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Letter from New Zealand ...

D.H.P. Dunn

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Heads of all departments of each Catholic hospital.
Members of the joint conference committee of each Catholic hospital.

4. Programming
Speakers should be carefully chosen and should be the best qualified, whether they are Catholic or non-Catholic.

Morning Session
8:00 a.m. Mass (alternate time).
9:30 a.m. Keynote Address.
10:00 a.m. First Conference.
10:45 a.m. Intermission.
11:00 a.m. Second Conference.
11:30 a.m. Third Conference or Panel Discussion.
12:00 noon — 12:30 p.m. Lunch (Bishop).

Afternoon Session
2:00 p.m. Fourth Conference or Round Table Discussion with an appointed leader for 10-15 people.
3:15 p.m. Intermission.
3:30 p.m. Final Conference.
4:45 p.m. Adjournment.
5:00 p.m. Mass (alternate time).

Letter from New Zealand...

In spite of its small population (2½ millions), New Zealand receives a disproportionate amount of interest and goodwill throughout the world. The outstanding medical event of the past year was the introduction of intrauterine foetal transfusion by Dr. A. W. Liley. By transfusing blood into the baby's peritoneal cavity at about 34 weeks maturity he has been able on several occasions to salvage one otherwise doomed by severe Rh immunisation.

The Catholic medical status is improving rapidly. A doctor at the end of his professional life can remember being the only Catholic serving, say, half a million people. Now there would be at least 50 such doctors in a similar community. They are united in the Guild of St. Luke, which is affiliated with the English Guild. There are about four meetings yearly in the main centres, a retreat, and social events. Following the ecumenical spirit of the good Pope John, there are now joint meetings with doctors and clergy of other religions, and from these has arisen a warm feeling of fellowship and mutual respect.

In the recent past the main concern of the Catholic body has been for defence and consolidation, but now it seems likely to develop and flower once again. The incidence of Catholicism in the general population is about 14%, but in the younger age groups it may be as high as 20%. After 90 years of secular education the milieu is largely de-Christianized, and in the medical field the main problems are those of contraception, therapeutic abortion, and sterilization. The outlook is, however, much more healthy in these respects than it was a generation ago.

The basic task for the Catholic profession is not merely to act as a brake on these errors but also to present positive ideals of the beauty and richness of Christian marriage and the intellectual life. There is a great need for Catholics to take on positions of leadership in all aspects of community life.

With its absence of illiteracy and poverty, and its uniform middle class structure (some would say mediocrity), New Zealand forms a convenient social laboratory in which many innovations have been readily introduced in the past. Physicians will be interested in the national health service which has been working for about 25 years. Unlike the British scheme it favours general practitioners rather than specialists, many of whom, especially in internal medicine, find it difficult to make a living. One lesson which can be learned from our experience is that the profession ought to take the initiative itself in introducing some comprehensive form of health insurance, rather than to leave it to the...
State, which then appears in people’s minds as being more concerned with their interests than the doctors themselves. Catholic doctors should be first in the field in ensuring for patients a fair deal in medicine, and protection from economic disaster when illness strikes. The New Zealand scheme illustrates the folly of the State’s accepting responsibility for every minor ailment in the community. Attempting this, together with an unwillingness to accept the barrier of a means test, leads to waste, extravagance, crushing taxation, and bureaucratic control of the profession. The Christian tradition has always been to resist undue limitation of the citizen’s freedom by the State, whose function should be to organize service and help in distress, rather than to dominate the whole of life; but it is difficult to preserve a nice balance.

The Guild in New Zealand is grateful to its colleagues throughout the world, particularly in the United States, Australia and Britain, for the sense of purposeful solidarity which it takes from them.

D. H. Dunn, M.D.
122 Remuera Rd.
Auckland, New Zealand

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Dr. Braceland
(Photograph courtesy Fabian Bachrach)

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Current Literature:

Titles and Abstracts


The psychiatric indications for termination of pregnancy continue to be much debated. In addition to scientific aspects there are religious and ethical ones as well. These include such questions as: (1) Has the fetus a soul? (2) If it does, what happens to the soul if the fetus dies unbaptized? (3) At what stage does the fetus become a “person”? The most general answer to the last question seems to be at quickening. The state of English law regarding the general question is also somewhat uncertain. Consequently the psychiatrist’s decision is often a difficult one. Remedies to improve the situation are urgently required, and these are both legal and medical.


The increasing complexity, success, and social facets of modern medicine are three important reasons for reconsidering the moral aspects of medicine. For the past three years a joint study of medicomoral problems engendered by modern medicine has been carried out at Vanderbilt University, Nashville, Tennessee. The prime movers are a physician (Dr. Elliot V. Newman, Professor of Experimental Medicine) and a philosopher (Samuel E. Stumph, Ph.D., Chairman of the Department of Philosophy). Expanded discussions are planned.


The sophisticated techniques of diagnosis and treatment available to the modern physician tend to threaten the personal relationship that should exist between physician and patient. This is particularly evident in the area of communication, and yet communication is an important aspect of proper medical practice. There are many difficulties. For example, patients frequently fail to comprehend what is being said. “The properly oriented physician will have evaluated the intellectual and emotional capability of his patient,” and he must avoid communication difficulties such as those related to his own semantic inadequacies or to the patient’s lack of attentiveness. And for the patient “with a severe diagnosis and limited prognosis, the road ahead should be straight. Perhaps it will not be pleasant or comfortable, but it should be unobstructed and never dead-ended.”

Material appearing in this column is thought to be of particular interest to the Catholic physician because of its moral, religious, or philosophic content. The medical literature constitutes the primary but not the sole source of such material. In general, abstracts are intended to reflect the substance of the original article. Parenthetical editorial comment may follow the abstract if considered desirable. Books are reviewed rather than summarized. Contributions and comments from readers are invited.