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Nagai Takashi

IN THIS ISSUE

JOURNAL OF THE CATHOLIC MEDICAL ASSOCIATION (UK)

CATHOLIC MEDICAL ASSOCIATION (UK)

PRAYERS BEFORE MEETINGS

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

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

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

PRAYERS AFTER MEETINGS

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

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

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or visit www.catholicmedicalassociation.org.uk.

EDITORIAL

THE CATHOLIC CHURCH AND THE SEX ABUSE CRISIS

DR PRAVIN THEVATHASAN

The ex-Cardinal McCarrick scandal has once again highlighted the sex abuse crisis in the Church. When the first wave hit back in 2002, there was anger both within and outside the Church. Many people who do not like the Catholic Church made use of the crisis for their own reasons and, like many others, I tried to defend the Church. My CTS booklet on sex abuse is now dated and, to a certain extent, it was a defence of Pope Benedict. [1] I still believe that he did as much as he could to rid the Church of this "filth". Most seminaries are much healthier than they used to be. Seminarians want to be priests because they want to serve the Church. It is true that most of the abuse allegations are historical.

And yet, if anything, there is more anger now than before. How did McCarrick get away with it for so long? How is it possible that none of the bishops knew about "Uncle Ted" and his predilections for young men? How many souls lost their faith due to his scandalous behaviour? Are there others like him? Admittedly, McCarrick was a media-savvy man who was much liked by the secular media. He famously felt uncomfortable denying Holy Communion to pro-abortion "Catholic" politicians. [2] We can now comprehend his 'who am I to judge' position.

In an interview with Carl Olson published in Catholic World Report[3] (August 6, 2018), the veteran conservative Catholic journalist Philip Lawler argues that the sex abuse crisis is a three-part scandal. Firstly, some priests abused young people. Second, the revelations gave ample evidence of widespread homosexuality within the clergy. Third, the scandal showed that bishops covered-up evidence of abuses. With The Dallas Charter, the American bishops addressed the first part of the scandal. The second and third parts have not been addressed to date.

Lawler goes on to say that the Vatican has not, as yet, established clear standards for holding bishops accountable for their handling of the issue.

The liberal journalist Robert Mickens appears to agree with Lawler to a certain extent. Writing in The Washington Post [4], he states: *"There is no denying that homosexuality is a key component to the clergy sex abuse (and now sexual harassment) crisis."* He notes that almost all US victims are male, whether they are adolescents, post-pubescent teens or young men. Predictably, however, he suggests that gay clergy need to be affirmed.

McCarick has the common profile of a clergy abuser. His ultimate downfall, according to Lawler, was an encounter with an under-age boy. Lawler asks: *"Doesn't it stand to reason that someone who would chase 19-20 year olds would be a danger to 16-17 year olds? For that matter, wasn't his desire for young men-of legal age or not-enough to disqualify him from higher office?"*

Another high-profile case was that of Canadian Bishop Raymond Lahey. He was imprisoned for possessing child pornography images on his computer. He also had 155,000 other pornographic images on his computer. The psychiatrist who assessed him concluded that he was not a paedophile but had an interest in gay sado-masochistic fantasies. Writing in the Canadian Catholic Register [5], Deborah Gyapond reported that Lahey had *"engaged in a number of homosexual one-night stands before settling into a ten year relationship with a man."*

In my booklet [6], I was keen not to focus unduly on the issue of homosexuality. After all, the majority of homosexuals show no sexual interest in children and most children abused in the wider society are female. However, it must be admitted that there is a specific problem in the Church. Also, in the light of recent scandals in Maynooth, Honduras, Chile, the United States and elsewhere, there is surely an on-going need for vigilance. Not to mention drug-fuelled gay orgies in the Vatican [7].

In an important article in the Catholic World Report [8], Father Vincent Twomey argues that widespread dissent from the Church's teachings on sexual ethics was a contributory factor. After the Second Vatican Council, large chunks of the Church's moral teachings were ignored. I might add that it became fashionable to borrow indiscriminately from popular psychological theories about being non-judgmental, value-neutral, affirming etc. A misplaced idea of empathy surely led some bishops to effectively turn a blind eye to sinful behaviour among clergy. There was also an undue reliance on counselling and moral guilt was minimized if not ignored.

Father Twomey cites the example of the book The Sexual Celibate by Dominican theologian Donald Goergen which was published in 1975 [9]. In it, it is asserted that

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

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

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

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

THE SUPREME COURT AND DEATH FROM DEHYDRATION

DR ANTHONY COLE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr Anthony Cole,
Chairman, Medical Ethics Alliance,
Broadheath, Worcestershire

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

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NEWS

THE SUPREME COURT DECISION ON CLINICALLY ASSISTED NUTRITION AND HYDRATION

DR PHILIP HOWARD
MA GDIPLAW LLM MA MD FRCP

On Monday 31st July 2018 the Supreme Court was faced with the question as to whether "a court order must always be obtained before clinically assisted nutrition and hydration, which is keeping alive a person with a prolonged disorder of consciousness, can be withdrawn, or whether, in some circumstances, this can occur without court involvement." The answer was that a court order was not necessary where the cessation of hydration and nutrition was in the patient's "best interests." This brings in euthanasia by omission.

In the landmark case before the House of Lords in 1993 of Tony Bland, who was left in a persistent vegetative state in the Hillsborough disaster, it was held by the House of Lords that artificial feeding was medical treatment that could be withdrawn even though it would lead to his death as he had no "best interests." All four judges acknowledged that the withdrawal of hydration and nutrition was intended to cause Tony Bland's death. *"The proposed conduct has the aim for equally humane reasons of terminating the life of Anthony Bland by withholding from him the basic necessities of life"……. "the conduct....is intended to be the cause of death" (Lord Mustill). "The whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland" (Lord Browne-Wilkinson): "The intention to bring about the patient's death is there" (Lord Lowry). "It will (as it is intended to do) cause his death"* (Lord Goff).

The present case before the Supreme Court involved Mr Y who sustained a cardiac arrest and severe cerebral hypoxia and brain damage and never regained consciousness. He required clinically assisted nutrition and hydration (CANH) through a gastrostomy feeding tube to keep him alive. He died on 22.12.17 of a chest infection shortly before the case went before the Supreme Court.

Section 1(5) of the Mental Capacity Act (MCA) 2005 sets out that everything done for a person who lacks capacity must be done in his *"best interests."* In deciding *"best interests"* all the relevant circumstances must be considered including considering so far as possible the person's wishes and feelings beliefs and values that would influence his decision if he had capacity. Account must be taken of the view of those who are responsible for his interests and welfare. When deciding about life-sustaining treatment the person making the determination must not be motivated by a desire to bring about his death.

Section 5 gives healthcare professionals and carers protection from liability where there is a reasonable belief that the person lacks capacity and that the actions are taken in the patient's best interests. According to Lady Black *"if these conditions are satisfied, no more liability is incurred than would have been incurred if the patient had had capacity to consent and had done so."*

The court has powers under sections 15 to 17 of the MCA to make personal welfare decisions for those who lack capacity subject to the provisions of the Act and in particular the patient's best interests. In the first case to come before the Supreme Court in 2013 after the Mental Capacity Act 2005, Baroness Hale stated that *"the focus is on whether it is in the patient's best interests to give the treatment, rather than whether it is in his best interests to withhold it or withdraw it." She continued: "If the treatment is not in [the patient's] best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it."*

Lady Black recognised that there must be a *"full recognition of the value of human life, and of the respect in which it must be held. No life is to be relinquished easily."* Nevertheless, she admitted that "there may come a time when life has to be relinquished because that is in the best interests of the patient."

For Lady Black the essential point was the *"best interests"* of the patient. The issue was *"not whether it is lawful to withdraw or withhold treatment, but whether it is lawful to give it. It is lawful to give treatment only if it is in the patient's best interests."* Therefore, if the doctor considered that it was not in the patient's *"best interests"* then it would be unlawful to give it. However, if it was considered in the patient's *"best interests"* to give the treatment then the doctor *"will be entitled to the protection from liability conferred by section 5 of the MCA 2005."* Therefore a great deal will hinge on the professional ethics and integrity of the responsible clinician. However, for the avoidance of doubt, *"No one would discourage an application in any case where it is felt that the assistance of the court would be valuable. And if a dispute has arisen and cannot be resolved, it must inevitably be put before the court".*

Lady Black recognised that *"It is likely, where CANH is withdrawn from a patient who is clinically stable but suffering from a prolonged disorder of consciousness, that death will result from the withdrawal of CANH."*
Nevertheless, to deliberately bring about the death of a patient would appear to contradict Section 4(5) of the 2005 Act, which Lady Black confirms *"imposes the safeguard that the person making the decision must not be motivated by a desire to bring about his death."*

St. John Paul II outlined the ethical position in relation to the provision of hydration and nutrition, howsoever provided in 2004:

'I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act. Its use, furthermore, should be considered in principle ordinary and proportionate, and as such morally obligatory insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering". He continued, "death by starvation or dehydration is in fact the only possible outcome as a result of their withdrawal. In this sense it ends up becoming, if done knowingly and willingly, true and proper euthanasia by omission"

(John Paul II, 2004. Care for patients in a permanent vegetative state).

The Supreme Court decision will mean that where there is no welfare attorney empowered to make healthcare decisions on behalf of the mentally incapacitated patient, what is decided by the doctors to be in the patent's ***"best interests"*** will depend upon the individual judgment of the clinician. Where the doctor concludes it is in the "best interests" of the patient to receive hydration and nutrition it can legally continue, otherwise it must cease. As Dr Peter Saunders of the Christian Medical Fellowship has rightly observed ***'It will make it more likely that severely brain-damaged patients will be starved or dehydrated to death in their supposed 'best interests' and that these decisions will be more influenced by those who have ideological or financial vested interests in this course of action."***

The intentional killing of patients though dehydration will not require judicial review if it is deemed in the ***"best interests"*** of the patient. The doctor will be the decision maker where there is no donee of lasting power of attorney. It is now increasingly important for patients to make clear their intentions with regards to receiving treatment and that they regard tube feeding as ordinary care. It is also important that donees of lasting power of attorney over healthcare decisions are appointed so that they can indicate the patient's wishes are and make decisions on behalf of mentally incapacitated persons.

PRACTICAL MEDICAL ETHICS

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

DR HELEN WATT,
ANSCOMBE BIOETHICS CENTRE

This presentation was given on 23 August 2018 at a World Meeting of Families workshop on 'Love made Fruitful: Amoris Laetitia on Cherishing the Gift of New Life'.

"The gift of a new child, entrusted by the Lord to a father and a mother, begins with acceptance, continues with lifelong protection and has as its final goal the joy of eternal life. By serenely contemplating the ultimate fulfilment of each human person, parents will be even more aware of the precious gift entrusted to them."

These compelling words from Chapter 5 of Amoris Laetitia (166) have a unique meaning for parents who learn after prenatal tests that their unborn child has a serious, perhaps even life-limiting condition. The anguish of this discovery, which tempts many to consider abortion when this is routinely offered, can instead resolve into a loving and peaceful acceptance of the baby as the pregnancy progresses. Like any terminally ill child, the unborn baby with a life-limiting condition is a precious gift for his or her parents, to be accepted and welcomed and nurtured in the remaining weeks and days. The baby's life has meaning, and should be lovingly supported, as should the mother and father themselves, not just by health care professionals but by parents who have personally experienced such a pregnancy and know the peace and joy, as well as the sorrow, it can bring.[1]

We sometimes hear that to take a pregnancy to term, knowing that the baby has a serious medical condition, requires one to be uniquely strong. However, women who have done this will sometimes protest that they are not saints[2] or especially selfless or uniquely equipped in any way to have their baby.[3] Women can be strong, they say, and pregnancy is not a disease: to present being pregnant as 'extraordinary support' demeans them and their children, and can increase pressures on women to end pregnancies seen as heroic in the extreme. Parents do suffer deeply after a very poor prenatal diagnosis, but then somehow find the strength to carry on – just as parents routinely find a similar strength with a sick child who is already born.

As one mother has explained,[3] the pregnant woman needs to grieve for the healthy child she expected, but at the same time, needs to be allowed and supported to form a relationship with the actual, living child inside her. And research has found that women who continue with their pregnancies in these situations report significantly

less despair, depression and avoidance than those who undergo abortions.[4] There is always a better solution, including for oneself, than taking the life of one's own unborn child.

Would a woman be entitled to choose to abort if she somehow knew that continuing the pregnancy would make her suffer more? Or what if she is afraid that her baby will suffer, though she herself may wish to have the child? It is natural to want to protect one's child from suffering, and doctors of course should be concerned to treat any suffering for the baby there may be. However, no child should have his or her life deliberately ended because of parents' fears that he or she will suffer, whether momentarily at birth or as a result of a lifelong medical condition. When their child will die is not for parents to say: they do not own the child who is a separate human being with his or her own dignity and rights. It is not enough to love the child in some sense: he or she must be loved with complete respect and his or her bodily presence [5] cherished till the end.

We sometimes hear of respect for the remains of aborted children, which may be returned to the parents for burial or cremation after the abortion. Yes, indeed the child's remains should be respected – but how much more the living child, whose sacred life is what makes sacred those remains! The offer in advance by abortion providers of photographs, handprints and footprints to be taken from the dead child after the abortion is at best sentimental and at worst, deliberate emotional exploitation. This is vividly expressed by one grieving post-abortive mother, who describes the abortion clinic in these terms:

"Everything about the clinic was deceptive. The pictures they take and the way they try so hard to make what you're doing seem like your losing your baby naturally. But there is nothing natural or normal going on behind those walls." [6]

So many women grieve their babies after abortion: both babies diagnosed with a serious medical condition and far more often, healthy babies aborted for more clearly social reasons. As Ireland prepares to follow so many other countries in offering this catastrophic choice to pregnant mothers, let us all renew our commitment to support the women and men for whom that choice is a perennially painful memory. And let us support the women and men who today are facing a very distressing pregnancy, so that they may indeed see their child as a gift entrusted to them in this moment, but destined for eternity.

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LEARNING POINT

NATURAL FAMILY PLANNING AND THE MIRENA INTRAUTERINE DEVICE.

We were asked

Can someone just summarise,…

How does the progesterone in Mirena affect the signs used in NFP?

We replied

The Levonorgestrel in Mirena obliterates cyclical variations in discharge, it is probably a little more serous in the first half of the cycle, and uniformly mucussy in the second half, with no dry periods. (anecdotal). It is unlikely physiologically to affect basal body temperature

THE HOLY FAMILY IN EXILE

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

EDITORIAL

The Editor writes...

By the time you read this, our third annual CMA youth conference 'Catholics in Healthcare: Building a Culture of Life' will have taken place. The take home message from this conference is that our Catholic faith should permeate our entire lives.

The CMA's Committee for the New Evangelization continues this theme focusing on 'building a culture of life' with the 2019 youth retreat entitled: The Role of the Family in Building a Culture of Life. Thus in the build up to this, the current edition of Semper Idem focuses on the family.

After the birth of our Lord, Joseph received a message from an angel in a dream.

"Rise, take the child and his mother and flee to Egypt, and remain there till I tell you; for Herod is about to search for the child, to destroy him." (Mt 2:13)

In order to flee the persecution of Herod, Joseph led the Holy Family into Egypt. The Holy Family was threatened with certain death by Herod (a man who is reputed to have killed his favourite wife, and three sons!). The family remains under attack, although the attacks are rather different. In this edition of Semper Idem, Piers Shepherd of the Family Education Trust writes about two contemporary attacks on the family.

Then in the bioethics column, Thaddeus discusses what is healthcare. In the book review, Gregory Scriptorum reflects on the importance of starting out everything with prayer and the desire to be in uniformity with God's will when providing healthcare.

At the February 2019 youth retreat, there will be talks addressing the importance of the family and a young nurse will offer a heartfelt reflection on how prayer helped her family to journey through the death of her father, and then caused her to choose to dedicate her life to palliative care nursing. We will also reflect on the life and work of Fr Patrick Peyton, known as the Rosary Priest, who encouraged devotion to the rosary and is remembered for his famous catchphrase: the family that prays together stays together.

In these times, the Church seems to lurch from crisis to crisis. Let us remember to turn to prayer and the study of the Faith, and to not lose heart. To this end we encourage all young (18yrs +) Catholics in Healthcare to come to the February youth retreat.

THE FAMILY UNDER ATTACK

BY PIERS SHEPHERD OF THE FAMILY EDUCATION TRUST

Since 1971 the Family Education Trust has studied the causes and consequences of family breakdown. We have consistently sought to defend the traditional family from an increasing onslaught which both seeks to undermine it and to weaken the role of parents as the primary educators of their children.

One of our most important outreaches is that of keeping our supporters updated about the latest attacks on the family. At present, two of the most pressing issues are the attempts to liberalise divorce laws and to remove the right of parents to determine what their children are taught about sex and relationships.

Divorce on Demand

Under the Divorce Reform Act 1969 the sole ground on which a divorce can be obtained is evidence that 'the marriage has broken down irretrievably.' In order to prove irretrievable breakdown the petitioner must present evidence of their spouse being at fault or else the couple must have lived apart for a number of years. The government recently announced that it will consider legislating in favour of 'no fault' divorce, meaning that couples would be able to divorce without giving a specific reason for their decision.

The government's announcement was prompted by a long campaign carried out by The Times newspaper, the Marriage Foundation and the family lawyers group, Resolution. Under this campaign's proposals, one of the spouses can simply give notice that the marriage has broken down and the divorce can be finalised after a period of six months.

The Coalition for Marriage, of which Family Education Trust is a part, has produced a fact sheet opposing 'no reason divorce'. It states eloquently of the plans to eliminate fault from the divorce process:
Removing the need to prove such a breakdown means that the law would allow spouses to walk away from the most significant commitment in their lives without providing a reason.

Making divorce easier is unlikely to have good outcomes for children. A study from the Marriage and Religion Research Institute highlighted numerous negative consequences for the children of parents who divorce including a greater alienation from parents and a higher likelihood of engaging in crime, drugs and risky sexual behaviour.

Relationships and Sex Education

Another ominous danger facing the family is the coming implementation, in September 2019, of compulsory Relationships Education (RelEd) in primary schools and compulsory Relationships and Sex Education (RSE) in secondary schools. The most concerning part of the new legislation is that parents

will have no right to withdraw their children from RelEd in primary schools and the government has indicated that it plans to limit the right of parents to withdraw their children from RSE in secondary schools. It has been suggested that in the latter case the right may revert to the child once they reach a particular age.

We do not know the exact form that RSE and RelEd will take but the government consultation on the issue, which closed in February, gives us some clues. The consultation document attempted to reassure those concerned that teaching will be age-appropriate, the rights of parents respected and faith schools free to teach about sex and relationships in accordance with their religious and moral beliefs.

However, there are serious causes for concern. One is the prominent endorsement of the government's plans by Stonewall. This suggests that teaching about same-sex partnerships could form a significant part of primary school RelEd and ministerial responses to parliamentary questions have consistently insisted that all young people 'whatever their developing sexuality and identity' should feel that RelEd and RSE are inclusive of their 'needs'. The consultation document also bore less resemblance to previous sex education guidance, which made ample reference to parents, and is more like the 2014 document Sex and Relationships Education (SRE) for the 21st Century, published by the Brook Advisory Service, which provides confidential information on contraception and abortion to young people, including those under the age of consent.

Family Education Trust was active in encouraging our supporters to respond to the consultation and in suggesting the insertion of positive content including information about the importance of loving parents for a healthy childhood, the complementary virtues of motherhood and fatherhood, the association of marriage with a higher degree of stability than other living arrangements, and how stable families contribute to a healthy society.
We will continue to be alert to the government's plans for RSE and RelEd and will seek to influence the political process in a manner favorable to marriage, family and the welfare of children.

http://familyeducationtrust.org.uk/

THE BOOK REVIEW

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

Uniformity with God's Will

by St Alphonsus Liguori
TAN Books and Publishers, 2009
Paperback, 31 pages

A few years ago I decided to read Uniformity with God's Will, one of St Alphonsus Liguori's most well-known books. It appealed to me as a practical book to help strengthen my spiritual life. St Alphonsus (1696-1787), a Doctor of the Church, founded the Congregation of the Most Holy Redeemer. The Redemptorists exist to bring Christ the Redeemer to the poor and marginalised of society.

This backdrop helps us to understand the key message of the book; namely that the more we submit our will to God's will the more we love God. St Alphonsus goes on to explain that we have to bear certain crosses and difficulties in life; but if this is God's will we should embrace these: "It would be the greatest delight of the seraphs to pile up sand on the seashore or to pull weeds in a garden for all eternity, if they found out such was God's will." This challenged me but as I read on I realised what a strong and profound message this is.

In today's society it is so easy to follow the status quo. This book re-iterated to me that when making decisions in all aspects of our life we should ensure our will is in unity with God's will. Of course this cannot be done without a personal relationship with God Himself through prayer.

When starting work as a doctor I was overwhelmed by the many decisions I had to make – prescribing, diagnosing and of course difficult ethical decisions. We should always seek to make these decisions in conformity with Natural Law which is a manifestation of God's will and not based on the secular values of the day. This is not always easy but, to quote St Alphonsus: "To do God's will -- this was the goal upon which the saints constantly fixed their gaze."

The Bioethics Column

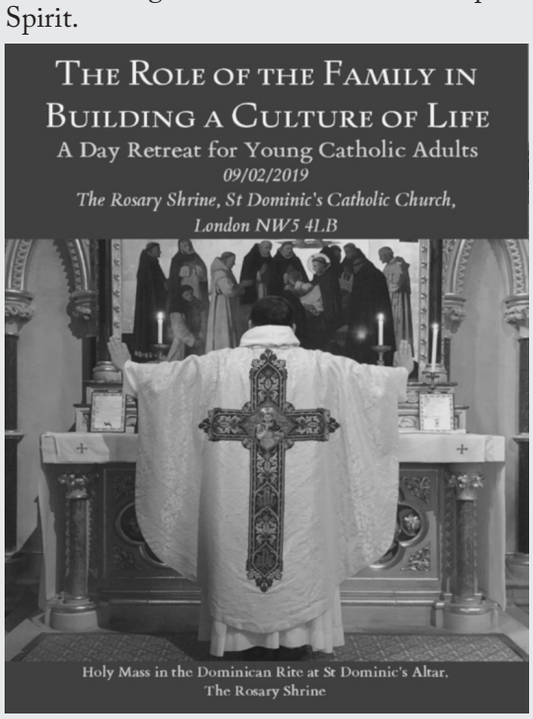
What is healthcare?
By Thaddeus, a young Catholic bioethicist

As promised in the last issue, we will now consider what healthcare is, and what that means for us as Catholics working (or training to work) in healthcare. This will provide the necessary foundation for future reflections on the principles governing ethical reasoning in healthcare.

Healthcare, is the care of health, but there is actually quite a lot of debate on what health is, with opinions ranging from the absence of disease and infirmity to a state of total (physical, mental and social) wellbeing. The

risk of using a wide-ranging definition of health is that this might include such a variety of aspects of daily life that it becomes indistinguishable from other areas of life and become too intrusive into private affairs of people, such as their home economics and how they choose their friends. While the way we spend our money and the people with whom we choose to spend our time surely have an impact on our wellbeing, it is clearly ridiculous to think that buying someone an expensive car (which might well improve their social and psychological well-being) should constitute healthcare! As such, it is perhaps best to understand health as the physical and psychological state in which the members of one's body can appropriately fulfil their function. This recognises both the good of God's creation (Genesis 1:31), that we as people have purpose, and that we need to take care of our bodies to be able to fulfil that purpose. Importantly, health is only one of the goods of life, and as various Saints have testified, it can be sacrificed for other goods: one's spiritual goods, the salvation and well-being of our brethren, and the glory of God.

Recognising that as healthcare professionals we are responsible for the health of our brethren, for whom (as much as for us) Christ died on the cross and who are made in the image of God, should keep us on our toes. We are not only responsible for the provision of a service (both as professionals but also as servants of our Lord), but we must do it in a manner that respects the dignity of every individual in the unbroken Tradition of our forefathers who always emphasized the worthiness of every life, however weak. In our day and age, this involves not only opposing abortion and assisted suicide or euthanasia, but with the progress of medical science and technology will involve careful use of any new advances in medicine. When offering treatment and care we should always keep in mind that God gave us bodies which are good, and form as much a part of us as our souls do, and should not be instrumentalised for the purpose of fulfilling vanity, which damages what should be the temple of the Holy Spirit.



More details on page 8 and at www.facebook.com/cmaenglandandwales

SEMPER IDEM

CONFERENCE REPORT:

EVANGELIUM CONFERENCE (17-19/08/2018) THE ORATORY SCHOOL, READING

BY A YOUNG CATHOLIC STUDENT

The Evangelium weekend (Friday – Sunday) was a wonderful opportunity for time in prayer, growth in knowledge of the Faith, and friendship for young Catholics. The liturgies were beautiful and included Adoration and Benediction in the evening alongside daily Mass during which the Franciscan Sisters of the Immaculate led the chant and hymns. Opportunities for confession were also given and many people took advantage of the opportunity to discuss questions with fellow Catholics, lay and clergy alike. We were blessed to have Mass celebrated by Bishop Mark Davies who was present at the conference to give a talk entitled 'Renewal of Faith in the Holy Eucharist'. This was fitting in the lead up to the National Eucharistic Congress. The grounds of the Oratory School are stunning and provided the opportunity for walks and sports in the afternoons and we were fortunate to have beautiful weather. We were also treated to delicious meals from the school kitchen.

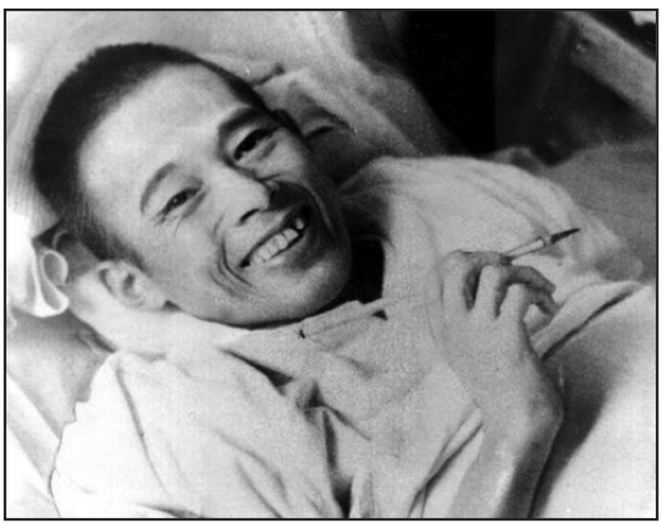
The theme of the conference was: 'explaining the Catholic faith in the modern world.' Particularly relevant to this topic was the presentation by Kerry Day in which she addressed the very pressing issue of gender ideology. She broke down the concepts clearly and concisely and clarified the many areas, which often cause confusion in a very compassionate manner. Additionally, Ryan Day spoke about Humanae Vitae, a topic which has been discussed a great deal in this the year of its 50th anniversary. Of particular interest was the historical context of the encyclical and the changes that took place in the official position of other non-Catholic denominations regarding contraception. This provided an excellent background for helping us to understand the contemporary context. Both these topics were particularly pertinent to the overall theme of the conference as these issues are frequently discussed on the news and pushes to change legislation occur frequently. Within the wider theme of the conference there were however a wide range of talks and workshops of different difficulties were offered making the conference accessible. We heard about Dr Jacob Phillips' ongoing research on Mary and Marian devotion; from Fr Peter Stravinskas who described in detail the way in which our methods of exegesis contrast with other denominations. All of these excellent talks, presentations and workshops are available online. The apologetics panel responded to a wide range of questions and this proved to be very informative. Issues ranging from liturgy to recent changes in the catechism were discussed in depth.

It is wonderful to see that this endeavour which has been running for just under 20 years is growing and continues to provide excellent support for young Catholics in their growth in faith.

FAITH IN MEDICINE

THE LIFE OF NAGAI TAKASHI

PIA JOLLIFFE



On August 9 1945 the atomic bomb was dropped on Nagasaki. In an instant, the bomb killed tens of thousands of people. Among the survivors was Nagai Takashi (his surname Nagai is given first in the Japanese manner), the then Dean of Radiology at Nagasaki University. This man of heroic virtue offered his life for the proclamation of peace and justice amidst Japan´s war and post war society.

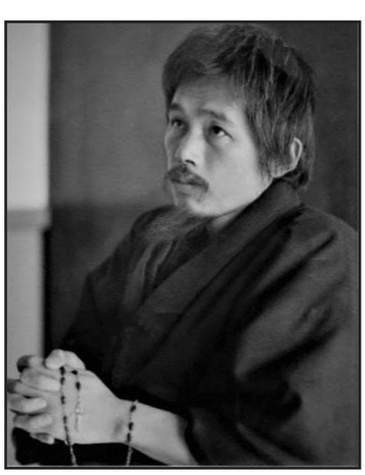
Nagai Takashi was born on 3 February 1908 in Matsue, a village located in Shimane prefecture, Japan. His grandfather, Nagai Fumitaka was a practitioner of traditional Chinese herb medicine (kampo yaku) and his father, Nagai Noboru, studied Western medicine and worked as a medical doctor in a local hospital. Nagai Takashi's mother Nagai Tsune was a member of an old samurai family. Takashi was her first born son. At the time of delivery her husband was on sick call and Tsune found herself alone with the birth attendant. Labour was difficult and Tsune struggled with pressing the baby out. The birth attendant found that the head of the child was too big and suggested crushing Takashi's head. At this moment the mother vehemently opposed the killing of her child and after a while indeed gave birth to her son (Glynn 1988: 18).

Takashi grew up with the teachings of Shintoism. After graduating from high school, he entered in 1928 at the age of 20 years Nagasaki Medical College. During his time as a medical student he became interested in Christianity. So as to learn more about Christian life style, he started renting a room with the Moriyama family whose ancestors were local leaders of the "hidden" Church throughout the Tokugawa period (1603-1867). After his graduation in 1932 Nagai suffered an acute infection of the middle ear. This accident had serious consequences for his future medical career because his hearing turned out be permanently impaired. This, in turn, meant that work with a stethoscope would be impossible. Therefore, Nagai Takashi decided to specialize in Radiology.

From 1933 to 1934 Nagai served as an army physician in Northeast China, known to foreigners as Manchuria, which was invaded by the Japanese in 1931. Moriyama Midori, the only daughter of his host family in Nagasaki, sent Takashi a Catholic Catechism to Manchuria. Takashi subsequently studied the teaching of the Church. After his return to Japan he converted to Catholicism and was baptized on 9 June 1934 taking the baptismal name Paul. He married Moriyama Midori in August of the same year. Takashi and Midori had four children of whom only son Makoto (born in 1935) and daughter Kayano (born in 1941) survived infancy.

After confirmation in 1934, Nagai became a member of the Saint Vincent de Paul Society and served the medical needs of the poor of Nagasaki. He received his doctorate in medicine in 1944. One year later, in June 1945, he was found to be suffering from chronic myeloid leukaemia and was given three more years to live. Two months after this diagnosis, Nagai survived the atomic bombing of Hiroshima whilst at work in the university hospital. Although he suffered from a severed artery on the right side of his head, he engaged with his colleagues in medical relief work. His first-hand observations of the experience of the atomic bomb have been translated and published in English under the title Atomic Bomb Rescue and Relief Report (Nagai 2000).[3]

Sadly, Nagai's wife Midori did not survive the atomic bombing. When Takashi returned to the ruins of their home on 11 August he retrieved Midori's remains, including a melted rosary which she held in her carbonized hands. Their children Makoto and Kayano happily survived the atomic disaster because at the time of the atomic blast they were staying with relatives on the countryside outside of Nagasaki.



After the end of the war, Nagai and his two children resumed their lives in Nagasaki's Urakami district. In 1946, Nagai completed his well known book Nagasaki no kane (The Bells of Nagasaki) which expressed the thoughts and feelings of millions of Japanese in regards to the atomic bombing.

Because Japan was occupied by the US Americans at that time, the publisher who accepted the manuscript for publication had to request from the US censorship office permission to print the book. This permission was not granted until 1949 under the condition that the book carried a number of pages from the U.S. military court´s

documentation of the Japanese attack of American bases and of Manila on the Philippines (Glynn 1988: 208-209). In 1948 Nagai moved to a small hut which his friends had built for him. It was called Nyokodo ("As Yourself Hermitage") and consisted of a small room with an altar, a book case and a bed. Importantly, the hermitage had a view on Urakami Cathedral. The two children lived with relatives close-by Nyokodo and visited their father regularly. Thus bed ridden in his small hut, Nagai wrote most of his thirteen books. He also continued his medical research (see photograph).

He also continued his medical research.
Photo taken by Pia Jolliffe during a visit to the Nagai Takashi Memorial Museum, Mynkodo in December 2017

In May 1950 Nagai Takashi received a gift of a rosary from Pope Pius XII. In his biography of Nagai Takashi, Fr Paul Glynn (1988)[1] notes that this rosary never left Nagai's bed until he died holding it on 1 May 1951. In his preface to Fr Glynn's book the Japanese Catholic author Endō Shūsaku notes:

"Christians and non-Christians alike were deeply moved by Nagai's faith in Christ that made him like Job of the Scriptures: in the midst of the nuclear wilderness he kept his heart in tranquillity and peace, neither bearing resentment to any man nor cursing God" (Endō 1988: 10)

Indeed, Nagai Takashi was a man who practiced the heroic virtues. A person of heroic virtue typically practices the moral virtues with ease whilst the three theological virtues – faith, hope and charity – are practiced to an eminent degree. Nagai was a man of faith who in the midst of Japan´s war with China found the serenity to read and study the Catechism. As a consequence he became a Christian and put his faith into practice. He did not abandon his belief in the salvific message of Jesus Christ and the Church even in the midst of great personal and social suffering and bereavement. In a speech given on November 23, 1945 during a Requiem Mass at Urakami Cathedral Nagai compared Nagasaki to "the chosen victim, the lamb without blemish, slain as a whole burnt offering on the altar of sacrifice, atoning for the sins of all the nations during World War II" (Nagai quoted in Glynn 1988: 188). He concluded his speech saying "Let us be thankful that Nagasaki was chosen for the whole burnt sacrifice! Let us be thankful that through this sacrifice, peace was granted to the world and religious freedom to Japan" (Nagai quoted in Glynn 1988: 189-190). Of course, many of his fellow Catholics found it difficult to see – like Nagai Takashi – God´s providence at work even in the atomic bombing. And yet, Nagai repeated his message in subsequent writings (e.g. Nagai 1995) thus touching the hearts and minds of thousands of Japanese citizens, Christian and non-Christian alike.

Because of his heroic virtues and offering of life to God, there exists today among the faithful a considerable interest for the initiation of Takai Nagashi´s beatification process. However, he is not yet officially called a "Servant of God" [4] . For this to happen, the Congregation for the Causes of Saints needs the Catholic bishops of Japan to clearly explain Nagai´s heroic virtues and thus to ask for an initiation of his beatification process.

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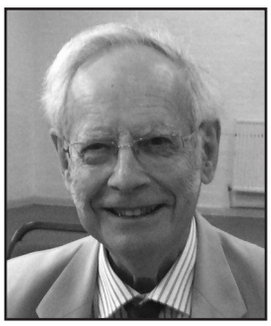
PAPERS

CHILD ABUSE: HOWEVER DID WE GET HERE?

DR IAN JESSIMAN



I left the monastery in Autumn 1964. I had spent 6 years in simple vows (2 in Rome) thinking I had a vocation to contemplative prayer but, in the end, deciding my role really lay in practising medicine.

During my experience in a Benedictine school (1943-49) and as a would-be monk (1958-64) I heard or saw nothing that would constitute abuse. Only on three occasions, to the best of my memory, had I come across any suggestion of homosexual behaviour: Some inappropriate behaviour by two boys in the dormitory on one occasion, a rumour of a past episode concerning two would-be members of the community who had been dismissed, and second-hand account of a homosexual approach in Rome. I heard and saw nothing even remotely approaching child abuse. On the other hand one had learned from older monks, who had had experience of 'outside work' in the parishes, that some sort of unspecified dubious behaviour was rife among the secular clergy in certain regions. Of course, if one was ignorant of such matters one was unlikely to recognise them!

Child sex abuse clearly did not begin in the 1960s. Dark rumours of 'incest' in the Borough circulated when I was a student at Guy's in the 1950s. These matters, however, were regarded as private and not the concern of 'outsiders'. Such transgressions must have been occurring from time immemorial, but seem to have become more widespread in the 1960s and '70s.

If there was a loosening of the moral code how did it come about? In the 1960s it seems that there was an almost universal loss of the Judaeo-Christian value system (which dated back to the ancient Greek civilisations or even earlier) with its fundamental emphasis on self-respect and self-esteem. In a sense Vatican II was both a result of this contemporary movement and an attempt to address it, but it failed to 'follow through' and the Church, and individual communities, were left to adjust to the changed ethos as best they could. Vatican II was largely seen as a 'loosening of the apron strings' The increasing availability of TV, and ready access to pornography, came at the same time. Teaching, and not solely in the Church, seemed to be abandoned in favour of the belief that all that was good and laudable would emerge in each of us 'automatically' as we grew older and studied the world around us. A generation of Catholics grew up who simply had never heard of the existing moral teaching of the Church. Morality became largely a matter of personal choice and the debacle of Humanae Vitae did nothing to increase the willingness of people to listen. The notion of right and wrong seems to have been replaced by a notion of freedom, and the authority of conscience by the panacea of consent. From here, of course, it was no distance to believing that consent by another was being given or could be presumed. Abusers were able to claim they were acting out of love.

For the male, human nature being what it is, the act of intercourse involves an element of power. The victim is usually one in a subservient position who feels themselves unable to resist and, thus, that they themselves are guilty. Perhaps the perpetrators, on their side, could convince themselves that such behaviour (e.g. mutual masturbation) was of no great harm and did no permanent injury to anyone. But no one had any concept of the destructive effect on the victims.

A naive outsider, unfamiliar with such things, might have suspected that those who had complained of abuse had been exaggerating their histories to seek compensation. Evidence given before the Child Abuse Inquiry shows that this was by no means the case. Some of the complaints involved sexual misbehaviour of the gravest degree – exaggerated by the fact that the victims were generally minors in the care of the perpetrators.

We are then led to ask how such behaviour could have taken place in religious communities, vowed as they are to the highest ethical and moral standards. Many Catholic schools already had strict ethical codes for social contacts between members of the religious community and the pupils. So it seems quite incredible, considering the moral code upheld and enforced by the Church, that its members, and in particular the self-selected leading members, should have felt able to justify themselves in breaking the code. The fall in numbers of the membership of religious orders, following Vatican II, would have had a demoralising effect and weakened both mutual support and supervision. It might have been expected that any transgressions would have been minor, but this was by no means always the case and many of the allegations, particularly those which have been upheld in court or even admitted – were very serious. As such behaviour was (to the virtuous) virtually unthinkable such reports were at first disbelieved and then denied. If this were not enough they were then concealed. There was no understanding of the grave harm being experienced by (done to) the victims and to pay attention to their needs would have been an admission of guilt. There was also a view that Holy Priests could do no wrong and that they had undergone an ontological change at ordination. Nonetheless, it is clear that many offenders realised their behaviour was gravely sinful and they would avoid saying mass until they had been to confession.

The Church, meanwhile, continued to regard such offences as relatively minor and, more significantly, as a simple matter of choice. The offender could therefore express a firm purpose of amendment (often genuine) in confession and be forgiven having promised not to do it again. Some underwent psychiatric assessments and 'treatment' and were 'cleared' (even by psychiatrists) to return to their previous posts. It was not recognised that paedophilia was

probably innate and certainly – like much other sexual behaviour - an addiction. At the recent enquiry the opinion was voiced that such behaviour was not within self-control.

Treating the matter as a simple failure of obedience the offenders would be believed, forgiven and reinstated. It was some time before this was seen to be inadequate. The church considered such sins as parallel to most others so that an admission of guilt and a request for absolution was the right and proper course. There seemed no point in informing the police who were not expected to have any effective methods of correction. Only later was it recognised that paedophilia is partially an inherent trait and partially an addiction.

A particular difficulty, especially for the Benedictines, is that the Abbot has direct concern for the members of his community (family) but only indirect concern, through the school officers, for the children in their care. In conjunction with the natural tendency to deny that such evils could happen there was a tendency to hush up such events so as to avoid the serious criticism and disdain which might be expected. All this, however, is now considered more reprehensible than the sin itself.

Corporal punishment and fagging, mentioned in the enquiry, had been an accepted part of previous generations of boarding school life but are now seen as particularly liable to bullying and abuse. In all these things the Church was caught off its guard and did not see the dangers coming.

The various reports by the Church in this country, (Catholic Bishops 1994 and 1995, and particularly the Nolan (2001) and Cumberledge (2006-7) reports) did not directly apply to the religious orders, except by their own choice. The 'paramountcy principle' (that the welfare of the children was the prime concern) was increasingly accepted, but the tendency to accept every complaint as 'proven' without defence was seen in many quarters as gravely unjust. There was widespread concern that the processes introduced as a result of the paedophilia scare were unfair and that mere accusation could end a career. Perhaps this led to the Abbots being reluctant to accept them in their entirety. "The child protection system had 'no concept of divine grace'". Whilst not overlooking that the ingenuity and persistence of paedophiles can (like the rest of us) be enormous it must also be remembered that the Abbot is the father of a community of which the miscreant remains a member.

For the future it will be necessary to ensure that would-be religious undergo a proper selection process and full instruction in such matters during their training. My own selection (by the novice master) was mainly concerned with my ability to sing, so as to be able to participate in the offices. Thereafter I can only remember the issue of sex and sexual orientation being raised on one occasion in a private interview with the novice master. It seems that at some point, in some clerical circles, masturbation was increasingly accepted as quite innocent. Perhaps this was a reflection of immaturity? If that was the case it suggests the selection process had fallen far short of the standard required and the training process has been equally defective.

What of those in these communities who have steadfastly adhered to the teaching of the Church and the Rule of St Benedict? They can only try to increase the unity within their community and to demonstrate remorse and repentance for what happened 'on their watch'. They should seek to make reparation, as far as may be possible, and achieve reconciliation with the victims. What else is now to be done? The two issues which seem to have been of particular concern to the Australian abuse enquiry were celibacy and the seal of confession. In the Monastic life, lived in community as we know it, celibacy is a sine qua non. For the secular clergy, living separately, this is not the case and celibacy could be voluntary. With regard to confession it would surely be possible for absolution to be made dependent on self-reporting? Or could it be made a 'reserved sin' - though not to one's own Abbot or Bishop? With this in mind it might also be wise for confession to members of one's own community to be forbidden? Otherwise such a practice might seem to be imposing an unfair pressure on one's fellow monks.

I am not in a position to argue about the concept of religious 'vocation'. But it seems that in some way the single hearted search for God has been forgotten. It looks as if a spiritual renewal is needful with a greater concentration on prayer and contemplation and less emphasis on 'corporal works'. This isn't just a call to the religious (monastic) orders but to the whole church, including the hierarchy and the Vatican, to seek a return to a more 'devoted' way of life. I remember finding it strange, when I left, that there was strong movement towards outside 'missions', just when the world seemed most in need of ways of meditative and contemplative prayer. Is this the way we should now be moving?

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Child Abuse (Addendum) September 2018

My paper was written at the turn of the year, after attending a number of the hearings by IICSA (Independent Inquiry into Child Sexual Abuse) on the English Benedictines, so I do not feel that it needs revision in the light of their recent report (on Ampleforth and Downside). My interest had been drawn to the subject partly because of my background, but more because of an inability to understand how such things could ever have happened, least of all in the Church with its high moral standards. May I add a few words?

In the early 1960s, during and after the time of the Vatican Council (II) and before Humanae Vitae, there was widespread expectation in the Church that contraception would be officially accepted. At least implicitly, this entailed the rejection of the important Thomistic concept of 'sins against nature' (masturbation, etc.). Against this background masturbation and homosexual activity came to be, equally, considered blameless. Meanwhile homosexuality came to be deemed a natural condition, created by God.

Following from all this it looks as if homosexual behaviour had come to be seen as permissible, regardless of any vow of chastity, whether in the religious life or the secular priesthood. Separately there were some in society who even argued that it was harmless and even beneficial to young people. Obviously no one had asked the victims.

The Church missed the chance that it had, after the Council, to revise its moral theology and, in particular, its version of the natural law (still largely based on Aristotle and the early Greek philosophers' understanding of nature). I wonder if it might consider doing so now?

I.J.

A CASE AGAINST THE OPT-OUT SYSTEM OF ORGAN DONATION

DR AGNETA SUTTON

A new opt-out donation law, 'Max's law', is to be introduced in England if Parliament gives its approval to the proposed change. Named after 10-year old Max Johnson from Cheshire, who waited nine months for a new heart, the proposed law may come into force in 2020.

Under the new opt-out law, most adults aged 18 or over would be presumed organ donors after death, unless they have added their details to the NHS Organ Donation Register and said that they do not want to donate their organs, or if their family strongly believes that the deceased would not have wanted to serve as an organ donor. In other words, what will be introduced is a 'soft opt-out' system, as distinct from a hard opt-out system.

The government's plans were first announced following the Prime Minister's speech at the 2017 Conservative Party Conference. The government subsequently published a consultation document on 11 December 2017 inviting responses until 2 March 2018. According to the government's response, ***Consultation on introducing 'opt-out' consent for organ and tissue donation in England***,[1] published on 5 August 2018, some 80% of people are willing to donate their organs after death, yet few people register as organ donors . Furthermore, in the last ten years the number of organ donors has increased by 75%, while 'deceased transplants' have increased by 56%. Nonetheless, there is a shortage of donors and some 6,500 people are waiting for organs.

Some 17,000 people responded to the consultation. It may be noted that looking at the government's summary of the key findings it is not clear whether most of the respondents were in favour of a change from the opt-in to the opt-out system. We are told that there were 'mixed views' about what should happen if a person had not opted out, though most respondents thought donation should go ahead anyway.

It is also noted that some Jewish and Muslim respondents 'expressed concerns' about the proposed changes. The government invites people to register their organ donation decision as from December 2018.

Summarising the proposed opt-out system, the government announced that there will be a 12-month transition period between the passing of the new law and its coming into effect. It will be possible to state your faith in the Register and 'religious and cultural considerations will form part of discussions with the family'. There will always be a family consultation before a donation goes ahead and 'the family will be given the opportunity to provide information if their loved one would not have wanted to donate their organs or if their recorded decision was not the most recent'. And children under 18, people lacking capacity and those who have been resident in England for less than 12 months would be excluded.

The question is: Should we, or should we not, welcome the proposed change to the law? At present England has an opt-in system. This means that your organs may only be used for donation after your death: (1) if you carry an NHS organ donor card; or (2) if you do not carry such a card, your next of kin gives permission for your organs to be used; or (3) if you have nominated another person to deal with the use of your body after death, and consent is given by your nominated representative. However, if you do carry a donor card, your family cannot intervene and object to organ donation.

The reason why the government wants to change from an opt-in to an opt-out system of organ donation is obvious. It is hoped that this would increase the number of organs available for donation. The government says that if an opt-out system were introduced in England, it might save up to 700 people each year. The question is would it? And are there other considerations that ought to be taken into consideration as well? Are there other reasons for or against a change in the law?

It is noteworthy that the Nuffield Council on Bioethics, an independent think tank, has expressed concern about the proposed changes to the law. Following the announcement by the Prime Minister at the Conservative Party Conference in 2017, the Nuffield Council made a brief response noting that 'the case for moving to an opt-out

system in England has not yet been made, as existing evidence fails to show that the opt-out system has led to more organs being made available for transplant'.[2] This was with specific reference to a report commissioned by the Welsh Assembly Government (WAG) following the introduction of an opt-out system in Wales in 2015.[3] The WAG report published on 30 November 2017 shows that the opt-out system has not increased organ donations. Deeply critical of the government, the Nuffield Council also noted that in February 2017 Nicola Blackwood, the then Parliamentary Under-Secretary of State for Health, had said that government was monitoring the impact of the new legislation in Wales, but in fact no such monitoring has taken place.

As the Nuffield Council says, the government ought not to introduce the proposed change until there is evidence that it actually would increase the number of donations. Indeed, the Government should not change the law 'until there is evidence it works, and until we are confident that it won't undermine people's trust in the system in the long term'.[2] The last point is significant. The introduction of an opt-out system could undermine the public's trust in the health services. It could generate fear of state-sanctioned acts of cannibalising the dead.

The Nuffield Council also points out that the government's consultation document is potentially misleading, inasmuch as it states that 'a person is considered a possible organ donor following their death only if they actively took steps to consent in their lifetime'.[2] Thus, as the Nuffield Council observes: 'This is not correct: agreeing to be an organ donor (via the Organ Donor Register) is just one way that people can become donors after they die; families can also consent to organ donation, regardless of whether their relative has agreed in their lifetime'.[2]

Reiterating its concerns in its subsequent August 2018 ***Response to the Government's plan for an opt-out system for organ donation,*** the Nuffield Council further notes that 'more public awareness, more investment in staff training, more specialist nurses and ensuring that all families are central to the donation process would do more to help those in need of an organ.'[4] Quite rightly it also declares that 'for an opt-out system to work ethically, people need to be fully informed so they can make an active choice about whether or not to donate'.

More recently a study by Queen Mary University of London has expressed the view that it is unlikely that an opt out-system would increase the number of dead donors.[5] Yiling Lin, one of the researchers, says of the plans to launch an opt-out organ donation system that 'what we show is that it is unlikely to increase actual rates of organ donation or reduce veto rates, all it will do is increase thenumber of people on the organ donation register'. And Dr Magda Osman, lead author of the report, says that we 'need to offer people a way to indicate explicitly what they wish to do. This would involve an expressed statement of intention if they wish to donate, or an expressed statement of intention if there is an objection to donate. This reduces the ambiguity in trying to infer what one wanted to do when it comes to donating their organs'. The report, which was published in the ***Journal of Experimental Psychology:*** Applied,[5] is based on three studies in which the researchers asked American and European participants 'from countries that have either a default opt-in or a default opt-out system to take on the role of a third party to judge the likelihood that an individual's "true wish" was to actually donate his or her organs, given that the decedent was registered to donate on the organ donation register…. Overall regardless of which country participants came from, they perceived the donor's underlying preference to donate stronger under the default opt-in system and mandated choice systems as compared with default opt-out and mandatory donor systems'.

These findings are significant. Even under a soft opt-out system, the suggested change to the English law would amount to a radical change. There are good reasons for having reservations about the proposed new law, and not only because it is doubtful whether it would increase the number of organ donations. Organ donation raises questions about bodily integrity in the case of dead as well as in the case of live donors. Respect for the dead means not treating their bodies as mere raw material. The dead body of a person is surely to be respected as more than a potential source of spare parts. The dead body is the body of a person who belonged to a family. Quite rightly the views of the family would be taken into account under the new law. But what if the family do not want their dead relative to be a donor? What pressure might they be put under? And who would have the last say?

Also, does the term 'organ donation' not suggest an intentional and declared act of giving? To speak of organ donation in the case of an opt-out system is a misnomer. Under an opt-in system organ donation is truly treated as a gift on the part of the donor. Not so under the out-out system. Under the opt-out system your dead body is actually treated as a property of the state. Under an opt-out system the dead body is effectively a state-owned organ reserve, that is, a state-owned reserve of bodily spare parts. Is there not something Orwellian about this?

How can you speak of real consent under a presumed consent system, that is, under an opt-out system? Normally we speak of a requirement of informed consent in the context of health care. Should we not expect informed consent in the context of organ donation as well as in the context of medical care? Why should the state have a greater say in the case of the dead than in the case of the living? A mandated choice system would be more respectful of the individual person, or of individual choice, than an opt-out system. Though this is what might be called a nudging system. For by forcing a person to make a choice, you put a moral pressure on the person. An opt-in system is the only system that allows the individual to volunteer in the true sense of the word.

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CONSENT FOR ORGAN DONATION AFTER DEATH – THE LEGAL ASPECTS

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The principle that one can donate an organ to others is not by itself wrong; on the contrary it has been approved by Christian Churches amongst others. So, Pope Benedict VX1 in an address to the International Congress on Tissue Donation (2008) said that:

"Organ donation is a peculiar form of witness to charity. In a period like ours, often marked by various forms of selfishness, it is ever more urgent to understand how the logic of free giving is vital to a correct conception of life. Indeed, a responsibility of love and charity exist that commits one to make of their own life a gift to others, if one truly wishes to fulfil oneself. As the Lord Jesus has taught us, only whoever gives his own life can save it (cf. Lk 9: 24)."

However, he then went on to emphasise the ethical considerations which must underpin any regulation of organ donation:

"Therefore, it is necessary to put respect for the dignity of the person and the protection of his/her personal identity in the first place. As regards the practice of organ transplants, it means that someone can give only if he/she is not placing his/her own health and identity in serious danger, and only for a morally valid and proportional reason."

The vital word here is 'give' and the reasons for such giving and this is where we come to the question of consent for organ donation after death. It is useful here to recall why the Human Tissue Act 2004, which regulates this area, was passed. The previous legislation was the Human Tissue Act 1961 which provided by s.1(2) that the person lawfully in possession of the body of a deceased person (often the hospital or other place where the person died) could authorise the removal of any part from the body for use for the purposes of therapy, education and research where they had no reason to believe, having made such reasonable enquiries as were practicable, that either the deceased or any surviving spouse or relative objected to it. In addition, by s.1(1) a person could give express consent to donation of their organs after death provided that this was done in writing or orally in the presence of two or more witnesses during his or her last illness.

The effect was that consent could, in effect, be presumed, and this led to abuses following which Inquiries were set up which resulted in the replacement of the 1961 Act by the 2004 Act. In particular, as Price notes, *"the Reports on the Inquiries: catalogued local practices resulting in relatives, principally parents of dead children, lacking appreciation of subsequent tissue retention and use for research following (generally coroners') post-mortem examinations, often resulting in the burial or cremation of loved ones without the realisation that they were not 'complete', .."*

As Price points out: *'It was a common theme of the Inquiry Reports that the law should be reformed so that 'informed consent' rather than an 'absence of objection' should become the central guiding legal principle justifying removal, retention and use of cadaveric material for various permissible purposes,..'*

This was carried through into the 2004 Act so that, as Price puts it: 'the notion of consent constitutes the unifying theme of the legislation, described in Parliament as its 'golden thread'.

The significance of all this is that the proposals of the Government to require individuals to 'opt out' of organ donation would remove this element of consent which the 2004 Act and the Inquiries which preceded it thought were so essential. As the Government's Consultation on Introducing 'Opt out' Consent to Organ and Tissue Donation in England puts it:

Changing to an opt-out system in relation to organ and tissue donation in England would require people to actively withhold their consent if they did not want it to be a possibility after death, and certain changes to legislation would be needed to achieve this.

There are the following points to be made:

(a) The Government needs to justify its contention that the element of express consent, thought essential in the 2004 Act, is now considered unnecessary.

(b) Following on from this the Government needs to explain how the specific abuses identified by the Inquiries (see above) which led to the requirement of express consent would not re-occur once this requirement is removed.

(c) The Government needs to explain why, when there is growing emphasis on the need for informed and express consent (see e.g. the General Data Protection Regulations 2018), these proposals go right the other way.

(d) If the system of requiring opting out does go ahead there will need to be certain exemptions such as for those aged under 18, those who lack capacity, those who are visitors to England and those who have expressed an objection on religious grounds. Once these have all been accounted for, would it not be easier anyway to continue the present system given that there will be many who will fall into these categories and registers will have to be maintained of those in them?

AN INTRODUCTION TO NATURAL FAMILY PLANNING -

DR LUCY AND FR MICHAEL BEMAND-QURESHI

It is now the 50th anniversary of arguably the most controversial papal document of modern times: Paul VI's encyclical ***Humanae Vitae***. It is a document that is criticised or dismissed far more often than it is actually read - and as a relatively short and accessible document, it is something that every Catholic with even the slightest interest in the church's teaching on marriage really ought to read.

The encyclical ***Humanae Vitae*** was preceded by a papal commission studying the moral acceptability of contraception, prompted by what has been described as the greatest scientific advance of the 20th century: the hormonal contraceptive pill. It is well known that the Pope Paul VI disagreed with the opinion held by a majority of members of the commission and, exercising the power of the keys, insisted that there should be no change in the Church's long held teaching that the use of contraception is objectively contrary to the divine will. This teaching has been reaffirmed by each of his successors, and in a particularly solemn form, bearing all the hallmarks of a statement of infallible teaching, in Pope St John Paul II's apostolic exhortation ***Familiaris Consortio*** (1981).

The aim of this article is to explore the principles behind an alternative approach to family planning and responsible parenthood, which is entirely in harmony with the church's teaching - the approach commonly referred to as Natural Family Planning or NFP.

Ironically, though NFP is often dismissed as being something only ultra-serious Catholics bother with, there are some who think that NFP isn't Catholic enough: part of a so-called 'contraceptive mentality' that is hardly better than using contraceptives. On the contrary, NFP is fundamentally different. To see why, we need to understand a little of what the church actually teaches, and what prompts it, as a lone voice in our society, to reject the use of contraception.

Marriage preparation should include a proper introduction to the principles of NFP, but in practice the amount of information couples receives often falls short, if it is even mentioned at all. Despite the best efforts of Pope St John Paul II, the church's teaching in this area is not well understood, even by many priests, and even where there is a desire to pass on this teaching there is a shortage of instructors able to address the practical side of NFP. Ideally, NFP should feature (with appropriate sensitivity) in the remote preparation for marriage that occurs in catechetical programmes for young people, in the home, and in the delivery of Sex and Relationships Education in schools.

The four criteria of conjugal love

The teaching on contraception in ***Humanae Vitae*** is presented in the context of a rich theology of marriage, entirely consistent with all that the church has taught before but with a new emphasis on conjugal love. The love of husband and wife must fulfil four criteria:

- Fully human - not merely natural instinct or emotional drive but an act of free will leading to human fulfilment.
- Total - sharing everything in a gift of oneself to the other.
- Faithful and exclusive until death.
- Fruitful - going beyond the love of husband and wife to bring new life into being.

This love is clearly not just expressed in the vows made on the wedding day, but something lived each and every day and expressed in many different ways. There is one act, however, which communicates this love in an especially powerful way, and that is of course the sexual union of husband and wife. Though marriage is not just about sex, it is very significant. The two key aspects of sexual intercourse - uniting the couple, and generating new life - coincide with what the church has always held to be the key reasons for marriage: mutual companionship, and the raising of children. If their sexual union is to be an authentic expression of their love then it too must fulfil each of the four criteria above.

Marriage is not only a sacrament of the church: John Paul II described it as the 'primordial sacrament', a kind of sacrament of creation in that it is a sign of God's goodness and love in which all people are invited to share. The fact that most intimate physical union between man and woman occurs in the very same act which is capable of generating new life cannot be a mere coincidence. Marriage is never just a private matter, nor is it merely a human matter either: sexual intercourse always has the potential to be an occasion when, knowingly or not, the human couple and God cooperate in the work of creation. That is why the church considers sexual intercourse as a profound gift to be treated with reverence and respect. That stands in

contrast to the view that prevails in much of society today, which sees sex as 'no big deal'; indeed Paul VI predicted such a shift in his encyclical 50 years ago.

It is notable that if we exclude the different aspects of sexual union, that is to say if we separate the unitive aspect from the procreative aspect, then the four criteria of authentic conjugal love are no longer fulfilled. This separation occurs in various ways:

- It goes without saying that the unitive aspect is completely missing in cases of non-consensual sex or in an abusive relationship. There is clearly not a human or free act nor an act of giving to the other.
- When a couple have sex outside marriage, even in a long-term relationship, the unitive aspect is not fully present as the total and exclusive commitment essential to conjugal love has not been made.
- The use of contraception not only negates the procreative meaning, the criterion of fruitfulness, but also diminishes the unitive dimension as there is no longer a total gift of self - the gift of fertility is excluded.

'Responsible parenthood"

Having clearly set out that inseparable connection established by the Creator between the unitive and procreative meanings of the sexual act, Paul VI goes on to teach about 'Responsible Parenthood'. This, he says, can include the decision to have more children, as well as the decision 'for serious reasons and with due respect to moral precepts ... not to have additional children for either a certain or an indefinite period of time.'

The practice of NFP evidently fulfils the four criteria for conjugal love: it emphasises sexual intimacy as a conscious choice for the other, it involves the total giving and receiving of each other through cooperating and respecting each other fully, it only makes sense in the context of a faithful and exclusive union, and it is based on a desire to cooperate with the creator of life.

The teaching that spouses could legitimately delay having children was not something introduced by Paul VI as a sop to those who wanted to see contraception legitimised, as earlier teaching also spoke of this. Notably Pius XII in his ***Allocution to Midwives*** (1951) stated that the use of infertile periods is lawful provided the reasons are sufficiently serious, and in the ***Allocution to Family Associations*** (1951): expresses hope that 'science will succeed in providing this lawful method with a sufficiently secure basis'. As early as 1880 a Response of the Sacred Penitentiary states that spouses using the periods of abstinence to avoid pregnancy 'are not to be disturbed'.

'Contraceptive mentality"

The question arises of what constitutes 'serious reasons'. It is, first and foremost, the responsibility of the couples to discern for themselves if it is right for them to avoid pregnancy for the time being, and many things can be considered serious reasons: health of the couple and other children, economic circumstances, difficulties with previous pregnancies. No one outside a marriage, unless a couple have chosen to discuss their reasons, can know what has led to that discernment. The charge that NFP is often used with a 'contraceptive mentality', citing a phrase of John Paul II, is unwarranted and represents a misuse of this phrase. A brief survey of John Paul II's use of the phrase 'contraceptive mentality' in documents from ***Familiaris Consortio*** onwards shows that it refers consistently to the damage done to society and the human person by the widespread acceptance and use of contraception. Undoubtedly NFP can be used selfishly, but it is not for others to judge that, and it certainly isn't correct to equate even allegedly selfish use of NFP with contraception. Moreover, those couples who take on NFP, with the self-discipline and sacrifice it entails, surely deserve the benefit of the doubt: one has to assume that a couple choosing NFP are by the fact of that choice showing that they are taking this issue seriously.

NFP is intrinsically opposed to a contraceptive mentality. Paul VI had this to say: 'Self-discipline of this kind is a shining witness to the chastity of husband and wife and, far from being a hindrance to their love of one another, transforms it by giving it a more truly human character.'

Nevertheless the phrase 'Contraceptive mentality' does remind us not to think of NFP as just another contraceptive method. NFP is not 'catholic contraception', as it differs fundamentally in its approach. Those who practice NFP are not doing anything to prevent conception occurring, and always have to be open to the possibility of pregnancy occurring. Not that NFP methods are unreliable - they aren't - but it is a very different mindset: most abortions are due to contraceptive failure but that is unthinkable to a Catholic couple practicing NFP.

It is important that our use of language reinforces the distinction between contraception and NFP, especially in teaching young people or in medical settings. Though it is easy to start talking about 'safe' periods, perhaps it is better to talk factually of fertile/infertile periods. Indeed, the same approach is very useful for couples trying to conceive, and for the investigation of health problems, therefore some practitioners prefer to talk about 'natural fertility awareness' rather than NFP. The NHS Choices website lists NFP as a method of contraception - it should hardly surprise us they use this language, and we should be glad it is at least being presented as an option (after all people who aren't Catholic may choose a natural method for their own reasons) - but we should not make that mistake.

How it works

NFP is an umbrella term for a number of methods which use different biological signs to determine when conception may or may not occur. Different methods suit different couples and those who practise or teach NFP may have limited knowledge of how other methods work. It can therefore be difficult for couples wanting to start NFP, and for priests preparing couples for marriage, to know where to begin.

The various methods nevertheless rely on some basic biological facts. As readers of this publication will surely be aware, pregnancy occurs when a female egg is fertilised

by a male sperm. An egg is released once per cycle, and typically survives 12-24 hours. The male sperm can typically survive up to five days inside a woman's body. Therefore there is a window of about six days when sexual intercourse could lead to pregnancy. The object of NFP is to determine when this fertile period begins and ends. The most basic method, but least reliable, is simply to use calendar data to estimate fertility based on the length of the menstrual cycle. The most common methods of NFP are based on observation of certain signs, either by themselves or in combination: these include changes to cervical mucus, other changes to the position and feel of the cervix, and temperature on waking. Drs John and Evelyn Billings pioneered the use of cervical observations to determine fertility and their work led to the Billings Ovulation Method. The Creighton Model FertilityCare system also uses cervical observations though adopts a different approach to charting and interpreting the signs, whilst the Sympto-Thermal Method (taught by the Couple-to-Couple League and the NFP Teachers Association) combines observation of cervical mucus and temperature. The key to all these methods is learning the method from a trusted teacher, observing and charting the signs of fertility, and applying the rules carefully to identify the start and end of fertility.

The above methods use secondary signs that are triggered by the rise and fall of certain hormones during the cycle. A different approach is to measure the hormone levels directly. An example is Persona, sold in pharmacies and produced by Clearblue who make a range of pregnancy and fertility tests. This device tracks the levels of oestrogen and luteinising hormone. However the original model's advertised success rate of 94% does not compare well with other methods, and since it merely gives a traffic light indicator it doesn't give much information about what is actually going on in the cycle. Since the device never received FDA approval in US and therefore could not be marketed there, the Institute of NFP, part of the College of Nursing at Marquette University in Milwaukee, Wisconsin developed their own hormone-based method. They had previously come up with a method that combined a simple classification of mucus with calendar data, and following extensive research adapted this method to use the hormone data from the Clearblue Fertility Monitor - a device similar to Persona but designed to help couples conceive. Though this counts as 'off-label' usage and the Monitor includes a stern warning not to use it as 'contraception' nevertheless there was some unofficial cooperation between MU and Clearblue in developing what is now known as the 'Marquette Method'.

In practice the method involves testing a sample of urine on waking on certain days of the cycle, and the device reports L, H or P: H (high) indicating a raised level of oestrogen which occurs in the days before ovulation, and P (peak) indicating a surge in lutenising hormone, which means ovulation is expected in the next 24-48 hours. The period of potential fertility is considered to last for four full days after the first P. Identifying the start of fertility relies on data from past cycles as the increase in oestrogen does not usually occur early enough to take into account the maximum survival period of the male sperm.

Marquette University has carried out several trials into the efficacy of their methods - mucus only, mucus combined with the hormone monitor, and the hormone monitor only. Although the second method is most conservative by design, the lowest failure rate is with the monitor by itself, perhaps because that is the simplest method. The results of the trial are impressive: across two recent trials 311 participants using the monitor had zero 'method failures' - that is, zero unintended pregnancies occurred when the rules were followed correctly. The most recent of those trials, involving 197 people, recorded 893 correct use cycles with 100% success.[1]Marquette University has also developed a protocol for postpartum and breastfeeding use, and claims the method is suitable for perimenopausal women. Although there are currently no accredited teachers based in the UK, the method is intended to be self-taught using information available online. Users of the method can access support from other users and from researchers at the College of Nursing via an online discussion forum or one-one messaging (a subscription is required to access some of this support). The Marquette Method is by no means perfect, and one issue is that the lutenising hormone surge is not always picked up by the monitor - on average this is expected approximately 1 in 10 cycles but the reality for an individual may differ. The algorithm is designed to take this into account, essentially falling back on historical data - this means assuming ovulation was as late as it ever has been in the last six months, which may mean an artificially shortened non-fertile window (and if this happens often, its little better than a calendar method). To avoid this situation, Marquette now suggests an additional test in the evenings prior to the anticipated ovulation day, using simple ovulation test sticks - obviously this makes more work, as it isn't possible to know in advance if the morning test will work that cycle!

Challenges and benefits of using NFP

For a Catholic person who desires to live in faithfulness to the church's teaching, it is not simply a matter of weighing up the pros and cons of NFP compared to other approaches to family planning. Nevertheless it is important to acknowledge that there are challenges to using NFP, as well as additional benefits.

The benefits first, and it is worth noting that some non-Catholics use NFP for these reasons:

- It is 'natural' in the everyday sense that no chemicals, hormones or foreign objects are involved (however it is worth noting that the Church uses 'natural' in a different sense: 'natural law' is what we can determine from the evidence of creation using the faculty of reason that is proper to our human nature, as opposed to that which we can only discern with the supernatural gift of faith. A 'natural' interpretation of the biological data concerning the purpose of sexual intercourse leads to the rejection of contraception. Contrast this with the Church's acceptance of much of modern medicine, which is aimed at restoring the integrity of the human person).
- In particular, there are no side of effects from long-term hormone use.

- Greater spontaneity is possible once the non-fertile period has been established, as there is no need to interrupt intimacy to use a barrier device.
- All NFP methods work best when the couple work together and NFP methods promote good communication and respect for each other. Research suggests that NFP-practising couples have dramatically lower divorce rates.
- Abstinence encourages couples to find other ways of expressing affection.
- Arguably periodic abstinence makes them value sexual intercourse more as a gift from God and a gift each spouse makes to the other and receives from the other.

However...

- It can be very frustrating that, as a direct consequence of the fertility cycle, the times when a couple most desire to enjoy lovemaking are the times when it is not possible if avoiding pregnancy, and the times when it is possible are the times when it is least desired. Sensitivity on the part of both spouses, and the recognition that both are affected, is key to addressing this. It is especially hard when holidays and days off don't coincide with infertile times. Abstinence is by definition a sacrifice, and we can accept it and offer it up to God. On a practical level, it may help to plan date nights and give extra time to each other, without placing undue pressure.
- It can be hard observing signs or testing when working long or irregular hours, night shifts, weekends etc - something medical professionals will appreciate.
- NFP requires commitment to learn a method and follow it strictly.
- Depending on the method chosen there may be some costs involved to cover tuition and materials, at least initially. Although family planning services are provided by the NHS, these tend to focus on contraceptive methods; NFP instruction is not offered universally.

To finish, let us recall the particular part healthcare professionals have to play in promoting an authentic vision of family life and sexual intimacy, and resisting the consequences of the 'contraceptive mentality' which Paul VI foresaw and John Paul II so often warned against. In the words of Paul VI:

"we hold in the highest esteem those doctors and members of the nursing profession who, in the exercise of their calling, endeavour to fulfil the demands of their Christian vocation before any merely human interest. Let them therefore continue constant in their resolution always to support those lines of action which accord with faith and with right reason. And let them strive to win agreement and support for these policies among their professional colleagues. Moreover, they should regard it as an essential part of their skill to make themselves fully proficient in this difficult field of medical knowledge. For then, when married couples ask for their advice, they may be in a position to give them right counsel and to point them in the proper direction. Married couples have a right to expect this much from them."

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Also two earlier studies (note these involved using the monitor and mucus together, rather than the monitor by itself):

[3] R. Fehring et al., Cohort comparison of two fertility awareness methods of family planning, Marquette University, 2009.
R. Fehring et al., Efficacy of cervical mucus observations plus electronic hormonal fertility monitoring as a method of natural family planning, Marquette University, 2007.

In both studies the correct use unintended pregnancy rate for using the monitor and mucus observations together was approximately 2%, and the imperfect use pregnancy rate approximately 12-14%

NEWS

BUFFER ZONES AROUND ABORTION CLINICS

There was little good news in the summer about the protection of ethical medicine. But one very good piece of news was the Home Secretary's decision not to impose buffer zones around every abortion clinic in the land.

He concluded that such a move would be disproportionate to the scale of the problem. That decision was especially courageous given how shrill is the proabortion lobby. Clare McCullough of the Good Counsel Network has been repeatedly on television and radio and pointed out that those who pray and defend life are peaceful and do not harass women seeking abortion. But they do offer help and many hundreds of women have "turned around" as a result of the help they offer. On the other hand, proabortion organisations such as "Sister supporter" have been far from peaceful and have indeed created disturbances around clinics where they have demonstrated. The ***Be Here for Me*** campaign (picture) is run by women who were helped by people praying outside abortion clinics and seeks to protect the right to stand with those who need support.

We must hope and pray for their success so that organisations such as Good Counsel and 40 days for Life can and will be able to carry on their peaceful work, supporting women as they decide to keep their babies.

BOOK REVIEWS

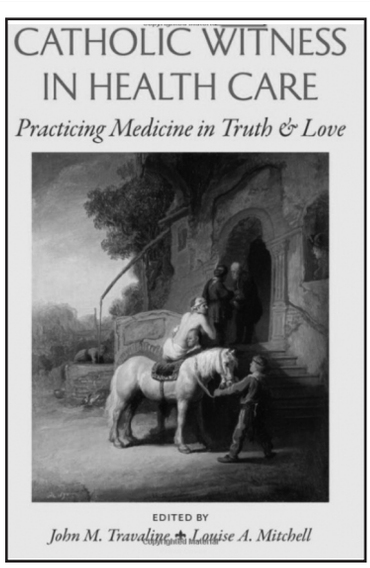
CATHOLIC WITNESS IN HEALTH CARE.
PRACTICING MEDICINE IN TRUTH & LOVE
EDITED BY JOHN M. TRAVALINE & LOUISE A. MITCHELL

REVIEWED BY PRAVIN THEVATHASAN

I found the entire book both readable and captivating. It strikes the right balance: orthodox and charitable. It covers a whole range, including reproductive health, pediatrics, surgery, psychology and, very interestingly, the formation of medical students. For the purposes of this review, I will examine some chapters I particularly enjoyed.

In his chapter on foundation of authentic medical care, J.Brian Benestad argues that at the heart of medical ethics is the idea of virtue. Unfortunately, people rarely speak of it. Instead, they are driven to speak of autonomy and rights. The two competing and most popular ethical theories taught in medical ethics courses are Kantian ethics and utilitarianism. They have little time for virtue.

In his chapter on Catholic anthropology and medical ethics, Peter J. Colosi asks what motivated Peter Singer to care for his terminally ill mother and break his own rules? Because Singer, for all his dreadful views, is human. We are driven by our love of individuals, not systems or charters or theories. Ours is a person-centered ethic. I find myself utterly moved by those who care for severely disabled people, people who at one level cannot contribute to the good of society but at another level give us so much.



In her chapter on reproductive health and the practice of gynaecology, Kathleen M. Raviele says that there are two meanings in the marital act, the unitive meaning and the procreative meaning. Both meanings ought always to be respected. Catholic physicians ought to develop expertise and evangelize.

Salpingostomy is the direct killing of unborn life and is unethical. The pregnancy rates after salpingostomy and salpingectomy are the same. Most interestingly, in a recent review, it is reported that nine women with pulmonary hypertension chose to continue with the pregnancy and they all survived.

The chapter on the formation of Catholic medical students is excellent. Medical formation is a time to gain technical competence but also to practice "the gift of self that is required to practice medicine." Science alone is not enough. What is needed is empathy. The Church considers health care as an integral expression of her mission to humanity.

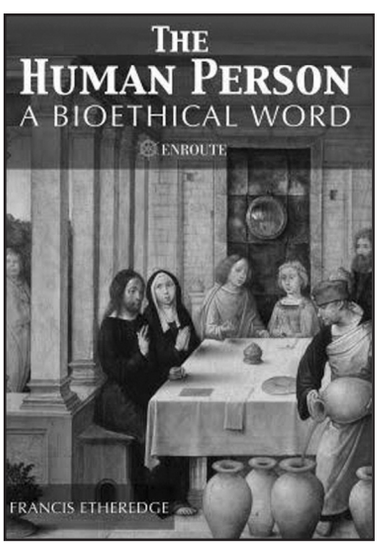
In her chapter on Catholic psychologists and the spiritual dimension, Wanda Skowronska cites Paul Vitz in noting that secular psychology has little to offer those who are suffering. In Christ, we have an unexpected new narrative. Suffering is the prelude to a new and extraordinary world of understanding. Christianity starts with suffering and ends with joy. Secular psychology starts with optimism and ends with pessimism!

Human nature is good and so is everything created by God. However, human beings possess a special dignity as created in God's image. That is the ultimate message of this splendid work.

Catholic Witness in Healthcare is published by The Catholic University of America Press.

THE HUMAN PERSON. A BIOETHICAL WORD BY FRANCIS ETHEREDGE

REVIEWED BY PRAVIN THEVATHASAN



Bioethics is for everyone because it asks what it means to be a human person. In order to understand bioethics, we need to understand what it means to be persons. This is one of the messages of this important work. A certain paradox can be noted: science tells us that life begins at conception and this truth is clearer than never before.
Nevertheless, we carry out acts that destroy these embryos as never before. Evolutionary theory dictates that the fittest must survive. The disabled are thus to be got rid of. The survival of the fittest is regarded as appropriate because of another myth: the myth of overpopulation.

What Etheredge is saying makes perfect sense. Either the human person is a created word that demands absolute respect or it is a thing to be manipulated for utilitarian purposes. There is really no middle ground.
The human person is always a person in relation. Persons are thus called to be conceived by spousal union. This union is in harmony with the action of God the creator of the word. It is thus unethical for persons to be created by means of technology outside of the spousal union. The spousal union is intended as relational and loving and it is fitting for the child so conceived to grow by means of such relations and, of course, the on-going relationship with God.

Bioethics these days is a secular discipline focused on biology. But, says Etheredge, the human person is a transcendent being. So it is entirely appropriate for there to be a chapter in this book on metaphysics: something not to be found in most works of bioethics.

Bioethics is not an abstract discipline. It should always be seen in the context of living out the vocation to marriage. What Etheredge has succeeded in doing so well is to argue the case for created beings as mysteries of divine action. We are biologically, psychologically, socially and spiritually what we are from conception and we are persons. Does that not resonate with the call for those of us in health care to adopt a holistic approach?

That Etheredge has given us good and even excellent reasons to respect human persons from conception is without doubt. What then are we to do with so-called "spare embryos"? It is my view that orthodox Catholics are going to come to different conclusions on this issue. Etheredge puts forward powerful arguments in favour of embryo adoption. The way it was conceived was, after all, hardly the fault of the embryo. Surely, it is reasonable for the embryo to enter into relationship? My own equally sincerely held view is that a tragedy has already ensued when its conception took place and little can be done to undo that tragedy. Humanae Vitae taught clearly, and Etheredge would certainly agree, that spousal union is the only morally sound means of conceiving and continuing in relationship with the other.

All in all, a brilliant work, combining ethical soundness with spiritual uplift. Thoroughly enjoyable and should be read by all, not just specialists, whatever that word means these days.

The Human Person. A Bioethical Word is Published by En Route Books & Media

CORRESPONDENCE

NATURAL FAMILY PLANNING IN THE UK

Dear Editor,
I was very interested to read Dr John-Paul O'Sullivan's discussion paper on NFP in the UK. I thought it was encouraging and interesting to hear about how NFP is advancing on a global level. Unfortunately here in the UK we are in a sad state. There seems to be low morale amongst NFP teachers and users, who feel unsupported by the Church and the NHS. The aim is to just keep some kind of service running and the resources are not there for service development.

Regarding NFP and the NHS, there are a few NFP teachers in sexual health clinics in England. The ones I have heard of teach the symptom-thermal method of NFP. However even the few services that exist in the NHS are being cut, due to lack of demand.

Lack of funding seems to be a key issue- both in sustaining current services and developing new services. It is a really good point "that the healthcare provider should contribute to the cost of NFP is a point that goes untested in the UK". NFP is something that should be provided on the NHS. However I think that as long as NFP organisations providing free teaching exist there is no impetus for the NHS to fund providing an NFP service- when they can just refer to an organisation that provides that for free. If we were to have NFP services that charged, then patients could demand for the NHS to fund their consultations, as it is within guidelines for NHS services to offer NFP as an option for family planning. And if they were refused a service then they would be in a position to put in a complaint or even take out a lawsuit. I think that patients demanding NFP teaching and complaining if their demands are not met is the only way that the NHS will take the provision of NFP seriously.

John-Paul makes a great point when he says about taking a lead from the Palliative Care movement when it comes to fundraising. When have I ever seen a fundraiser for NFP? Never! Yet there are fundraisers for so many other issues. The NFP organisations should definitely get their thinking caps on and start fundraising events. Not only would this raise much needed funds but also raise awareness and start a discussion in the local community about NFP.

To counter the pervasive contraceptive mentality and create a culture of life, early education is needed. Education about charting cycles and NFP needs to start at school age. There are various programmes that may be a possibility: TeenSTAR is an evidence based educational programme for teenagers that has a good track record but requires committed teachers. Alternatively showing videos and encouraging discussion- for example showing the new documentary called 'Sexual Revolution: 50 years since Humanae Vitae'.

In terms of educating healthcare professionals and extending the call for support from Catholic healthcare professionals in Humanae Vitae, why not organise SSCs or electives for medical students, which could also be of benefit in terms of research? Inspiration could be taken from the American group FACTS (Fertility Appreciation Collaborative to Teach the Science).

Let's be grateful for all the work in NFP that has been done here in the UK over the past 50 years and be inspired to move things forward.

Yours faithfully,
Dr Jessica Almeida (GP near Glasgow)

SUICIDE BY PARENTS OF CHILDREN KILLED IN ROAD CRASHES.

Sirs,
The suicide of Reece Platt-May, recently found dead after his two sons were killed in a "hit and run" tragedy, deserves greater scrutiny as it demonstrates how road crashes can impact upon other members of the immediate family.
This seems especially true when a family member senses injustice or feels powerless. Sometimes there is a delayed reaction to the tragedy that may include "organic memories", also known as "body memories", that remain outside the realm of the intellect.

In these respects "hit and run" is like abortion and euthanasia in that the tragedy is not an isolated event but one that can affect other family members, causing for example internalised rage, depressions, nightmares and preoccupations with death.

The Platt-May boys had been crossing the road when they were hit by Robert Brown, a cocaine user who had been "driving like a madman" after release from prison days earlier. Brown was jailed for nine years but is likely to be released after half that period.

Let us compare the case of Brenda Geransar, who a decade ago had killed herself on an underground track following the death of her teenaged daughter killed by a drunk driver, Peter Jones. He was jailed for 33 months but was automatically released after half that time.
Mrs. Geransar's suicide was bad enough but the tragedy was worsened by the fact that two weeks later Jones was granted a "town visit" for "good behaviour" and was photographed by a journalist in a local pub.

A 1997 study funded by the European Commission found that some 25% of interviewed parents of children killed in road crashes still suffered from "suicidal ideation" after three years. What little psychological support they received came mainly from relatives and friends and occasionally from family doctors but "hardly ever from institutions".

Antony Porter

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