Finnis, Emeritus Professor of Law at Oxford University, faced a petition to remove him from teaching responsibilities because of his disapproval of same sex activity. Had he endorsed any form of violence towards homosexuals, he should certainly have been fired. But he did not. He was putting forward a philosophical argument against all forms of sexual activities not open to the good of procreation. If he is to be condemned for homophobia, he might as well be equally condemned for heterophobia. It would seem that one of the reasons for his condemnation is that he has violated a "safe space" for students. But surely a function of universities and indeed all free communities is tolerance of unfashionable views.

In the United States, where the Democrats are moving away from being the abortion party to being pro-infanticide, there was the bizarre spectacle of Democratic politicians accusing a candidate for the federal bench of being a member of the Knights of Columbus (Catholic Herald, December 22, 2018). It would appear that membership of a mainstream Catholic organization is out of bounds for the freedom loving Democrats. There was the still more Kafkaesque case of the Covington Students (Catholic Herald, February 14, 2019). While waiting to return home following the March for Life, they were

shown seemingly taunting a native American. There was immediate condemnation by Hollywood celebrities, by Jesuit James Martin and even by their bishop and Catholic school. It later transpired that they were the ones who had been victims of racial and homophobic abuse. It was the native American who had confronted them, not vice versa. The boys later received apologies when the truth finally came out. But not from Alyssa Milano who condemned the students for protesting against a woman's right to reproductive freedom and she saw no reason to condemn the appalling treatment they had received. So, you are free to abort but not free to campaign against abortion.

It would appear that freedom of speech is all well and good in liberal circles so long as you are promoting liberal causes.



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

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

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.com 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

NEWS

ASSISTED SUICIDE AND THE ROYAL COLLEGE OF PHYSICIANS: THE PROFESSION HAS NOT MOVED ON THIS ISSUE, SO NEITHER SHOULD THE COLLEGE

Despite the court case (page 4) the Royal College of Physicians did indeed use the results of its survey to support its new position of neutrality on assisted suicide. Those who brought the court case against the College made a press statement on the 23rd March.

At the time of going to press the case is currently ongoing

Statement for released on 23rd March 2019 by Paul Conrathe on behalf of
 Dr Kathy Myers FRCP, Retired Consultant in Palliative Medicine, London
 Dr Adrian Treloar FRCP, Consultant Old Age Psychiatrist, London
 Dr David Randall MRCP, Registrar in Renal Medicine, London
 Dr Dermot Kearney FRCP, Consultant Cardiologist, Gateshead

We are disappointed but not surprised by the decision of the Royal College of Physicians to move to a position of neutrality on assisted suicide.

The Council of the RCP made clear its desire to see the College adopt a position of neutrality on this issue. It is very difficult to achieve a majority for any particular position in a vote with multiple options, and the conventional approach in such cases is to accept the view of the largest group.

The College decided to require a 60% supra-majority to maintain opposition to assisted suicide, in a three way question, making today's outcome almost inevitable.

The results of this survey justify our decision to challenge the Royal College of Physicians in court over its handling of this poll.

We note that:

- 43.4% in this survey believe the College should continue to oppose the legalisation of assisted suicide, compared with 44.4% in 2014 - in both cases representing the largest group of doctors.
- Once people answering 'don't know' are removed (this option was not present in 2014), 55% of those who expressed a personal opinion on assisted suicide are opposed to its legalisation, compared to 57.5% in 2014.
- Only 25% of RCP members and fellows support the College's new position of neutrality (down from 31% in 2014), and neutrality is the least well supported of the three potential positions the College could hold.

The results therefore show that the views of RCP members and fellows are virtually unchanged since 2014 – making the College's new position at odds with the opinions expressed by the largest group of grassroots Members and Fellows.

The College has dropped its historic opposition to assisted suicide despite the largest group of respondents being personally opposed to this and supporting public opposition to assisted suicide. The new position of neutrality is supported by a mere quarter of the College.

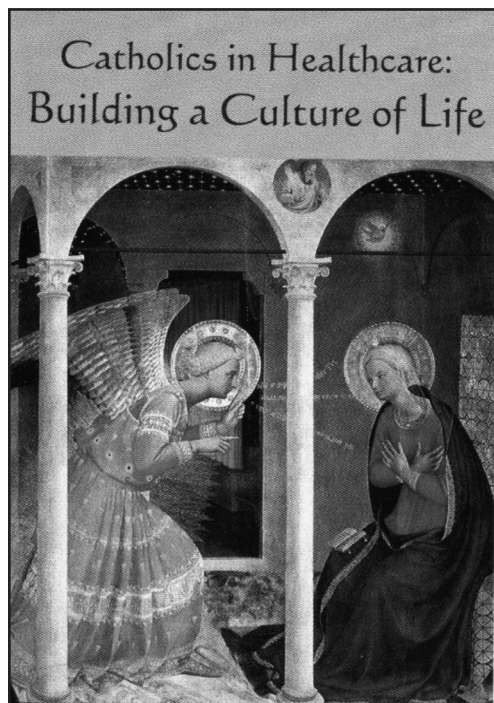
We were disappointed not to receive permission today to challenge the decision of the College in the High Court on technical grounds.

Sick and vulnerable people are at risk as a result of College neutrality on assisted suicide. The profession has not moved on this issue, so neither should the College.

FAITH IN MEDICINE

THE FAMILY: BUILDING THE CIVILISATION OF LOVE

DR ADRIAN TRELOAR



The February 2019 CMA Youth Retreat focussed upon “The Family: building the civilisation of love.” Along with some other very moving presentations we greatly enjoyed presentations on what it is to be a man and a woman.

The Book of Genesis tells us that God said, “Let us make mankind in our image, in our likeness, so that they may rule over the fish in the sea and the birds in the sky, over the livestock and all the wild animals, and over all the creatures that move along the ground. So God created mankind in his own image, in the image of God he created them; male and female he created them”^[1]. That in itself is a revolutionary thought. Mankind made in his image, male and female he created them. In other words both men and women are differing forms of the very humanity of God. In women we see some aspects of God more clearly than we do in men (and vice versa).

One of the great challenges of our current age is to work out what is special to manhood. Women clearly do some things (like childbearing and motherhood) which men cannot do. And they are also recognised as being (often) more emotionally literate, sensitive and aware than men.

But I suspect that most men do not know what they do which makes them especially men. Women can fly fighter jets, run blue chip companies, fight in the front line, they make fantastic doctors, nurses and managers. It is right and proper that women drive buses and ambulances. So much that used to be thought of as a male task is open to women, although currently just six per cent of pilots and seven per cent of train drivers are female.^[2]

There is plenty to worry about. The number of students disclosing mental health issues has risen five times in a

decade^[3]. Suicide rates are three times higher in men than women (although that is almost certainly a feature of being a man more than it is a by product of men not knowing what it is to be a man).

We know that some traits are more common in men than women. Map reading, spatial awareness, some aspects of organisation and task completion and mechanical skills are more often expressed in men than women. Just as Genesis tells us, those abilities complement female strengths such as sensitivity, multitasking and emotional literacy. Intriguingly, one expression of those differences is that Autism and Asperger’s syndrome is diagnosed much more frequently in males than females and yet Anorexia Nervosa is much more common in women than men.

What therefore makes men men? Well the obvious answer is their Y chromosome. But what makes a male identity? What are the behaviours and ways of thinking that are “manly”? Well that is a very difficult question and having asked a few good Catholic men and women I can assure you that it is a question with which many struggle. Having asked quite a few men what they think the answer so often comes back as “*Well women can do all these things and there is nothing unique that makes a man a man.*”

My grandfather expressed a very interesting view of manhood. In a letter to the Daily Telegraph in 1963^[4] (we have republished this in our correspondence section) he clearly described the horrors of the trenches alongside the pointlessness of “*going over the top*”. He wrote “*I was spared the horrors of the Salient and the Somme., but the heroism and devotion of the men who went to almost certain death in their senseless, repeated and hopeless attacks, is perhaps the finest saga in the story of British manhood.*” Which is the view of a man born in 1897. To our eyes today, his statement is bewildering. How can death in senseless and repeated attacks possibly be the finest saga in the story of British manhood? Upon reflection, what I see is that doing what was right, following principles and being willing to die for them was seen as a central part of that manhood. He saw that men gave their lives for what they thought was right. Remarkably, my Grandfather was back in France on the Normandy beaches one day after D-day in 1944. He followed the advance, setting up local governments post liberation.

“I was spared the horrors of the Salient and Somme, but the heroism and devotion of the men who went to almost certain death in their senseless, repeated and hapless attacks, is perhaps the finest saga in the story of British manhood”.

Guy Curtis 1963

My wife reminded me of another image of manhood that comes from the sight of the Belgian Miner's Pilgrimage to Lourdes. The short, strong miners turn up in their full regalia with polished brass mining lamps and the works. And as the Blessed Sacrament processes past, they kneel humbly before Our Lord. In humble submission and



adoration of Him. Perhaps that love and respect is a very central part of manhood.

Finally, St Joseph must also be the great example of manhood. Quietly sticking by his wife Mary despite the scandal of her virgin birth, he was a solid rock, protecting, defending and keeping the Holy Family safe. Imagine St Joseph during the Flight into Egypt. He must have been exhausted. And, as a man, slept peacefully beside his wife Mary and Our Blessed Lord. Protecting, vigilant but fast asleep. Orazio Gentileschi worked that out. In his painting "The Rest on the Flight into Egypt" we see St Joseph exhausted and flat out beside Our Lady and Our Lord. He has fed the donkey, protected his family and sleeps, beside his wife. He is fleeing from Herod to another country resting close to the heart of his Saviour.

Exhausted and a true refugee. As a man giving everything to protect and provide for his wife and family.

We cannot publish this picture by Orazio Gentileschi as we cannot afford for the fees for permission to do so.

Manhood is a concept that has become obscured by our present civilisation. The loss of that concept cannot be good. Without it, our mental and physical health are placed at risk. As St John Paul said "The Future of Humanity Passes by Way of the Family". Manhood is central to the family. Womanhood is also, of course, utterly crucial. But we should neglect neither. Medicine and society need to be helped to celebrate and to understand the unique and special charisms which come with being men and women. If and when diversity theories obscure those differences, those theories may be deeply harmful.

We would welcome insights, images and vignettes from others which might give us further clues as to what manhood and womanhood are.

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NEWS

WORLD MEDICAL ASSOCIATION TO DEBATE ENDING ITS OPPOSITION TO EUTHANASIA

The World Medical Association is to debate a change sought by doctors from Canada and the Netherlands calling on the WMA to adopt a neutral position on euthanasia and / or assisted suicide as opposed to the current position of outright opposition. The revised official position deletes the statement that the act of deliberately ending the life of a patient, is unethical.

Here is the CMA (UK)'s response.



The World Medical Association (WMA) was founded in 1947, in the aftermath of World War II and the subsequent Nuremberg Trials. At that time, the role of doctors in the participation of crimes against humanity had come under the spotlight. The crimes committed and condemned included experimentation on human subjects without consent, the torture, inhumane treatment and murder of civilians and prisoners and participation in the infamous Nazi Euthanasia Programme.

After the initial WMA formation, the Declaration of Geneva was formulated by the Association and approved by its General Assembly in Geneva in September 1948. It was considered a modern version of the traditional Hippocratic Oath and indeed was written in the format of a solemn Oath, ending with the declaration "I make these promises solemnly, freely and upon my honor".

The Oath begins with the words "At the time of being admitted as a member of the medical profession: I solemnly pledge myself to consecrate my life to the service of humanity." Of particular note and relevance, the eighth pledge in the original Declaration read "I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity". In October 1949, at the third General Assembly held in London, the Declaration of Geneva was reiterated in the International Code of Medical Ethics by the declaration that "a doctor must observe the principles of the Declaration of Geneva approved by the World Medical Association".

Even after a minor amendment relating to maintaining patient confidentiality after a patient's death, the revised Oath in August 1968 still contained the pledge that the doctor would maintain the utmost respect for human life from the moment of conception. This promise was made

in the same year that the Abortion Act of 1967 came into force in the UK.

It was not until the next revision in October 1983 that the Declaration of Geneva omitted any pledge to protect human life from conception. The revised version from the 35th World Medical Assembly in Venice included the watered-down pledge that “I will maintain the utmost respect for human life from its beginning even under threat and I will not use my medical knowledge contrary to the laws of humanity”. This position was maintained with the next revision published after the 46th WMA General Assembly meeting in Stockholm in September 1994.

A further revision of the Declaration was approved at the 170th Council Session of the WMA in May 2005 at the organisation’s headquarters in Divonne-les-Bains, France. By that stage, the original promise to respect human life from conception was long forgotten as the accepted wording in that section of the Declaration now became “I will maintain the utmost respect for human life”. This aspect of the current Declaration was further approved most recently at the 68th General Assembly in Chicago in October 2017. It is now known as “The Physician’s Pledge”.

By omitting, in the later versions of the Declaration of Geneva, any mention of respecting human life from conception or even from the more ambiguous “from its beginning”, the WMA is, of course, giving approval to the practice of abortion, now carried out on a widespread basis throughout the world by people who continue to call themselves “doctors”. A more consistent and ethical approach would have been to continue with the position that human life was worthy of the utmost respect from the moment of conception and that anybody entering the medical profession, and wishing to be recognised as a physician, must uphold that tradition. The practice of abortion should have remained condemned as a crime against humanity and an act of professional misconduct just as it was considered in 1947 and also as it was considered at the time of Hippocrates in the fourth or fifth century BC (“I will not give to a woman a pessary to cause abortion”).

A solemn Oath is meant to be sacred, unchanging, eternal. Changing the wording of an Oath to suit changing political ideas and changing fashions renders the Oath meaningless and greatly discredits the organisation that claims to abide by it. It brings the organisation and its members into disrepute. It is difficult to take the World Medical Association and its empty promises seriously at this stage of its existence despite the claim that it represents ten million doctors worldwide. Yet the organisation is taken seriously by many in political power.

It is another cause for major concern that some factions within the WMA are attempting to soften the Association’s longstanding opposition to euthanasia, even though it was originally founded on the principle that euthanasia and other similar atrocities must never be allowed to happen again and that physicians must never collaborate with forces that seek to advocate euthanasia programmes. A motion was brought to the General Assembly meeting in Reykjavik, Iceland in October 2018 by delegations from

Canada and The Netherlands, calling on the WMA to adopt a neutral position on euthanasia and / or assisted suicide as opposed to the current position of outright opposition. The motion was fortunately withdrawn due to a perceived lack of international support. If passed, it would not be long before enthusiastic support for euthanasia would become the norm if lessons are to be learned from the abandonment of “the utmost respect for human life from conception” and the gradual widespread acceptance of abortion.

We now learn that an alternative motion is to be put forward for the forthcoming WMA Council meeting in Santiago, due to take place April 25th to 27th this year. The current official position of the WMA on these issues is as follows:

“Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient’s own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness.” And, in relation to physician-assisted dying,

“Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient.”

The proposed amendment reads “The World Medical Association is opposed to euthanasia and physician-assisted dying. Euthanasia is defined as the voluntary act of deliberately ending the life of a person at his or her own request. Physician-assisted dying refers to cases in which a physician deliberately enables a patient to end his or her own life by prescribing or providing medical substances whose sole intent is to cause death. It is not the task of the physician to participate in euthanasia or deliberately enable a patient to end his or her own life. No physician should be forced to participate in euthanasia or assisted dying, nor should any physician be obliged to make referral decisions to this end. However, the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient”.

While this new proposed wording seems quite benign as it clearly reiterates that the WMA “is opposed to euthanasia and physician-assisted dying” it nevertheless represents a definite softening in this opposition. It is very likely that this softened approach is designed to appease the Canadian Medical Association whose leadership made the decision to resign from the WMA in 2018, allegedly due to ethical concerns over plagiarism in the inaugural speech made by the new WMA President. It is possible, however, that the Canadian resignation may have been related to frustration or anger over the WMA not supporting its position on euthanasia. It could represent an effort by Canada to bully the WMA into gradually

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PAPERS

OFFERING A SECOND CHANCE: ABORTION PILL REVERSAL

DR DERMOT KEARNEY MRCPI



The Newcastle branch of the Catholic Medical Association (UK) held its latest meeting on Wednesday 24th October 2018. The meeting was held at the University Catholic Chaplaincy, newly located at St Andrew's Church on Worswick Street in the centre of Newcastle. The topic for discussion was "Offering a Second Chance: Abortion Pill Reversal" with an opening presentation given by Dr Dermot Kearney.

Of the 192,900 abortions carried out on residents of England and Wales in 2017, 66% were performed by pharmacological means and are commonly referred to as "medical abortions" (as opposed to "surgical abortions").^[1] The number of medical abortions has been steadily rising year by year over the last decade and that trend is likely to continue.

Medical abortion involves the pregnant woman taking an initial drug called Mifepristone followed by a second drug, Misoprostol, one or two days later. Mifepristone (also referred to as RU-486) blocks the biological action of Progesterone, a naturally-occurring steroid hormone that is essential for maintaining a pregnancy. It acts primarily by competitively binding to endometrial Progesterone receptors and thereby interfering with the attachment of the developing foetus to the endometrium, resulting in deprivation of oxygen and nutrients essential for the continuing survival of the foetus.^[2] Misoprostol, taken one or two days later, is a prostaglandin that causes uterine contractions and the expulsion of the killed foetus from the uterus, thereby completing the abortion.^[2]

"Medical abortion" using the combination of Mifepristone and Misoprostol should not be confused with so-called "emergency contraception", also commonly referred to as "the morning after pill", in which different pharmacological agents (Levonorgestrel or Ulipristal) or intra-uterine devices are used within 3-5 days of "unprotected" sexual intercourse. In some cases, such intervention prevents

conception from taking place by inhibiting ovulation (a true contraceptive effect) but in many instances, abortion is induced at the very earliest stages of pregnancy by inhibiting implantation or natural development of the already formed embryo within the fallopian tube or within the uterus. In "medical abortion" using Mifepristone and Misoprostol, implantation has already been established and the drugs are used to intentionally end the life of the developing foetus. "Medical" abortions are carried out at any stage from early pregnancy and generally up to fourteen weeks gestation. The law in Britain, however, allows for drug-induced abortions to take place up to 24 weeks gestation.

With the increasing use of pharmacologically-induced abortion, as opposed to surgical abortion using vacuum aspiration or dilatation and curettage techniques, some women change their minds about proceeding with the abortion even after they have taken the first Mifepristone pill. In recent years, the Catholic Medical Association (UK) and other pro-life organisations have received calls from women in distress in this situation. These women are desperately seeking advice and assistance to help them save the lives of their babies and preserve their pregnancies. They are seeking an abortion reversal treatment. Such treatment is available, although it is not truly "abortion reversal". The treatment is Progesterone and, when effective, it inhibits the effects of the abortion pill Mifepristone, preventing abortion from taking place in many cases.

Effects of Abortion Pill Reversal Therapy

This Progesterone-based "reversal" treatment has been available in the USA for many years and, to date, has helped to preserve the lives of hundreds of babies who might otherwise have perished to abortion.^[3] The best available research shows that the treatment is effective and safe for both the developing foetus and the mother.^[3]

In brief, if the mother proceeds with the abortion by taking both of the prescribed abortion drugs the foetus has a 1-2% chance of survival. Those few who survive, when "medical abortion" has failed, are almost always subsequently killed by the abortionist resorting to surgical abortion.

If the mother, however, changes her mind after taking the first Mifepristone drug and doesn't take the second Misoprostol drug but doesn't receive Progesterone therapy to save her baby, there is a less than 25% chance that the child will survive.

If she changes her mind after taking Mifepristone and seeks help, receiving Progesterone in a timely manner within 72 hours after taking the first abortion pill, there is an overall 68% chance that the baby will survive.

With Progesterone "abortion reversal" therapy the chances of foetal survival are greater when the initial abortion pill has been taken in later stages of pregnancy, with survival

rates up to 77% if the pregnancy has already advanced to 9 weeks. If the abortion pill is taken at an early stage of less than 5 weeks gestation the chance of foetal survival is 25%, even with Progesterone therapy.

Potential objections addressed

Objections have been raised, largely by pro-abortion groups, about the use of “abortion reversal” treatment. Each of these objections is easily refutable. It has been claimed that there is no scientific basis for Progesterone therapy in preserving pregnancy after Mifepristone has been taken. Progesterone has, however, been used for several decades in trying to help women preserve their pregnancy from suspected miscarriages and it is also used in many fertility units to help support pregnancy in assisted fertility management (in-vitro fertilisation). Furthermore, a well-designed animal study from Japan clearly demonstrated the efficacy of Progesterone in inhibiting the effects of Mifepristone.^[4] In that experiment, a control group of pregnant rats was administered Mifepristone while the other treatment group received both Mifepristone and Progesterone. In the control group that received Mifepristone only, 33% of the rat pups survived. In the treatment group that received Progesterone in addition to Mifepristone the pup survival rate was 100%. This study importantly demonstrated that Mifepristone blockage of Progesterone receptors was reversible by simple administration of Progesterone. The success rates reported in human studies from the US also support the use of Progesterone as “abortion pill reversal” therapy.^[3]

Some have questioned the safety of Progesterone in pregnancy for both the mother and the developing foetus. There is no evidence of any risk to either mother or developing child, especially if the use of Progesterone is short-term. The risk of birth defects in children born where Progesterone has been administered to save their lives is exactly the same as the risk of birth defects occurring in children born after completed pregnancies in the general population.^[3]

There is no increased risk to the mother where Progesterone has been administered in the early stages of pregnancy and neither is there any increased risk of prematurity.

Recommended treatment regimens

Progesterone treatment is already available and is inexpensive. It can be administered in a variety of ways. The recommended Progesterone treatment regimens from the US studies are as follows:

Progesterone micronized capsules by oral administration: 400mg as soon as possible after Mifepristone ingestion followed by 400mg twice daily for three days and subsequently 400mg each night until the end of the first trimester; or alternatively Progesterone 200mg by intramuscular (IM) injection as soon as possible after Mifepristone ingestion followed by 200mg IM injections on days 2 and 3 followed by 200mg IM injections on alternate days until 7 injections in total have been administered.^[3]

Drug-induced abortions in the USA are licensed up to 10 weeks gestation but are allowed in the UK in later stages

of pregnancy. The exact duration of oral Progesterone treatment in abortion pill reversal requires adaptation in each individual case in this country, if the pregnancy has already advanced beyond the first trimester.

The Catholic Medical Association (UK) is keen to promote the use of Progesterone therapy for women who change their minds after taking Mifepristone and who seek help to save the life of their unborn. Submissions have been made to the Royal College of Obstetricians and Gynaecologists and to the Royal College of General Practitioners and also to NHS England seeking support in this area. Formal replies are awaited. In the meantime, it is important for doctors, nurses, midwives, pharmacists and the general public to be aware that such treatment is available, that it is safe and, in many cases, that it can be effective in helping to save the lives of unborn children.

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WMA continued

accepting that euthanasia may not be so abhorrent after all.

It is particularly surprising and perhaps sad that the proposed amendment is being brought forward by representatives from the German Medical Association. Of all the nations affiliated to the WMA, the last one to consider any move that could lead to acceptance that euthanasia or physician-assisted dying is anything other than unethical should be Germany, considering the lessons that should have been learned seventy odd years ago.

The Catholic Medical Association (UK) is of the firm opinion that maintaining current opposition to and outright condemnation of the practices of euthanasia and physician-assisted dying is the only ethical position that the World Medical Association should pursue. There is no need to change current policy relating to these issues.

WOULD YOU REFUSE A DYING MAN WATER? CONCERNS ABOUT THE WORKING OF THE MENTAL CAPACITY ACT

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ALLIANCE



An appeal

In this article we are appealing to members of the public to tell us where they have seen examples of the Mental Capacity Act working well for their loved ones, making things difficult for their loved ones, being used to provide excellent care, or being used to excuse poor care etc. Each section of this article therefore attempts to set out key areas of concern. We believe that we need to be able to discuss more widely and in greater depth the problems of the Mental Capacity Act. We need to know more about its problems and weaknesses as well as its strengths.

Introduction

The Mental Capacity Act ^[1] was introduced in 2005. At the time it was stated that it would “enable decision making for the mentally incapacitated”. 15 years later, we believe that there are some real concerns with the way in which the MCA is working. In 2013 the House of Lords stated that Deprivation of Liberty (DoLS) legislation is “not fit for purpose” and yet reform of DoLS remains unachieved and elusive.

We believe that, in addition to the problems of DoLS, the MCA itself has real limitations and poses substantial risks for people who lack capacity. Those risks are even greater in people who not only lack capacity but who are also disabled, elderly, frail or who suffer from dementia etc. We worry that the MCA can easily be misused to deny care to such people or may be associated with poor care. We are concerned that the structure of the Act may predispose towards poor care and poor outcomes. An Act designed to protect the vulnerable may be doing exactly the opposite. It can be used to enable the withdrawal of

the opposite. It can be used to enable the withdrawal of care, including nutrition and hydration from mentally incapacitated people and can be used to cause death by withdrawal of clinically -assisted nutrition and hydration. We are also concerned that the Act asks clinicians to think of alternatives to the best care even in situations such as personal care for incontinence etc. That requirement, along with the Act’s requirement for clinicians to consider “less restrictive options” for care can push clinical care options towards riskier clinical practice and negligence.

We believe that the limitations of the Mental Capacity Act, need to be modified by good evidence-based clinical practice which benefits patients and their families.

But we also think that the evidence of the MCA doing harm needs to be collated so that it can become coherent. At present, while there are many reports and concerns about it, those reports are either newspaper articles or multiple anecdotes. We are therefore appealing for people to share with us their experiences of the MCA. We want to know more about its strengths and problems. Our key concerns and associated questions are set out below

1. There is an overarching concern that mentally incapacitated patients and their families/carers struggle to know what to say and how to say things to those providing care

Families repeatedly report worrying that the care they are seeing offered is unacceptable, but they dare not say anything because they are afraid that if they do the staff will “take it out” on their loved ones. Protecting very unwell and dying people at the moment of their greatest vulnerability and maximum dependence upon the mercy of others is very onerous. Taking action to protect your loved one may well make your loved one more vulnerable. There is a very strong imbalance of power, knowledge and (often) negotiating skills between families and healthcare staff.

Families really struggle to know how to protect and speak out for their loved ones. While this was clearly the case before the introduction of the MCA, it has not improved since 2005 and may be worse.

2. The healthy do not choose the same way as the sick

The Mental Capacity Act is deeply imbued with a set of assumptions that, while we are healthy, we can predict how we will be when we are unwell and how we will choose in those circumstances. An example would be advance refusals that require doctors to leave a patient untreated, or un-hydrated so that they will die. The way we thought about ourselves when we were healthy informed the way

we thought we would want to be cared for when we were unwell. But how we felt at that time (even though we knew so little about the future illnesses we feared), is taken as the arbiter of how someone should be cared for in their infirmity.

And yet, we know clearly that once someone is ill they see things differently. The healthy do not choose or think the same way as the sick. So often, we see sick people asking for the very care they would have wanted to avoid when they were well. And yet the MCA can require clinicians to avoid treating people in their illness. Many families have said, for example, "she would never have wanted to be treated in this way" when in fact it is clear that now she does want that treatment.

And yet the MCA enables the ideas and prejudices which we had when we were younger and well to become set in legally-binding writing which can then appear to cause substantial harm and distress later.

3. Mental capacity assessments are complex and subject to doubt and uncertainty

The law states that capacity must be assumed until demonstrated otherwise. However that provision protects doctors and nurses who provide poor care more than it protects the sick and vulnerable. For example, a verbally able but mentally incapacitated person may make a very clear rejection of treatment for a short-term consideration, but in fact be failing to understand or believe that not being treated will result in their death. The wording of the MCA effectively protects any clinician who can claim, with minimal justification, that the patient had not been demonstrated to lack capacity. And if the patient is presumed to have capacity and is refusing treatment, then they will be held to have died through their own choices. The doctors are protected because they will claim that they respected the autonomy of the patient.

The construct of "Best interests" which are used to determine treatment, is a construct which itself is based on fallible diagnosis and prognosis. It is widely accepted that doctors are often not able to make statements as to a person's prognosis or diagnosis. And yet, notwithstanding that, the law requires that a 'best interests decision' be made for such people. At times those "best interests" decisions will involve life-saving treatment. And yet they are often built upon uncertain diagnoses and shaky predictions of prognosis. There is a body of evidence for this especially in states of reduced consciousness. We are aware of patients in a locked in state, or seemingly in terminal unconsciousness who make a full recovery. NICE guidance on "End of Life care" sets out clearly that prognosis is far less accurate than many would hope [2].

Worse still, if clinicians do not want to treat a patient, they may well be able to use the provisions of the MCA to avoid treating them by making assumptions about what they would have wanted etc (see the subvertability of best interests decisions below).

4. Best interest judgements are very subvertable

The best interest process, set out by UK law states that decision makers think through the past and present wishes

of the patient and also consult with family members etc. While it is deeply shocking that consultation with family members often fails to occur, it must also be recognized that family members do not always incline to decisions which are truly in the interests of the patient. They may, at times, be struggling themselves with their loved one's illness. Or they may even be waiting for an inheritance. Decisions about life and death become made by people who are healthy and have not got experience of being unwell.

Seriously missing from the best interests process is any statement directing decision makers to consider what is good clinical care. In that context, best interests can easily be subverted. A conclusion that it is better for someone not to be treated and to be allowed to die may be entirely inappropriate for an incapacitated person, but very much what the relevant people who (by law) should be consulted really want for themselves.

It is worth noting that as opposed to the "best interests" consideration, Scottish Law uses "benefits" as an overall guide to clinical treatment decisions.

5. The MCA and withdrawal of nutrition and hydration

The MCA can easily be used to deny care and to deny food and fluids etc with the result that death is assured. When the MCA was passed into law, the withdrawal of food and fluids from people in persistent vegetative state had to be agreed by the Court of Protection. That requirement persisted up until the case of *Re Y* in 2018 when it was decided that if family and clinicians agreed that it is in the best interests of the patient, then clinically assisted nutrition and hydration (CANH) can be withdrawn in the expectation that death will result. And even though death is caused by dehydration and starvation, it is not necessary to put that onto the death certificate.

In addition to that, if it is concluded that it is not in the best interests of the individual to be given food and fluid, the terms and provisions of the MCA make it illegal to give that fluid. Consequently, to withdraw fluid and thus to cause death is not only legal, but giving food and fluid may be illegal. While case law has clearly demonstrated that that is true in CANH it may also be true even of orally administered fluids. As we have said, if it is concluded that giving food and fluids is not in the best interests of the individual, then giving fluids may simply be illegal. And that decision is no longer even safeguarded by the Court of Protection. Therefore, it may be illegal for a family member to offer fluids etc, and we note that, at times, family members who have done this have been threatened by staff saying they would call the police if they persist in offering fluids to their loved one.

While the MCA can enable good care to be imposed upon people who refuse it, it can also become legal tool which makes feeding and hydrating the sick, as well as offering them active treatments, an assault punishable by criminal law. The case of *Alfie Evans* is a good example of how Best Interests can be used in this way. Although *Alfie* was a child and not therefore subject to the MCA, Best Interest principles apply just as they do with the MCA. Lord Macfarlane stated in his High Court Judgment [3] that "*when in relation to all the other factors in*

the case a judge has concluded that it is not in the best interests of that individual to carry on living and it is in the best interests of that individual to be allowed to die, one asks how can it possibly be disproportionate to hold that that person's right to go to a different hospital in a different country to access treatment should in some way alter the outcome that has been determined." In that case the care that was prevented was transfer to a hospital in Rome for further assessment and care. And Baroness Hale ^[4] built upon that view when she stated *"It has been conclusively determined that it is not in Alfie's best interests, not only to stay in Alder Hey Hospital being treated as he currently is, but also to travel abroad for the same purpose. It is not lawful, therefore, to continue to detain him, whether in Alder Hey or elsewhere, for that purpose".* She continues *"The hospital must be free to do what has been determined to be in Alfie's best interests. That is the law in this country."*

In other words, having concluded that it was in Alfie Evans' best interests to be allowed to die, the State ordered removal of treatment and the State duly denied Alfie the opportunity of treatment elsewhere. Alfie died. The MCA can, in absolutely the same way, make it illegal to offer food and fluid to a dying person.

We should just note here and remind readers that there are circumstances (for example where severe choking will occur and cause great suffering to the individual every time any fluids are offered) when offering food or fluids might be genuinely wrong. Therefore, occasionally, a prohibition on food and fluid may be a reasonable and right clinical decision.

6. The MCA often makes good clinical decision making harder

The purpose of passing the MCA through Parliament was stated (at the time) to be enabling decision making in those who lack capacity. Sadly, the MCA set out a long list of requirements and processes to follow in making decisions. As well as requiring the "least restrictive option" which so often means that the care offered will be less safe etc. (see below), the MCA sets out many processes whereby it may be found that care ought not to be offered. While it also sets out a suggestion that failure to provide care is neglect, the provisions of the MCA mean that clinicians are required to be able to state (and very often to have recorded) that they had thought through the options, and considered all the alternative courses to what they thought was the best and right care.

Perhaps that makes the biggest difference for the simplest decisions. We would all agree that there should be careful thought and consideration given for complex and challenging decisions. But the law states that even for simple decisions (such as the provision of basic care, or cleaning someone up after they have soiled themselves) clinicians and carers must think carefully through the options and consider the alternatives.

In those who lack capacity, the provision of life saving treatment requires consultation with family, a relevant advocate or an independent mental capacity advocate. That may be a significant deterrent to initiating life saving treatment in those who lack capacity. A senior social services manager once reflected upon this stating that *"the*

MCA is forcing us to take more risks with people who lack capacity". While that may sometimes be a good thing, it also shows how much harder the MCA can make enabling good care for those who lack capacity. Many nursing homes now require a 4-5 page capacity assessment to be completed for each person who is to have a flu vaccination. Which undoubtedly shows how the MCA can make simple clinical decisions harder.

The MCA has within it a deeply embedded belief that simply refusing all care is an option even where death may result and even where great suffering may be caused. That is especially true with Advance Decisions to Refuse Treatment but it also affects most other parts of the Act. It is perhaps not surprising that those parts of the Act were especially strongly championed by those who campaign for euthanasia.

That means that even for simple decisions for things such as basic care, if clinicians thought the patient had capacity to refuse and was refusing treatment, then leaving them in their excrement may be defensible. And even if they lack capacity, a conclusion that leaving them was *"less restrictive"* or in their best interests becomes a defensible option.

In the end, leaving people to suffer alone may become a reasonable interpretation of the best way to provide care. It is, after all, the case that the MCA requires that clinicians think like this.

7. The MCA can increase the likelihood the people will suffer neglect

In its draft form, the MCA planned to exclude what was called basic care from the range of care that could be refused. Basic care included washing, dressing, necessary personal care and simple treatments including palliative care and treatment in the last days of life. However, as enacted by Parliament, all care decisions taken for an incapacitated person are subject to the MCA

That means that, for example, for a person with severe dementia who has been incontinent, the MCA sets out a process of capacity assessment, consideration of the options of care and a balancing of those options, as well as a consideration as to whether or not there is a *"least restrictive option"*. What that all means is that care staff are LEGALLY REQUIRED to consider the option of not cleaning and changing a person who has been incontinent. And of course that will also risk increased numbers of pressure sores etc. We are concerned therefore that the MCA may, of its very nature, be increasing the likelihood that people will suffer neglect and poor care. That problem is compounded by issues arising from the *"Least Restrictive"* principle which underpins the working of the Act (see below).

8. The MCA and life-saving treatment

The MCA specifically sets out that life-saving treatment is something that may be initiated, given, withheld, or stopped. And it specifically states that its provisions apply to all those forms of treatment regardless of whether or not the aim of intervention is to preserve life or to end life. That means two things.

Firstly treatment may be withdrawn and if nutrition and

hydration is not deemed to be in the best interests of a person then it becomes illegal to offer them nutrition and hydration (see below). Following the case of *Re Y* in 2018, the withdrawal of nutrition and hydration does not require Court of Protection approval unless there is disagreement. We noted above how hard families find it to disagree with the clinical staff caring for their loved ones. They are very vulnerable.

Perhaps even more remarkably, it will be necessary to involve an Independent Mental Capacity Advocate (IMCA) in cases where nutrition and hydration is to be started and where there is no other relevant person to consult. But if the IMCA or the “relevant person” (relevant persons are most often family members) is not happy (perhaps worrying about their inheritance etc) then it may be necessary to seek the permission of the High Court to give food and fluids. Without the agreement of the High Court, feeding a person may become illegal. It therefore turns out that following the case of *Re Y* in July 2018, giving food and fluids may well be more stringently “safeguarded” than the withdrawal of nutrition and hydration so that an individual will die.

9. The least restrictive option requires clinicians to provide care which is as close as possible to neglect and negligent care

The MCA states very clearly as one of its five fundamental principles that clinicians must consider the least restrictive option in deciding what care is right. While that sounds very sensible and seemed attractive when the Act was passed, it does produce some very serious dilemmas for families, clinicians and patients.

Consider for example a woman who is old, frail, unwell and who has pneumonia. Ideally intravenous antibiotics are clearly the best clinical option and would be advised without question to younger people or those with capacity. But in a woman who lacks capacity, and even if she is not objecting in any way, the law states that clinicians **MUST** consider the possibility of oral antibiotics as they are less restrictive but may still work. They are not, in fact, as likely to work. Therefore the woman may be more likely to die. But the law states that the least restrictive option should be considered. And if she might be going to pull out her drip, you can see that the Mental Capacity Act immediately forces clinicians to think about less safe and less effective solutions. Oral antibiotics are less restrictive, and they are an option, and as a result she may well be more vulnerable as a result of the provisions of the MCA than she would have been without it. Not surprisingly, the least restrictive option is almost always a less safe option. If a mentally incapacitated person has a tendency to wander, do you lock the door to prevent them wandering out alone and coming to harm. Or is allowing them the freedom to do that less restrictive of them?

10. Deprivation of Liberty Safeguards

We just note here that the House of Lords found in 2013 that Deprivation of Liberty Safeguards are not fit for purpose. They are cumbersome, process-heavy and do not appear to lead to effective safeguards for patients. And they are expensive to administer. As a result the Law Commission is bringing forwards amendments to the

MCA but five years on, those amendments are only just being brought before Parliament.

11. Conclusion

We believe that the MCA has real limitations and poses substantial risks for people who lack capacity. Those risks are even greater in people who lack capacity and who are disabled, elderly, frail or who suffer from dementia etc. The MCA can easily be misused to deny care to such people. While it is accepted that the Deprivation of Liberty Safeguards are not fit for purpose, we are very concerned that other parts of the Act are associated with poor care. Worse, the general provisions of the Act may indeed be causing poor care and poor outcomes. An Act designed to protect the vulnerable may be doing exactly the opposite. It can enable the withdrawal of care, including nutrition and hydration and can be used to cause death by withdrawal of clinically assisted nutrition and hydration. And it asks clinicians to think of alternatives to the best care even in situations such as personal care for incontinence etc.

We believe that the limitations of the Mental Capacity Act, need to be modified by good evidence-based clinical practice which benefits patients and their families. However we also think that the evidence of the MCA doing harm needs to be collated so that it can become coherent. At present, while there are many reports and concerns about it, those reports are either newspaper articles or multiple anecdotes.

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Dr Anthony Cole, J.P., FRCPCH (Edin) and
Chairman Medical Ethics Alliance

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DOUBLE EFFECT & ECTOPIC PREGNANCY – SOME PROBLEMS

MICHAL PRUSKI, PHD, MA, AFHEA



Abstract

This paper looks at the Catholic justification of medical interventions in ectopic pregnancies. The paper first shows that the way how Double Effect Reasoning is often applied to ectopic pregnancies is not consistent with the way Aquinas introduces this mode of reasoning. The paper then shows certain problems in common defences of the use of salpingectomies. The paper then re-evaluates the medical interventions used in the management of ectopic pregnancies, with both a focus on the aim of the treatment and the timing of the treatment.

Key words: Aquinas, ectopic pregnancy, double effect, salpingectomy, self-defence

Introduction

An ectopic pregnancy (EP) occurs, 'when a fertilised egg implants itself outside of the womb, usually in one of the fallopian tubes' (FT).^[1] Between 1-2% of all pregnancies in the English speaking world are EPs.^[1-4] EPs pose a grave risk to the mother's life and are almost always fatal to the developing embryo. So far the Catholic Church has not made any definitive pronouncement regarding EP treatments. Nevertheless, Double Effect Reasoning (DER) is often-invoked in both academic and popular writing to highlight the licitness of salpingectomies.

[5-7]

This article will first look at the way DER is usually formulated and how this contrasts with the Aquinas' seminal self-defence case which is credited for introducing DER. It will then highlight some inconsistencies relating to the application of DER to EP treatments, as well as how to approach removing the embryo from a Thomistic perspective. Finally, the article will discuss the issue of timing the removal of the embryo, which is seldom

discussed in the literature. This will lead to the conclusion of which treatments are licit under what circumstances.

Aquinas and Double Effect Reasoning

Aquinas is often credited for introducing DER in his *Summa Theologica* (STh; II-II q. 64, a. 7), though there is a lot of debate whether what Aquinas proposed is equivalent to the present day shape of this reasoning: its roots can be found in the Old Testament and a long line of scholars after Aquinas contributed to its present day formulation.^[9] DER is a tool for evaluating the licitness of an action when one knows that it will have good and bad effects. DER is usually presented as consisting of four principles:^[5]

- P1 The act itself cannot be intrinsically evil
- P2 The good effect cannot be realised through the bad effect
- P3 Only the good effect is willed
- P4 There must be a proportionate reason for accepting the bad effect

This contrasts sharply with STh II-II q. 64, a. 7, where Aquinas answers the question of 'Whether it is lawful to kill a man in self-defense?'^[8]

'Now moral acts take their species according to what is intended, and not according to what is beside the intention, since this is accidental [...] *Accordingly the act of self-defense may have two effects, one is the saving of one's life, the other is the slaying of the aggressor. Therefore this act, since one's intention is to save one's own life, is not unlawful, seeing that it is natural to everything to keep itself in "being," as far as possible. And yet, though proceeding from a good intention, an act may be rendered unlawful, if it be out of proportion to the end. Wherefore if a man, in self-defense, uses more than necessary violence, it will be unlawful [...]* Nor is it necessary for salvation that a man omit the act of moderate self-defense in order to avoid killing the other man, since one is bound to take more care of one's own life than of another's. But [...] it is not lawful for a man to intend killing a man in self-defense, except for such as have public authority [...]'

Aquinas highlights intention (P3) and proportionate response to the situation (P4) as the key factors influencing the evaluation of this situation: one can intend to preserve one's life from danger, and if the death of the one posing the risk to one's life is a proportionate means to this preservation, then this death is an acceptable consequence. P1 and P2 are omitted – it is hard to imagine how in the case given by Aquinas the good effect of defending oneself could have been achieved not through the bad side-effect of killing, injuring or maiming the aggressor (unless escape was feasible). Of course, an embryo cannot be an aggressor.^[10] Cajetan, later on, explicitly discusses the use of DER in killing an innocent person.^[9] There was also discussion whether a foetus could be considered an aggressor, and whether a child could be killed if they were used as a human shield by an aggressor.^[11] Nevertheless, what is clear is that Aquinas' reasoning for the justification of self-defence and current DER are

different from each other (it is also worth highlighting that Aquinas only considers the topic of accidental killing after first considering the case of self defence. [see STh; II-II q. 64, a. 8 and 12].

Inconsistencies in Application

When a salpingectomy is justified using DER, the format looks somewhat like this:

P1 Removing a FT is not intrinsically evil

P2 The good effect is mediated via the removal of the FT and not the death of the embryo

P3 Only the FT removal is willed

P4 The survival of the mother is a proportionate reason for accepting the death of the child

This description is often reinforced by an analogy with uterine cancer. [11, 13, 14] In uterine cancer the uterus is removed, and removal of any foetus in the uterus is accidental. By analogy, it is claimed that in an EP the inflamed FT is removed and the removal of the embryo contained in the FT is accidental. It is often highlighted that by removing the FT one does not directly (physically) act on the embryo, and this is what separates salpingectomies from the use of methotrexate and salpingostomies (two other interventions for EP). [15] Yet even the original proponent of this interpretation labelled it as a 'fine distinction'. [16] Indeed, there are several problems with this reasoning.

Firstly, the uterine cancer analogy is inappropriate because in that case it is the cancerous uterus that endangers the mother's life, while the foetus has no role to play in the pathology. In an EP, it is the developing child that is (unintentionally) causing the damage to the surrounding tissue, [17] and it is only by removing her/him from the FT that the risk to the mother's life can be removed (if the FT is damaged it might also need to be removed). Secondly, the description of these events concentrates too much on what is happening in the physical order, i.e. on what the surgeon's instruments are acting: the child or the FT (see e.g. reference 6). Aquinas would most likely not care if one punched the attacker or pushed a boulder that would crush them, but what were the intentions behind these actions and whether they were proportional. Indeed, some authors have highlighted problems with such focus on the physical order (as opposed to the intentional order). [18] If such a focus was correct one could claim that when giving methotrexate one is also not directly physically acting on the embryo, but on the other hand EP embryos located in parts other than the FT (e.g. in the abdomen) could not be removed unless a specific inflamed structure could be pinpointed that could constitute an envelope for the physically indirect removal of the embryo. As such, it is better not to talk about salpingectomies in terms of the removal of FT, but of the removal of the embryo, with the intention to preserve the mother's life. Indeed, it is the proximate end of the removal of the embryo with the final aim to preserve the mother's life, which distinguishes EP management from procured abortion, which has the child's death as the final aim.

Removing the Embryo

Two medical interventions for managing EPs involve the removal of the embryo: salpingectomy (where the embryo is encapsulated in the FT when removed) and salpingostomy (where only the embryo is removed). Methotrexate, which use of is sometimes defended by Catholic theologians. [11, 19, 20] targets the trophoblastic tissue, [21] which is part of the placenta and is necessary for the embryo's survival in the womb. [22] Also, methotrexate is potentially mutagenic to the embryo, [23] and as such attacks the embryo in a manner that is not necessary to achieve the safety of the mother (for a critique of this use of methotrexate and salpingostomy see reference 7). One could though raise the objections that whether one removes the embryo via surgery or uses methotrexate the consequences are the same – the death of the child.

Indeed, Jones [24] notes that salpingectomy is likely to violate a 1902 pronouncement of the Holy See. [25] This document declared it illicit to extract a premature foetus from the mother's womb, for the mother's and the foetus' lives should be preserved as far as possible. Jones [24], nevertheless, notes that we should place more emphasis on recent Holy See documents, because they allow us to clearly understand the principles underlying the earlier pronouncements. *Evangelium Vitae* [26] demonstrates that what is wrong in a procured abortion is the 'deliberate and direct killing' of the embryo, moreover the use of salpingectomies seems uncontroversial among theologians. It is firstly noteworthy, that even the 1902 pronouncement does not prohibit embryo removal in the first place. Secondly, methotrexate does not allow for respectful removal of the embryo; the child is chemically attacked and she/he might exit the womb at an unpredicted time. With salpingectomies and salpingostomies the child can be removed in a respectful manner and given appropriate palliative care – something that could be understood as appropriate care considering that she/he would otherwise die inside the mother's womb, perhaps with the mother suffering a potentially fatal haemorrhage in the process. Removal of the embryo could be accompanied by her/his transfer to the uterus – something that has been attempted, with some success, in the past. [27, 28] In the future transfer to an artificial womb could also become an option. [28] Even therapeutically experimental transfers would, in most cases, not be riskier for the embryo than keeping her/him in the ectopic location and would be a licit way of fulfilling the call to act as good Samaritans to the smallest of children. [5, 30] Yet, before reaching any conclusion about the licitness of any of these interventions we still need to consider Aquinas' consideration of the proportionality of the response.

When to Act

Considerations of when can an intervention be performed to resolve the EP are often neglected – when does it become reasonable to act because the risks are proportionate to accept the unintended death of the child? NICE outlines what treatment is appropriate under different circumstances and stages of the pregnancy, [31, 32] though the guidelines are concerned with the health of the mother and not ethical considerations of the child.

One the one hand in 40-70% EP cases the embryo dies spontaneously,^[33] while on the other hand there were a couple of reported cases of extrauterine pregnancies (neither of which therefore were Fallopian Tube pregnancies) where the babies developed to the age of viability, were delivered surgically and the mothers survived the process.^[34] As such, expectant management should be undertaken if there is no foreseeable danger to the mother's health in the near future. Pharmacological and other ways of symptomatic relief should be employed both to keep the mother as safe as possible and to try to advance the EP until the child reaches the stage of viability and can be surgically delivered. This is to some degree a heroic undertaking by the mother, but one that is somewhat characteristic of the parent-child relationship.^[17] In many cases the child will die by herself/himself, and their remains can be retrieved, if necessary, by any respectful means.

If the EP progresses to the stage when clinical judgment indicates that it would not be safe for the mother to continue with the EP, e.g. due to a risk of a potentially life-threatening haemorrhage, then child can be removed, and at these later stages, due to the damage to the FT a salpingectomy would be the likely recommended treatment. This reasoning is consistent with the principles of medical triage: to judge when the chances of the baby's survival are too low and the chances of the mother's death too high to continue focusing on the baby's treatment. The removed child should be given any appropriate life support and/or palliative care – one can then be sure that one did everything possible for the child, and that the side effect of the child's death was proportional to the risk of the mother's death.

Early intervention via, salpingectomy or salpingostomy, might become preferable if artificial womb technologies or procedures for ectopic embryo transplantation into the mother's uterus will develop, and if early intervention will facilitate the success of these procedures.

Summary

In the light of Aquinas' teaching on self-defence in STh; II-II q. 64, a. 7^[12] the most important considerations are those of the final aim of the act, and of the proportionality of the response used. In the case of EP management this final aim is the preservation of the mother's health, while in procured abortion it is the child's death. The aims of the composite components of EP management are secondary to this final aim. A proportionate response to the threat presented by an EP is one that preserves the mother's life, while giving the embryo the greatest chance of survival and treats her/him with respect. The child, who lacking intentions could not be an aggressor, should always be given appropriate life support and palliative care based on sound clinical judgment and respect for their dignity. Currently the strategy that fulfils these criteria the most is expectant management, most likely followed by a salpingectomy. With the advent of new technologies, salpingostomies might also become such a means. Methotrexate is conducive to a respectful treatment of the child, and in the presence of other options cannot be deemed a proportionate response.

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CORRESPONDENCE

WELCOMING A CHILD WITH EDWARDS SYNDROME

DERMOT KEARNEY WRITES ABOUT BELLA, THE DAUGHTER OF RICK SANTORUM FORMER REPUBLICAN PRESIDENTIAL NOMINEE.



<https://www.dailymail.co.uk/embed/video/1157832.html>

Dear Editor

In September 2018 I had the honour of attending the US Catholic Medical Association Annual Educational Conference in Dallas, Texas and of presenting a paper on the Catholic approach to management of high-risk pregnancy.

I was very much impressed by the organisation of the conference and the exceptionally high standard of the presentations. During the celebratory dinner on the final evening of the meeting, the key note speaker was Rick

Santorum, the former senator from Pennsylvania and a former Republican Presidential nominee. He gave an excellent speech that was in part humorous, always engaging and deeply moving. All of this was done without the aid of notes, slides or auto-cues.

Many may not realise that Rick and his wife, Karen, are parents to eight (seven living) children. Their youngest child, Bella, has Edward's syndrome (Trisomy 18) and it was predicted by the medical profession that she would not survive beyond one year after birth. She is now ten years old. His wife could not be present at the meeting but she asked him to say something very specific about Bella in his speech. What he related was overwhelmingly beautiful and profound.

He said [slightly paraphrased]

"Bella will never be able to do anything for me. She'll never make me a cup of coffee or fetch my slippers or help me with any tasks. She is incapable of performing any meaningful physical acts. In that sense, she can do nothing for me. All she can do is love me... Isn't that exactly the same as each one of us before God? There is nothing we can do for God. He doesn't need us to do anything for Him. He's God. And yet, all we can do is love Him. That's all we can do... Bella is a great teacher."

Dermot Kearney, Gateshead (President CMA (UK))

WELCOMING A CHILD AFTER PRENATAL DIAGNOSIS OF A SERIOUS OR LIFE-LIMITING CONDITION

DR JOSEPHINE TRELOAR.



Helen Watt's article ^[1] is very welcome indeed. I could not understand the need to push for legislation for abortion of babies with short life expectancy in Northern Ireland last year.

About 15 years ago I was giving a talk on difficult pregnancies and interviewed mothers who had been through such a pregnancy. I was worried that I was

treading on sensitive ground and the mothers would become distressed about revisiting the experience. The encounters were very different than I had anticipated. The mothers were glad to talk about their pregnancies and their babies and I was surprised at how at peace they all were.

Ironically I experienced one of these pregnancies very soon after that talk 15 years ago and the peace and experiences of the other mothers was one of the things that carried me through. For myself, my husband and my children the memories of baby Hope Mary Cecilia will always live on in our hearts. Bringing her to birth was a huge privilege. We lost a dearly beloved daughter but gained a saint in Heaven. We still ask her to pray for us each night.

Dr Josephine Treloar.

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WELCOMING A CHILD WITH PATAU'S SYNDROME

CLAUDIA LINTON



Baby Josephine at her baby brother's baptism

I am writing to add my experience to the excellent article by Helen Watt in the November issue of the CMQ. I think it is very important that women can feel encouraged and supported when they find their child is not expected to be able to live. So often they are alone and cannot access any help other than that which comes from "experts" who encourage you towards an abortion.

It was at my 23 week scan that we found out our daughter was going to be born with medical conditions that were, 'not compatible with life'. The two ladies that

were performing the scan were taking an awfully long time, we thought, and when they finally said they had to, 'pop out of the room for a minute', my husband and I got the giggles as the idea that something could be 'wrong' with our baby was not even on our radar. Suffice to say, with Trisomy 13, or Patau's Syndrome, being the diagnosis, which was confirmed by a subsequent amniocentesis - something I will forever regret and do not recommend - the reality of our baby's future with this life limiting condition, was like a punch in the guts.

Unfortunately, our Consultant was very negative and unsupportive. He was very persistent with regards to trying to make sure I knew we had 'options'. I certainly knew what 'option' he was talking about and had to eventually get quite insistent that we were in this for the long haul - no matter what! As you can imagine, by 23 weeks into my pregnancy our little Josephine, was very much alive and kicking - literally, and I couldn't understand how anyone could disregard this fact quite so flippantly - I felt. My priority was to deliver Josephine safely and to make sure she had all of her needs, whatever they were, dealt with as they would if this was a normal pregnancy and birth. The Consultant's priority was to disregard the needs of my baby and make sure that I was all that needed to be considered as he said, "...Trisomy 13 babies usually die before birth or not long afterwards."

Luckily for us, we were given the contact details of a couple who were doctors with a reputation for being very supportive and understanding of our position, and who would be a lifeline and a great support for us in the years to come.

Josephine's birth was very normal without any complications. She had a multitude of 'problems' externally and internally, but she was beautiful and perfect and loved instantly and entirely. Her older sister, who was nearly four at the time, could instantly see past the cleft lip and palate, her 12 little toes and club feet. She was just the much wanted and adored little sister that she had always longed for. Josephine spent the first 6 weeks of her life in the hospital so that we could get used to her needs and how to care for them. Once home, she grew

and thrived and was suffocated with love. She could laugh and smile and say mummy and ALWAYS had her arms open wide for a cuddle.

It was a chest infection, which progressed to pneumonia, that eventually led to her death - 10 days before her 4th birthday and 6 days after the birth of our fourth child. Just the week before, she had been a bridesmaid at my sister's wedding. It all seemed to happen rather quickly as we had always known that this time would come, but still, it was a devastating loss for all of us.

What a gift! What a blessing and a treasure she was! I will miss her to my dying day and I'm so glad that we had the opportunity to know and love her and for her to know and love us, and I can't wait to see her again.

WELCOMING A CHILD WITH ANENCEPHALY

MOTHER OF BABY WHO LIVED FOR TWO MINUTES: "SHE WAS ABSOLUTELY PERFECT IN EVERY WAY"



Abortion "was never an option for us, not even for a second."

A mother whose baby was diagnosed with a life-limiting condition in the womb has spoken out about how rejecting abortion gave her and her partner precious memories with their daughter.

The story of baby Freya and her brave young parents Erin O'Hara (24) and Jamie McCormick (23) gained media attention in October, when Erin spoke out about their decision to carry Freya to term, despite the devastating diagnosis of untreatable anencephaly. The couple, from Limavady, Northern Ireland, received messages of love and support from around the world.

"I would do it all again in a heartbeat"

Now, Erin has revealed that her daughter Freya Anne O'Hara-McCormick lived for two minutes outside the womb after she was born eight weeks premature on 7 December 2018.

Due to little Freya's condition her mother faced complications during her pregnancy and was in pain in the later stages. "The pain was awful, but I would do it all again in a heartbeat, if it meant I would get to see Freya again," Erin said.

The grieving mother also revealed how she shared the precious minutes of her daughter's life. "She was absolutely perfect in every way, just 2lb 4oz of pure joy," she said. "We would have given anything to have her longer, but I am glad that she didn't suffer and she passed

away peacefully.

"In her last moments, with one eye open, she stared right up into mine, holding her daddy's finger, and listening to the sound she knew best, my heartbeat. I will hold that memory of her with me forever."

Finding closure

Erin says that abortion was never an option for her and Jamie, even when they were told that there was no chance their baby daughter would survive. "Jamie and I have been utterly distraught since Freya's diagnosis a month ago and it has been undeniably difficult to come to terms with," she said in October. "People told me termination was an option, but we couldn't do it. We want this wee baby more than anything in the world and we will love this wee baby, no matter what."

There has been much discussion of abortion in the case of a life-limiting diagnosis (generally cruelly and inaccurately referred to as a "fatal foetal abnormality"), especially in the light of the court case claiming that Northern Ireland breached the human rights of Sarah Ewart, who travelled to England for an abortion when she learned her baby would not survive...

We are indebted to the Society for the Protection of the Unborn who first published this article on 5th February 2019.

You can read the full story at : <https://www.spuc.org.uk/news/news-stories/2019/february/mother-of-child-who-lived-for-two-minutes-refused-abortion>

Editors Note

This letter was sent to the Daily Telegraph in November 1963 “Lest we forget”
2nd November, 1963
The Editor
Daily Telegraph

Dear Sir

REMEMBRANCE DAY

Mssrs. Cullen and Husler seem to deplore the solemnity of remembrance Sunday, which was instituted to remind the nation of the sacrifice of 1,000,000 lives, many of them volunteers, who gave themselves to their country in the Holocaust of 1914/1918.

As one who served at the front in that war I cannot forget the fields covered with the dead, the cries of wounded men imploring their comrades to shoot them to end their agony. A South African with his skull shattered and his brains protruding, the burned out tanks in which men suffered the supreme torture. Nor can I forget the million women who lost sons and husbands, or lost the chance of having them.

I was spared the horrors of the Salient and the Somme, but the heroism and devotion of the men who went to almost certain death in their senseless, repeated and hopeless attacks, is perhaps the finest saga in the story of British manhood. Surely we can spare one hour in the year in recognition of their Calvary, and to remember those women who still mourn. To an old soldier, rejoicing, Revaille and extraneous issues brought into the Remembrance Services seem singularly out of place.

Let the million have their day

Yours faithfully
Guy Curtis

REPORTS

NEWCASTLE BRANCH



The Newcastle branch of the Catholic Medical Association (UK) held its latest meeting on Wednesday 24th October 2018. The meeting was held at the University Catholic Chaplaincy, newly located at St Andrew's Church on Worswick Street in the centre of Newcastle. The topic for discussion was “Offering a Second Chance: Abortion Pill Reversal” with an opening presentation given by Dr Dermot Kearney.

The paper describing this meeting is published on page 11 of this issue.

EVENTS

THE ANNUAL CONFERENCE OF THE CATHOLIC MEDICAL ASSOCIATION, HULL, 4TH MAY 2019 SEE PAGE 6

MARCH FOR LIFE LONDON UK LIFEFEST 19 SATURDAY 11TH MAY 2019

The March itself will run from 2pm - 4.30pm starting from the back entrance of Westminster Church House, 25 Great Smith Street, Westminster, London SW1P 3BN. It will end with Christian prayer and keynote speeches. Book your place at www.marchforlife.co.uk

March for Life UK have suggested the following 5 THINGS YOU CAN DO TO HELP MARCH FOR LIFE UK

1) Could you pray for our work?

2) Could you give out some leaflets?

Leaflets and posters for this year's event on Sat 11th May are now ready to distribute. It might seem early but we need to get the message out so people keep the date in their diaries and other events aren't arranged on the same day as so often happens. Could you share some leaflets at your local church or prayer group? Are you a member of another pro-life group or do you help out with youth who might be interested? Would you be allowed to leave some in your workplace? One leaflet given personally with a friendly word of invitation is worth many more left on a table where they might get covered up the following day by other literature. We can send you posters or leaflets if you get in contact - please help with this.

3) Could you consider becoming a coach leader for your area in 2019?

This might seem daunting but it really needn't. Feedback from people who have taken on this role in previous years has shown it can be so fruitful and worthwhile. We have a coach-pack which highlights step by step how you can go about this and provides you with all the tools you need including personalised

posters for your own local area. We are happy to talk things through with you on the phone if you have any concerns or drop us an email. You could be the one to bring a sense of pro-life community to your town. Help encourage those who maybe aren't so well formed in their pro-life beliefs or those who might feel nervous about taking the journey alone - this is a great way to make new pro-life friends. Our coach packs can be downloaded from our website or we can post one out to you (this doesn't commit you to organising a coach so you've nothing to lose).

4) Could you share our emails and social media posts with friends/family?

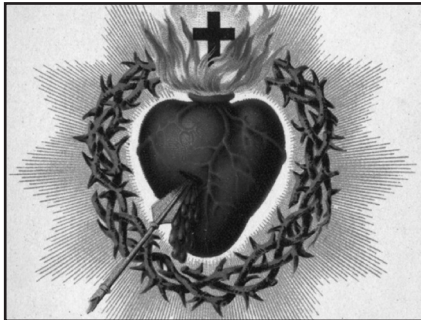
Sometimes we chastise ourselves or criticise others for overusing social media but here is a way to use it for good. I know personally of people who have changed their mind on abortion simply by reading their friend's social media posts. You don't have to get into lengthy debates, start by reposting/retweeting details of our event in May and let others know you intend to go. Pass one or two of our emails to a friend as a way of encouraging them to join you on 11th May in London.

5) Could you donate to this cause?

This is always a hard one to ask of people who are often giving very generously to various pro-life and other charitable causes anyway but could you give just a little bit more? We promise to spend it wisely. Running an event like this takes a lot of money - over £55,000 to be frank! London venues don't come cheaply (and we are hiring two of them this year), then there's an outdoor stage and sound equipment, travel & accommodation costs for our speakers, security to ensure everything runs smoothly, fees for road closures, advertising and promotion costs and much, much more. Don't underestimate the impact a public event like this has on the media, the public and on us as a pro-life community. We need to unite - no matter what the cost. Please help us fund this work if you possibly can - we are truly grateful for every penny we receive.

CONSECRATION TO THE SACRED HEART OF FIAMC MEMBERS

OPEN TO ALL CATHOLIC PHYSICIANS WORLDWIDE



Our President Dermot Kearney writes
 “This will be a wonderful occasion and it appears that those present will have a private audience with Pope Francis on the occasion - although it is likely that there will be several hundred doctors and their spouses and families present so it may not be a very personal or private encounter.

It would be lovely to have a representation from the CMA (UK) present if possible and Rome will be lovely in June. I may be able to travel - I'm not sure yet - but I would like to encourage some of you to consider this once in a lifetime opportunity”.

Although Fr Suaudeau says that the Consecration extends to all those present, my understanding is that the Consecration can apply to all Catholic Physicians worldwide, whether present in Rome or not and also not necessarily depending on membership of a Catholic Medical Association or equivalent.

INAUGURAL BRANCH MEETING OF CMA IN DURHAM

The next Catholic Medical Association Newcastle branch meeting will take place in Durham - at the

Catholic Chaplaincy,
 St Cuthbert's Catholic Church,
 Old Elvet, Durham, DH1 3HL
 on Thursday 21st
 March 2019 at 7.15pm.

The topic for discussion will be
 "Challenges Facing Catholics in Healthcare in 2019".

Provisional programme

Location: Urbaniana or Domus Romana Sacerdotalis or Maria Bambina depending on the number of participants

Start: Friday, June 21, 2019, AM 9

Closure: Saturday, June 22 6 PM

Friday 21 June

Morning: 9.30 AM, lecture on conscientious objection by Mr Étienne Monterro, lawyer,

in English, with simultaneous translation,

10.30am, presentation of the consecration to the Sacred Heart

11am, reflection and meditation in the chapel, on commitment.

11.30-12.30: silent adoration of the Blessed Sacrament, and blessing

13: lunch

Afternoon:

15h: second meditation

16h30: intervention by Bishop Duffé

17.00: Holy Mass during which the consecration will be done.

Saturday 22 June:

Morning: Audience with the Holy Father

Lunch around 13.30

Parking is free after 6.30pm and there are good parking facilities on the streets close to the Chaplaincy, although not in the Church grounds. As usual, light refreshments will be available at no charge. All are welcome to attend.

Contact Dr Dermot Kearney
 (president@castholicmedicalassociation.org.uk)
 for details of further meetings.

BRANCHES OF THE CATHOLIC MEDICAL ASSOCIATION (UK)

BRANCH	PRESIDENT	HON SECRETARY
Bristol	Dr Sophie Gretton	Dr Gemma Nickols gemmanickols@gmail.com
Cardiff	Mr Patrick Coyle, KCSG, FRCS.	cardiffcmabbranch@gmail.com
East Anglia	Dr Robert Hardie	Contact Dr Robert Hardie via our main office
Kent	Dr Adrian Treloar FRCP, MRCPsych, MRCP	Mrs Wendy Schiess kentcma@gmail.com
Leeds	Dr Phillipa O'Malley	Dr. Katherine Bridge cmaleeds@gmail.com
Manchester	Mr Johnathan Berry	Dr Mark Coley cmamanchester@gmail.com
Newcastle	Dr Dermot Kearney	Dr Dermot Kearney, 6 South Avenue, Ryton Tyne & Wear NE40 3LD derkearney@yahoo.com
Nottingham	Dr Tim Connery	Dr Peter Lavelle, 54 Parkside, Wollaton, Nottingham NG8 2NN email: peter54lavelle@hotmail.com
Portsmouth	Mr Edmund Neville	Dr Tim Goulder, Alexandra House, Hambleton Road, Waterlooville, Denmead, Portsmouth, PO7 6ES
Sheffield	Dr S.R. Brennan	Andrew T Raftery FRCS, 280 Ecclesall Road, South Sheffield S11 9PS control.freak@btinternet.com
Southwark	Dr. Berenice McManus	
Sussex	Dr. Joseph O'Dwyer	sussexcma@gmail.com
West Midlands	Dr Francis Leahy	Dr Pravin Thevathasan, 5 Mayfield Park, Shrewsbury SY2 6PD editor.cmq@catholicmedicalassociation.org.uk
Westminster	Fr Michael Jarmulowicz KSG. MRCPPath	Westminster Hon Secretary, c/o Catholic Medical Association (UK) 39 Eccleston Square, London, SW1V 1BX webmaster@catholicmedicalassociation.org.uk
Student and junior doctors		events@catholicmedicalassociation.org.uk
Committee for New Evangelisation		events@catholicmedicalassociation.org.uk

THE CATHOLIC MEDICAL MISSIONARY SOCIETY:

Is a charity, supporting medicine in developing countries.

Our website is at www.catholicmedicalassociation.org.uk/announcements/the-catholic-medical-missionary-society

Treasurer: Dr Steve Brennan (secretary@catholicmedicalassociation.org.uk).

To make a donation online please go to our donations service via www.catholicmedicalassociation.org.uk

If you wish to apply to the CMMS for support, please email catholicmedicalmissionary@gmail.com

AFFILIATED ORGANISATIONS

Scottish Catholic Medical Association www.scottishcma@gmail.com

Association of Catholic Nurses www.catholicnurses.org.uk

**JOIN CMA (UK), OR SUBSCRIBE TO THE CMQ
MEMBERSHIP/SUBSCRIPTION APPLICATION FORM & BANKER'S ORDER**

To **The Hon. Registrar**
The Catholic Medical Association (UK)
39 Eccleston Square, London, SW1V 1BX

(Please complete all relevant sections)

I apply to become a member of The Catholic Medical Association (UK) and send herewith a completed Banker's Order (below) or cheque for the appropriate annual subscription (Standard membership £50, [Concessionary rate* £30], Joint members £60, Student member £10). (* Concessionary Rate must be individually requested, see below)

OR

I wish to become a subscriber to the Catholic Medical Quarterly (£25 p.a.)

Name _____

Qualifications _____ Students - expected date of qualification _____

Telephone No _____ email _____

1. Permanent Address (or home address for students) _____

or home address for students _____

2. Professional address (or college address for students) _____

Preferred address for mailing (1 or 2) ____ Preferred Branch for membership _____

Signature _____

* This rate is intended for UK and Ireland members those who are not higher rate tax payers. Higher rate tax payers who Gift Aid their membership can claim back additional money in their annual tax return.

Declaration

My current income means that I am not a higher rate tax payer and I wish to claim the concessionary subscription rate of £30 per annum. I will notify you if I become a higher rate tax payer (above £41,000 per year, 2014 threshold)

Signed _____

The Catholic Medical Association (UK) Banker's Standing Order Date: _____

To Messrs (Name and Address of Bank) _____

Bank: Sort Code _____ Account No _____

Please pay forthwith to Lloyds Bank plc, Langham Place Branch, 324 Regent Street, London W1B 3BL (Sort Code No. 30-93-68) for the account of the Catholic Medical Association (UK), Account no. 00081844, the sum of £ _____ being my Annual Subscription for Membership and thereafter pay this amount annually every 1st October commencing 1st October next quoting my name and membership number on all transactions. This order supersedes all previous orders to this body or to the Guild of Catholic Doctors.

Signature:

