

February 1991

Letters to the Editor ...

Catholic Physicians' Guild

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Recommended Citation

Catholic Physicians' Guild (1991) "Letters to the Editor ...," *The Linacre Quarterly*: Vol. 58: No. 1, Article 1.
Available at: <http://epublications.marquette.edu/lnq/vol58/iss1/1>

Letters to the Editor . . .

Letter from Ireland

For some reason the media have made a great fuss about the arrival of the year 1990. As a people we were supposed to become changed, looking forward to the next century. We had joined the European Community and could be called Europeans. The richer countries were helping us with farming subsidies and the tariff barriers were coming down. The liberation of the peoples of Eastern Europe coupled with the perestroika and glasnost in Russia were the final proofs of great change. Unfortunately, as we know too well, these latter situations were altered by the as yet-unresolved problems of Eastern Europe and the Gulf crisis. Similarly, to speak of this country, all seemed well on the medical scene when I last wrote, but this situation was short-lived. A new Association has been formed called the Irish Hospital Consultants Association, which is now two years in being and thriving. It is separate from the Irish Medical Organisation. This Organisation was set up because there was such a diversity of problems between the various groups of doctors: house residents looking for better working conditions, general practitioners needing alterations in their contracts and specialists requiring more representation and direct contact with authorities. Consultants Association considered that in particular it had not enough input into management. It is well to know that doctors are not trained for this, but certainly no hospital should be run by people who have no direct contact with the patients. No doubt in future years there will be more to report on this matter.

In the past few years we have an increasing number of young foreign doctors coming here for post-graduate studies which are not available in their own countries. There have been difficulties with the recognition of some qualifications but this matter is presently under review and should be soon resolved. Within the European Community recognised medical qualifications are interchangeable between the

constituent countries. Doctors may set up practice without much difficulty, but this is not always true for graduates coming from parts of the Third World. This problem, of course, also exists when Irish graduates go to work in the U.S.A. if they wish to become permanent residents. In general, young Irish graduates do not stay too long at home once they have completed their compulsory intern year because career structures are such that each successive postgraduate year leaves fewer positions available in the specialities. They go abroad to gain experience, hoping to return sometime. The Irish have always emigrated but not always of necessity, but in this instance we lack funding for senior training posts. Again the number of variety of cases available is restricted because of the small population. Thus, we have the anomaly of young Irish doctors emigrating for training in the senior non-consultant posts and young foreign doctors coming to Ireland for a similar reason but of course for more junior and less favourable posts.

The number of Irish women going abroad for abortion purposes remains constant at about 4000 per annum. The Irish birthrate has dropped by about 20% in the past ten years with an associated rise in illegitimate births to nearly 20%. Continuing emigration of young Irish people is causing a definite alteration in the population structure, leaving a higher proportion of old people, and soon we will be in line with other European countries who have a negative population growth, although we still have the highest birthrate in Europe. As you know, abortion has not been legalised in this country, but the number performed abroad on Irish women will soon represent up to 7% of the conceptions in this country. Other methods of birth control include sterilisation of either partner. This would be more popular but it is an expensive procedure. It is also well understood that many hysterectomies are done for the complaint of menorrhagia in the 35 to 45 age group and have a permanent contraception component.

We now have 4000 cases of HIV Positive in this country, of which 174 are declared effective AIDS. Some of these patients contracted their disease through blood transfusion before the relationship was established. I know this looks like a very small number by comparison with other countries but our population is also very small. Much time and effort is being put into the education of young people in this matter, but a difficulty has arisen in that our hierarchy do not agree with advice on contraception being given to adolescents.

The country has just elected a new President, the seventh in its history and this time a woman who has no true connection with the two major political parties but is well known for her liberal views and progressive attitudes on women's problems. Of course this office is a ceremonial one and does not carry political power, but it does show that the old order changes and perhaps we should be looking forward to the 1990s.

—Robert F. O'Donoghue
Cork

Letter from Hong Kong

As the British Colony of Hong Kong enters the last decade of the century, it is entering a new era — an era of change, an era of uncertainty, because in seven years time, the sovereignty of the place, together with its six million population, would be handed over to the People's Republic of China. Many people are thinking of leaving and many have already voted with their feet. How to emigrate and how to accumulate the greatest wealth in the shortest period of time are two of the hottest topics in town. The Catholic Church, which represents two hundred thousand Catholics in Hong Kong, has declared its total commitment to the local community and recently published its Consultative Papers: "The Hong Kong Catholic Church — Towards a Glorious Decade". While denouncing the brutal suppression of the Democratic Movement in Beijing on June 4th last year, the local Church has tried to strengthen its link and mutual understanding with the Patriotic Church in China.

What about the Guild of St. Luke in Hong Kong?

Founded in 1953, the Guild of St. Luke remains active in the past years. With less than one hundred members, which represent 2% of the total number of doctors in Hong Kong, the Guild has tried its best to achieve the objective of the Guild — that is, to facilitate the intercourse among Catholic doctors and to uphold the principle of Catholic morality. Besides organising spiritual exercise such as Annual Retreat, the Guild has organised a variety of functions to attract its members, for example, the seminar on "Facing the Change in Hong Kong". A newsletter of the Guild is published quarterly and a 35th anniversary special issue with the theme "The Catholic Medical Services in Hong Kong: the Past, the Present and the Future" has just been published last year. We are glad that a number of young Catholic doctors and medical students joined our Guild in the past few years and we have been able to maintain our link with other Catholic organisations in Hong Kong and Catholic Doctors Associations abroad.

The coming ten years would not be easy for the Guild and the community of Hong Kong, but relying on God's guidance and directives, we would be able to see light in the distant darkness.

May the strength of our Lord Jesus Christ be with us and may God bless us all.

—Dr. YUEN Kar Ngai Robert
Immediate Past Master
Guild of St. Luke, SS. Comas
& Damian
Hong Kong

On Grisez Article

In his article "Should Nutrition and Hydration be Provided to Permanently Comatose and Other Mentally Disabled Persons?", Germain Grisez provides an excellent analysis of the obligation to continue to value the good of the existence of a human person even though permanently comatose. I have no difficulty with that analysis and thought his rebuttal of McCormick and O'Rourke to be sound. However, his treatment of the issue of cost is not so convincing. Grisez fails to address the

problem of allocating limited resources.

My own experience with the issue of nutrition and hydration for the persistently comatose over the past eight years in an Australian acute care public hospital was that the method of delivery of nutrition and hydration is a factor in determining the level of nursing dependency. The level of nursing dependency is a major determinant in finding a nursing home placement. Very often patients who are dependent on naso-gastric feeding cannot be found a bed in a nursing home. Nursing homes are short of nursing staff and therefore reluctant to accept the transfer of a patient who requires a high nurse-patient ratio.

The consequence of this is that if the doctor retains naso-gastric feeding, the patient would not be transferred and would continue to occupy an acute-care hospital bed. The cost of caring for a patient in an acute-care hospital is approximately twice that of caring for the same patient in a nursing home bed where there are fewer facilities and staff who are not so highly trained.

However the major cost of naso-gastric feeding the patient in human terms is that he or she occupies a bed for which there is great demand. At the time when I was last involved in such a decision, the hospital (a 600-bed teaching hospital) had a medical waiting list for beds of approximately 300 and a surgical waiting list of approximately 800. Those on medical waiting lists are patients who are usually awaiting admission for diagnostic procedures such as tests for cancer or for cardiac failure. People do die on medical waiting lists from treatable conditions. Thus the cost of keeping one comatose patient on naso-gastric feeding in Australia may well be the deaths of others. In the weeks or months that he or she occupies the acute-care bed, many other patients could have been assessed and had their conditions diagnosed and treated and hence their lives prolonged and disabilities overcome.

I was never made more aware of the resource allocation question than I was in these cases.

There is a need to address this issue to determine what principles should determine the allocation of resources. Does the feeding of a comatose person without which he or

she would certainly die have greater priority than the medical investigation and treatment of several others who may die without that investigation and treatment? What principles of justice should operate here?

The answer to the question posed in the title to Professor Grisez's article is not adequately answered unless the question of the just allocation of resources is addressed.

—Nicholas Tonti-Filippini
Canberra, Australia

Letter from New Zealand

The ecclesiastical event of the year was the consecration in Dunedin of Rev. Mrs. Penelope Jamieson as the world's first Angelical woman diocesan bishop. Among the distinguished guests was the first American Episcopalian female auxiliary bishop, Rev. Mrs. Barbara Harris. The local Catholic bishop and one of the Maori bishops declined to attend.

It was an haute couture occasion, her cope and mitre being in matching free-flowing patterns of mauve, purple and blue, but there were no Christian symbols. One of the problems was what to call the new bishop. Would it be "Her Ladyship"? She said: "Call me Penny!"

In an interview she said that she was not going to get involved in the abortion debate and she would not condemn homosexuality because several of her friends were in this situation and they "are very nice people".

In a public statement 34 leading Catholic women expressed support for her and, naturally, for the ordination of women. Among them were the regional Superiors of the Dominican Order and the Sisters of Mercy; also several nuns and lecturers on the staff of the diocesan seminary.

The expectation of life for the whole population is 71 years for males and 77 for females. In the indigenous Maori population these figures are 67 and 72. This is remarkable since in the early years of this century it was feared that the Maori population was going to be wiped out because of a decline in the birth rate and the deprivations of tuberculosis and rubella. At present Maori women have the highest incidence of lung cancer in the world, thanks

to heavy smoking. This same habit was remarked upon, and deplored, by the early missionaries when the country was first settled about 1840.

The recent General Election produced the most dramatic upset ever recorded — the ruling Labour (socialist) Government plunged from 56 seats to 40, while the new National Government soared from 28 to 68. The total population is only 3.3 million but there were 56 parties among the candidates. They included such bizarre groups as: Revolutionary Army Party, McGillicuddy Serious, Imperial British Conservative Wizard, Wall of Surf, Swinging Voters Outlet, No Confidence, and so on. The new Prime Minister, Jim Bolger, is interesting in that he is only the third Catholic to hold this post. He is a farmer and he has nine children! He has inherited a desperate financial mess and people realise that the days of unlimited social welfare are gone forever. He has immediately made cuts of 25 percent in the budgets for health, education and social welfare. The repercussions will be devastating but they were inevitable. The public hospital system, which had dominated the scene for 60 years, is in danger of collapse.

Bolger has also moved to restore the traditional friendship and alliance that this country has always had with the United States. It now transpires that the Labour Prime Minister, David Lange, had deliberately set out to offend these former allies, using the nuclear ships issue. He distinguished himself by ditching his original wife and shacking up with his speech writer who now appears to have been a major agent in the regrettable anti-Americanism. All those who, like me, had fought side by side with the Americans in recent wars devoutly wish to see U.S. Navy ships once again in our harbours.

For Catholics another important event was a new book on the priesthood, showing that this state is unique and irreplaceable. It will give encouragement to those good, orthodox priests who have lost confidence in their role. It is: "Priesthood" by Fr. Patrick J. Dunn; Alba House, New York. \$12.95. The publishers are so impressed with it that they gave a copy to each of the American bishops who were going to last October's Synod in

Rome. By a strange coincidence the author just happens to be one of my sons! (No, I am not on commission.)

—H. P. Dunn, M.D.
168 Upland Rd.,
Auckland, 5,
New Zealand

On Ethics, from ACP

Dear Dr. Mullooly:

As promised, the ACP Ethics Committee considered your letter about our *Ethics Manual*, as well as the article by Dr. Engelhardt, at its October 16, 1990 meeting.

Your concerns about our statement regarding abortion are of great importance to us, and will be considered again when we start work on the third edition of the *Manual*. However, our review of the language at this time leads us to stand by the current statement in the *Manual*.

You seem to be interpreting our statement as a duty to refer for abortion. We suggest no such duty. We merely say that in balancing the physician's right to personal moral choice with the patient's rights, the physician has a duty "to assure that the patient is provided the option of receiving competent medical advice and care." In assuring that the patient receives all relevant information from someone else the physician knows not whether the patient will have an abortion. In fact, it may be that in the face of all of the information and options presented, the patient decides against the procedure. The point is only that the patient has the right to all the relevant information. Thus, the physician who objects to abortion "need not become involved either by proffering advice to the patient or by involvement in the surgical procedure."

We have taken the opportunity to address this issue in more detail in a letter to the editor responding to Dr. Engelhardt's article. We hope the *Linacre Quarterly* will be able to publish the attached letter.

Thank you.

—Edwin P. Maynard, MD, MACP
Chair, ACP Ethics Committee

Re: Engelhardt Article

To the editor:

The American College of Physicians would like the opportunity to respond to the article by H. Tristram Engelhardt Jr., Ph.D., M.D. entitled, "Taking Pluralism Seriously, or is the Ethics Manual of the American College of Physicians Unsympathetic to Physicians with Religious Objections to Abortion?" which appeared in the August, 1990 issue of the *Linacre Quarterly*.

The American College of Physicians respects the personal views of all individuals, including all physicians. We also believe that physicians have certain obligations to their patients, in addition to having individual rights. Dr. Engelhardt seems to interpret our statement about abortion as a duty to refer for abortion. We suggest no such duty, and require no cooperation in abortion.

What we have said is that in balancing the physician's right to personal moral choice with the patient's rights, the physician has a duty "to assure that the patient is provided the option of receiving competent medical advice and care". In assuring that the patient receives all relevant information from someone else, the physician knows not whether the patient will have an abortion. In fact, it

may be that in the face of all of the information and options presented, the patient decides against the procedure. The point is only that the patient has the right to all the relevant information. Thus, the physician who objects to abortion "need not become involved either by proffering advice to the patient or by involvement in the surgical procedure".

Dr. Engelhardt notes that the College does support possible civil disobedience with respect to maintaining confidentiality. The crucial distinction that he misses, however, is that disobedience in that instance would be based on the physician's commitment to the patient's welfare, not to the physician's own interests or beliefs.

In reality, it is Dr. Engelhardt who does not take pluralism seriously. We have tried to express what we think is a reasonable and proper course in a difficult situation, balancing the physician's right to personal moral choice with his or her responsibility to ensure that the patient receives all relevant information necessary to exercise the latter's autonomous choice.

—Edwin P. Maynard, MD, MACP
Chair, ACP Ethics Committee
American College of Physicians
Philadelphia, Pennsylvania