PROCEEDINGS
(Draft copy)

XXIV FIAMC
WORLD CONGRESS

78th CPGP Anniversary and 2014 Annual Convention

“The Catholic Doctor in an Era of Secularization and Technology”

October 1 - 4, 2014
Fiesta Pavilion, Manila Hotel,
One Rizal Park, Manila
FIAMC Congress  
1-5 October 2014  
Manila Hotel (Philippines)  
http://worldcongressfiamcmanila2014.weebly.com/  

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  - Cardinal Pietro Parolin, Secretary of State (Text)  
  - Archbishop Giuseppe Pinto, Apostolic Nuncio to the Philippines (Text)  
  - Catholic Bishops’ Conference of the Philippines, Archbishop Socrates B. Villegas (Text)  
  - Mgr Jean-Marie Mpendawatu, Pontifical Council for Health Care Workers (Text)  
  - Manuel Po, MD, President, Catholic Physicians Guild of the Philippines (Text)  
  - Jocelyn J. Yamboa-Franco, MD, FIAMC World Congress Chair (Text)  
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I - Opening Ceremony, Messages

1. The President of the Philippines,
Benigno S. Aquino III, Malacanan Palace, Manila,

My warmest greetings to the World Federation of Catholic Medical Associations on the occasion of your 24th World Congress.
Healthcare continues to be a major channel through which the Philippine government aims to ensure the wellbeing of the Filipino people. This is why we welcome all initiatives that seek to improve the quality of medical services available to our citizenry, including the efforts of your organization to integrate a Christ-centered approach in the practice of medicine.
As Catholic physicians, you are in a unique position to ensure the dynamic synergy between faith and science. We count on you to rise above the sea of conflicting opinions by encouraging open and productive discourse on how we can harness advancements in technology to secure the welfare of your patients and bring the rest of humanity to greater heights. May you have a successful gathering.

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2. Republic of the Philippines, Office of the Mayor, City of Manila
Joseph Ejercito Estrada, Mayor

Greetings to the World Federation of Catholic Medical Associations (FIAMC), through the Catholic Physicians Guild of the Philippines (CPGP), as they prepare for their 24th World Congress!
Centuries before man entered an era of enlightenment, faith and science were traditionally and odds. Learned men of the cloth, pitted against those who worshipped the value of facts and research vs. beliefs and dogma, clashed many times over in their desire to bring people into their fold.
Now, as the 21st century continues to unfold, these two historical foes have at least been united, if not completely, then at least in regard to their shared objective of helping man achieve his optimum health potential.
This year's chosen Congress theme "The Catholic Doctor in an Era of Secularization and Technology," underscores the unique challenges faced by medical professionals whose faith allies
them with the Vatican. Yet the wellspring of faith that guides Catholic doctors in their work is never stronger than when they go out to do their work as healers of both body and soul. In essence, their work is not so much a profession as it is a calling. I laud the officers and members of the FIAMC and the CPGP for using their medical skills as a representation of their living faith. Healing is as much about the body as it is about the spirit, and I sincerely hope that this truth continues to be your guide as you go out and minister to the well-being of those in your care. Congratulations and Mabuhay!

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3. Republic of the Philippines, Department of Health, Office of the Secretary

Enrique T. Ona, M. D., Secretary of Health

Warmest greetings and congratulations to the administrators, officers and members of the Catholic Physician's Guild of the Philippines on the holding of its 24th World Congress with the theme, "The Catholic Doctor in an Era of Secularization and Technology."

Let this event serve as a reminder to all physicians and other health workers that our profession is essentially about service. The Department of Health commends your dedication to provide quality medical care and your commitment to promote excellence in your field.

The holding of this event is consistent with our goal of building a more progressive and accessible health care system in our country.

We look forward to working with you as we strive towards pursuing our goal of Universal Health Care or Kalusugan Pangkalahatan.

Congratulations and Mabuhay kayong lahat!

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4. Secretariat of State

Cardinal Pietro Parolin, Secretary of State

His Holiness Pope Francis was pleased to learn that the World Federation of the Catholic Medical Associations will be holding its twenty-fourth World Congress in Manila from 1 to 4 October 2014 and he sends warm greetings to all the participants. As you reflect upon the "The Catholic Doctor in an Era of Secularization and Technology", the Holy Father prays that this gathering may help all the participants to integrate the faith within their professional lives thereby offering
Christ, the Divine Physician, to the sick and suffering so that your work may radiate the joy of the Gospel that fills the hearts of believers (cf. Evangelii Gaudium, 1). Invoking the loving intercession of the immaculate Heart of Mary, to whose care your esteemed Federation is entrusted, the Holy Father willingly imparts to all present his Apostolic blessing as a pledge of grace and peace.

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5. Apostolic Nunciature in the Philippines
Archbishop Giuseppe Pinto, Apostolic Nuncio to the Philippines, 14 May 2014

I convey my heartfelt felicitations to the officers and members of the Catholic Physicians' Guild of the Philippines (CPGP) as they hold their 24th World Congress on October 1-4, 2014, in Manila. As a way of greeting, allow me to share with you some words from the Apostolic Exhortation, Evangelii Gaudium, where His Holiness Pope Francis spoke about the importance of evangelization among those who are engaged in "secular" professions: "Proclaiming the Gospel message to different cultures also involves proclaiming it to professional, scientific and academic circles. This means an encounter between faith, reason and the sciences with a view to developing new approaches and arguments on the issue of credibility, a creative apologetics which would encourage greater openness to the Gospel on the part of all. When certain categories of reason and the sciences are taken up into the proclamation of the message, these categories then become tools of evangelization; water is changed into wine. Whatever is taken up is not just redeemed, but becomes an instrument of the Spirit for enlightening and renewing the world" (Evangelii Gaudium, 132).

I pray that this dream of the Holy Father for professionals in different fields, around the world, be true to your group.

Commending you all to the maternal care of the Blessed Virgin Mary, in the name of the Successor of Peter, I bless you.

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6. Catholic Bishops' Conference of the Philippines
+ Socrates B. Villegas, D.D., Archbishop of Lingayen-Dagupan, CBCP President

It is my distinct honor to greet all the delegates of the 24th World Federation of Catholic Medical Association (FIAMC) as they gather at the Manila Hotel on October 1-4, 2014.
In the face of rapid secularization and the advancement of technology, without consideration of its ethical and moral implications, the world today is in dire need of brave and committed Catholic physicians who are true to their calling of preserving and defending life from the moment of conception until its natural death. With the overwhelming support of government and business institutions which promotes anti-life practices enhanced by wide media coverage, to stand up for life and for truth becomes difficult. You are called to be witnesses by carrying the task of living out a daily martyrdom. There will be no renewal without a bold proclamation of the eternal truths regarding the sacred transmission of human life. Advance a culture of life in your practices. May your gathering strengthen your resolve individually and collectively to always continue to be on the side of life and truth. May St. Gianna Molla, a physician and a mother become an inspiration for you all and may she intercede for you in all your endeavors.

7. Pontifical Council for the Pastoral Assistance to Health Care Workers
Mgr Jean-Marie Mpendawatu, Secretary

8. Catholic Physicians Guild of the Philippines
Dr Manuel M. Po, MD, MPH, President CPGP

The Catholic Physicians’ Guild of the Philippines is celebrating its 78th Anniversary and Annual Convention and at the same time hosting the XXIV FIAMC World Congress. The theme of our celebration "The catholic doctor in an era of secularization and technology" is very relevant in our current practice as a Catholic Physicians. This memorable event focuses on the medical technological and bioethical issues that we should evaluate and weight vis-à-vis our moral and spiritual renewals in our dealings with patients and colleagues.

Let me congratulate the members of the organizing committee for their untiring efforts to ensure the success of this convention. To our speakers, our deepest appreciation for sharing their time and expertise.

To the pharmaceutical industries, and friends of CPGP, we are sincerely grateful for your support and cooperation.

To the officers of FIAMC and Asian Federations of Catholic Medical Associations; thank you for giving us the opportunity to host this event; and most of all, to the delegates of this convention,
warm welcome! Your active sharing and participation is most invaluable for the success of this congress.
Mabuhay and God bless!

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9. Catholic Physicians' Guild of the Philippines, 78th Anniversary, and 2014 Annual Convention
Jocelyn Yambao Franco, MD, Over-all Chair, XXIV World Congress of FIAMC

Mabuhay!
In behalf of the Catholic Physicians Guild of the Philippines (CPGP) allow me to welcome all the delegates to XXIV World Congress of the Fédération Internationale des Associations Médicales Catholiques (FIAMC) in Manila, Philippines. This gathering of the stakeholders in the field of bioethics is a timely occasion for all Catholic physicians to reflect on what has happened, on what is happening and on what the future of the medical practice has in store for us and the communities we serve. There has never been a more appropriate time than today to come together, think together and work together towards a better appreciation of Christ and His healing ministry.

The Philippines, being the beacon of Catholicism in the Southeast Asian region has tried its best to live the teachings of Christ in the many aspects of its peoples' lives. The Filipino environment which hones its citizens has integrated in different ways the essence of Christian living. In particular, medical education in the country has adopted and adapted universal principles in medical ethics as part of medical doctor's professional training and development.

This year, the CPGP has taken the lead in trying to organize this important event. Although limited in resources and manpower, the lean team which worked to make this event possible is undoubtedly blessed with the abundance of God. Allow me to express my deepest and sincerest appreciation to the XXIV FIAMC World Congress Organizing Committee for a job done in praise and honor of the One True Great Healer to whom we owe everything.

This year's theme "The Catholic Doctors in an Era of Secularization and Technology", will encompass experience, expertise and excellence in the ethical practice of the medical profession, a call that must be heeded by all of us destined to live by this vocation. The relevant topics to be delivered by an international bench of leading resource persons and key opinion leaders will hopefully enlighten, enable and empower all of us as we extend ourselves in the service of our communities.
Activities intended to nourish the mind and nurture the spirit have been lined up to ensure a pleasant and memorable experience for all.

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9. Fédération Internationale des Associations Médicales Catholiques (FIAMC)
Dr. Jose Maria Simon-Castellvi, President, FIAMC

"It is my pleasure to welcome you to the Manila FIAMC Congress! I would like you all to enjoy Science, Faith and Friendship. God bless the Catholic Medical Associations and their doctors!
Yours,

10. Message from His Eminence Oswald Cardinal Gracias
Dear Doctors, Fathers, Sisters and all the participants who have come from different parts of the world to attend the XXIV FIAMC World Congress
As High Patron of the XXIV FIAMC World Congress, I am truly delighted to greet each and every one of you at the very start of this important International event organized by the International Federation of Catholic Medical Associations (FIAMC) and the Catholic Physicians Guild of the Philippines (CPGP), here in Manila, Philippines. At the very outset I offer my heartfelt thanks the organizers of this World Congress for all your enormous efforts and hard work in meticulously planning, organizing and executing every detail of this event.
In a particular way, I want to appreciate each of you and the various organizations you represent, for your lives of commitment and dedicated service to the sick, the suffering and the dying and at the same time upholding the principles of the Catholic faith through the practice of medicine, individually and also through the various hospitals and healthcare institutions you serve. You have reached out and touched the lives of so many of our brothers and sisters and strived to preserve their dignity at significant moments of their existence.
The theme of the Congress, "The Catholic Doctor in an era of Secularization and Technology" is very relevant today. Every physician is faced with the many challenges brought about by the rapid scientific and technological advancements and is called to display courage to always stand for the truth. In a particular way, each of you is called to safeguard the sanctity of life and the dignity of every person right from the very first moment of conception. In this regard, Saint Pope John Paul II, in Evangelium Vitae stated "A unique responsibility belongs to health-care personnel: doctors, pharmacists, nurses, chaplains, men and women religious, administrators and volunteers. Their profession calls for them to be guardians and servants of human life. In today's cultural and social context, in which science and the practice of medicine risk losing sight of their inherent ethical dimension, health-care professionals can be strongly tempted at times to become manipulators of life, or even agents of death. In the face of this temptation their responsibility today is greatly
increased. Its deepest inspiration and strongest support lie in the intrinsic and undeniable ethical
dimension of the health-care profession, something already recognized by the ancient and still
relevant Hippocratic Oath, which requires every doctor to commit himself to absolute respect for
human life and its sacredness (1). Catholic healthcare ministry constantly strives to follow the
footsteps of Christ the Divine Healer who went about healing every disease and infirmity. The
challenging mission of the Catholic physician is to reach out to rural and semi urban areas and
slums and ghettos where healthcare services are hardly available, accessible and affordable. In
many parts of the globe, poverty, lack of drinking water, malnutrition, inadequate sanitation,
unhygienic environment and illiteracy are factory responsible for sickness and disease.
Apart from all the curative methods of healthcare undertaken today, what is most needed are
preventive and promotive health strategies and programmes especially for those who lack the
basic necessities of life and those who live in inaccessible areas. In Chapter 53 of his rule book,
St. Benedict wrote that "the greatest care should be taken in receiving the poor, for, in them Christ
is received more particularly than in the rich and powerful". This is the actual meaning of the
Christian life and apostolate, viz., to be at the service of the last, the least and the lost (2). In a
particular way this will also include the most defenseless, that is, the sick, the unborn child, the
child and its mother, the differently abled and the elderly who are life's most defenseless.
Blessed Mother Teresa who served the sick for so many years used to state that "by seeing with the
eyes of Christ, I can give to others much more than their outward necessities: I can give them the
look of love which they crave". Our service to the sick will make a tremendous difference when
we begin to see people with the eyes of Christ and reach out to people with the tender and
compassionate love that Christ had for the sick and dying.
I want to assure each of you of my prayers and good wishes for fruitful deliberations at the
Congress. The Gospel of life is at the heart of Jesus' message (Evangelium Vitae, no.1) and so
may each of us continue to protect, preserve and promote the gift of every human life! Last year,
Pope Francis in his exhortation to the medical professionals stated: "Be witnesses and diffusers of
the culture of life". Your being Catholic entails a greater responsibility; first of all to yourselves,
through a commitment consistent with your Christian vocation; and then to contemporary culture,
by contributing to recognizing the transcendent dimension of human life, the imprint of God's
creative work, from the first moment of its conception. This is a task of the new evangelization
that often requires going against the tide and paying for it personally. The Lord is also counting on
you to spread the "Gospel of Life" (3)
May God bless all of you. May the Blessed Virgin Mary, Health of the Sick, continue to protect us
and intercede for all of us engaged in the apostolate of healthcare.

1. Pope John Paul II, Evangelium Vitae, no. 89
Introduction

On many occasions Saint Pope John Paul II compared the selfless and dedicated service of to the sick and suffering with the attitudes of the Good Samaritan. On the Tenth World Day of the Sick he remarked that "the Gospel parable of the Good Samaritan captures very well the noblest sentiments and response of someone confronted with a fellow human being in suffering and need. A Good Samaritan is anyone who stops to attend to the needs of those who are suffering" (1). The Pope was referring to the countless men and women all over the world who have shown their commitment in the field of health care, such as directors of health care centres, chaplains, doctors, researchers, nurses, pharmacists, paramedical workers and volunteers. Hence, I want to begin this address by expressing gratitude to all these people and in a particular way to all of you who are gathered here for the FIAMC World Congress for your selfless gift of self in service to the sick, the suffering and the dying.

The theme of the World Congress aptly highlights the role, the duty and responsibility of the Catholic Physician in the age of secularization and technology. Undoubtedly secularization coupled with individualism and consumerism is increasingly making a negative impact in the lives of so many people, leading to a loss of the sense of sin and even of the divine, at the cost of the cherished Christian values. We need to search for constructive solutions of awakening people and rekindle in their hearts the longing for Jesus Christ and his message. In November 2012, in a meeting with members of the Pontifical Council for Promoting Christian Unity, Pope Benedict XVI stated that all Christians must face together the challenge of secularization. It is sad that that many people today do not think they need God in their lives. Hence, we need to think of creative ways to attract people to God and rekindle in them a simple and genuine love for the values of the Gospel.

With rapid advancements in science and technology, technological methods too are becoming increasingly ambivalent. The Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation (Donum Vitae) clearly states that “science and technology are valuable resources for man when placed at his service and when they promote his integral development for the benefit of all...thus science and technology require for their own intrinsic meaning, an unconditional respect for the fundamental criteria of the moral law: that is to say, they must be at the service of the human person, of his inalienable rights and his true and integral good according to the design and will of God”(2). Donum Vitae clearly states that science without conscience can only lead to one’s ruin.

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The Gift of Human Life and the Culture of Life Vs. the Culture of Death
Jesus’ mission was to make human life hope filled and fulfilling. Each one of us is called to live an abundant and fruitful life. As Jesus tells us so splendidly in the Gospel of John, I came that you may have life and life in abundance (John 10:10). Thus, human life is a precious gift of God and each one of us has the responsibility to protect it and care for it right from the very first moment of conception to its natural end.

The Catholic Church has always been a strong defender of life in all circumstances. Since the first century the Church has asserted that every procured abortion is a moral evil. The Magisterium has constantly and with increasing frequency spoken in defense of the sacredness of human life. In the Gospel of Life, Pope John Paul II strongly stated that the inviolability of innocent human life is a moral truth clearly taught by Sacred Scripture, constantly upheld in the Church’s Tradition and consistently proposed by her Magisterium (3). He insisted that the recognition of the inviolability of innocent human life is a duty of all people and should be recognized by all. Unfortunately, abortion is rampant across the globe. In today’s secularized society, we face a struggle between the culture of life and the culture of death. Those who are influenced by the culture of death, remove all reference to God from their lives. Once the sense of God is lost, the sense of man is also threatened and poisoned as the Second Vatican Council states: "Without the Creator the creature would disappear... But when God is forgotten, the creature itself grows unintelligible”(4). Consequently, those living in the culture of death can no longer consider human life as a splendid gift of God and as something sacred. We need to reawaken their individual moral conscience and also the moral conscience of society, the thirst for God and consequently a return to the culture of life. As Evangelium Vitae tells us that "it is always from this intimate sanctuary of the conscience that a new journey of love, openness and service to human life can begin”(5). We join Saint Pope John Paul II in making an appeal for a general mobilization of consciences and a united ethical effort to activate a great campaign in support of life and to promote a more human civilization.

Sadly, abortion is one of the most frequently performed surgical procedures and one of the most serious social justice issues of all times. Worldwide, every year, 19 million to 20 million women risk their lives to undergo unsafe abortions, conducted in unsanitary conditions by unqualified practitioners. In India in 2012, there were 620,472 reported abortions and if we include abortions that take place outside the authorized health facilities, the number of abortions performed in India could be 7 million. In India, every two hours a woman dies due to faulty abortion methods (6). Further a study published in the British Medical Journal, The Lancet, estimated that 4 million to 12 million selective abortions of girls have occurred in India in the past three decades (7). The Indian Census results of 2011 have revealed that child sex ratio (0-6 years) in India is 914 girls for every 1000 boys. This shocking scenario is a result of the widespread use of Prenatal Diagnostic tests. In South Asia, the lowest sex ratio rates are found in China and India (8). Prof. Amartya Sen, in his well known article "More than 100 million Women are missing", has demonstrated that during the last century, 100 million women have been missing in South Asia due to "discrimination leading to death" experienced by them from womb to tomb in their life cycles (9).

The New Artificial Reproductive Technologies too present grave ethical problems. In vitro fertilization often involves the deliberate destruction of human embryos. The artificial means of procreation are also chosen by couples for genetic selection of their offspring, but also lead to the destruction of embryos. Dignitatis Personae tells us that it is very unfortunate that “techniques of in vitro fertilization are accepted based on the presumption that the individual embryo is not deserving of full respect in the presence of the competing desire for offspring which must be satisfied”(10). Yet another disturbing phenomenon today is the tendency of many couples choosing to undergo to preimplantation genetic diagnosis after the embryos are formed in vitro, to ensure that only embryos that are free from defects or having the desired sex are transferred in the womb.
Immediately after this diagnosis is done, if the embryo is suspected to have a genetic defect or if the embryo is not of the sex desired, it is eliminated. This is an act of abortion. Dignitatis Personae explains that preimplantation diagnosis is “an expression of a eugenic mentality ... since it presumes to measure the value of a human life only within the parameters of ‘normality’ and physical well-being, thus opening the way to legitimising infanticide and euthanasia as well” (11).

The reproductive technology industry which focuses on artificial methods of giving birth has been forcefully promoting an understanding of reproduction which is both sterile and asexual. Women are being enticed with large sums of money to do something to their bodies that is totally unnatural and potentially life threatening. The commercialization of the human egg has grown as the demand for it has increased. Egg donation has never been studied in any meaningful way to demonstrate its safety. Further, surrogate motherhood is contrary to the unity of marriage and the dignity of human procreation. It fails to meet the obligation of conjugal fidelity and responsible motherhood. Surrogate motherhood is morally wrong. It affects the way people begin to view the birth of children. The affectionate conjugal embrace of husband and wife is the only context that properly receives and protects new life from a number of dangers, including commodification and exploitation. Let us call for a total banning of surrogacy.

In this regard, it is highly imperative to conduct awareness and educational programmes in our schools, colleges, hospitals and institutions, instructing them of the dangers of all these techniques which disrespect and destroy the innocent human embryo in the mother’s womb. At this important Congress, I want to make a wakeup call to all our medical professionals to deliberate and reflect on these important life issues where the fate of human life hangs in balance at the delicate moments at the very beginning of life. We need to work together in solidarity and propose a clear pastoral action plan to educate the consciences of people so that human life is respected and cared for, right from the first moment of conception. It is the duty of each of us to courageously oppose “all those practices which result in the grave and unjust discrimination against unborn human beings” (12).

Having said this, it is important to state that it is not enough to teach the Church’s moral teachings on life issues. We need to also give hope to people and thus, in our pastoral practice, it is important to teach mercy as well. We live in a broken world. And so there are many women who are heartbroken after performing an abortion and suffer from mental distress and abandonment, even decades after the abortion. It is neither helpful nor prudent to shame the women who have undergone an abortion. After a realization of the wrongness of the action, it is the response of mercy that is necessary to gently heal the woman’s wounded heart (13). That is why the crucial words of Pope John Paul II in Evangelium Vitae give us the Christian response. In this inspiring encyclical on life, one of the very significant paragraphs is no. 99 where Pope John Paul II addresses women who have had an abortion. This is what he told them:

I would now like to say a special word to women who have had an abortion. The Church is aware of the many factors which may have influenced your decision, and she does not doubt that in many cases it was a painful and even shattering decision. The wound in your heart may not yet have healed. Certainly what happened was and remains terribly wrong. But do not give in to discouragement and do not lose hope. Try rather to understand what happened and face it honestly. If you have not already done so, give yourselves over with humility and trust to repentance. The Father of mercies is ready to give you his forgiveness and his peace in the Sacrament of Reconciliation (14).

The Sanctity of Life and Manipulation of Technology through Stem cell Research

Every authentic progress in this field is to be encouraged, provided that it always respects the rights and dignity of the person from his or her conception (15). Indeed, no one can claim the right to destroy or indiscriminately manipulate the life of the human being. All those who work in the healthcare need to realize that they are putting themselves at the service of life. Pope John Paul II aptly stated that the Church appreciates the efforts of those who, by engaging in research or treatment, help to improve the quality of the service offered to the sick. However, it is of great

necessity, with regard to medicines, treatments and surgical operations, for clinical experimentation to be conducted with absolute respect for the individual and with a clear awareness of the risks and, consequently, of the limits involved. In this important area, Christian medical professionals are called to bear witness to their ethical convictions and to be constantly enlightened by faith (16). According to Dignitatis Personae, “research initiatives involving the use of adult stem cells, since they do not present ethical problems, should be encouraged and supported” (17). Hence, Dignitatis Personae reiterates that “methods which do not cause serious harm to the subject from whom the stem cells are taken are to be considered licit. This is generally the case when tissues are taken from: a) an adult organism; b) the blood of the umbilical cord at the time of birth; c) fetuses who have died of natural causes. The obtaining of stem cells from a living human embryo, on the other hand, invariably causes the death of the embryo and is consequently gravely illicit: research, in such cases, irrespective of efficacious therapeutic results, is not truly at the service of humanity” (18) and presents serious problems from the standpoint of cooperation in evil and scandal (19). Researchers should never use wrong means to achieve good ends. Even if the embryonic stem cell research would be of great benefit to many suffering from various diseases, it cannot be carried out at the cost of destroying human embryos. In this regard, Pope Benedict gave clear insights as follows:

Scientific research provides a unique opportunity to explore the wonder of the universe, the complexity of nature and the distinctive beauty of life, including human life. But since human beings are endowed with immortal souls and are created in the image and likeness of God, there are dimensions of human existence that lie beyond the limits of what the natural sciences are competent to determine. If these limits are transgressed, there is a serious risk that the unique dignity and inviolability of human life could be subordinated to purely utilitarian considerations. But if instead these limits are duly respected, science can make a truly remarkable contribution to promoting and safeguarding the dignity of man: indeed herein lies its true utility. Man, the agent of scientific research, will sometimes, in his biological nature, form the object of that research. Nevertheless, his transcendent dignity entitles him always to remain the ultimate beneficiary of scientific research and never to be reduced to its instrument (20).

The Mission of the Catholic Physician to the Patients: Trust building, Solidarity, love and Service

The central mission of the Catholic physician in healthcare is reaching out in solidarity, care, compassion and love to the sick and suffering. In the Apostolic Exhortation Christifideles Laici, Pope John Paul II stated: “In the loving and generous acceptance of every human life, particularly if weak or sick, the Church is today living the basic moment of her mission” (21). A relationship of trust is of paramount importance in the doctor-patient relationship. When a patient trusts a doctor it means that the patient is convinced that the doctor will not only take interest in the well-being and health of the patient but will provide the most appropriate treatment and the necessary medical care (22). Every medical professional knows that in order to have a sound medical practice, it is essential to earn and be worthy of the trust of the patients. I would like to reproduce here some words of advice to physicians: “A doctor’s duty is to serve with love and empathy: he is called to lovingly serve the sick. If this is absent, then there is no main engine, no ‘soul’ and ‘heart’. Then everything degenerates and medical practice becomes an abstract application of concepts of disease (morbns) and medication (medicamentum) to a patient. But in reality patients are not abstract ideas consisting of abstract symptoms: they are living beings, soulful and spiritual and suffering; each is quite individual in the makeup of his or her body and soul and totally unique in his or her illness. This is how a doctor must see the patient, understand the patient, and

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18. Congregation for the Doctrine of the Faith, Dignitatis Personae, no. 32.
19. Congregation for the Doctrine of the Faith, Dignitatis Personae, no. 32.
20. Pope Benedict XVI, Address to participants in an international conference on stem cell research, 14 Nov 2011, Vatican City.
treat the patient”(23). When a patient realizes that the medical professional is listening to him, an atmosphere of trust is gradually formed. Other important aspects of trust building are the confidentiality maintained by the doctor and the informed consent obtained from the patient before any medical intervention is carried out.

Disclosure of Facts and Management of Bad News:
The patient on his or her part must disclose all the necessary details of the illness to the doctor including the symptoms and any past illness or disease. The medical professional on his or her part is to inform the patient of the actual illness the patient is suffering from. Many times the telling of truth to the patient becomes very challenging, especially if it is a difficult truth to be told to a dying patient. At times the patient may not be psychologically prepared or may be too fragile to receive the truth. On the one hand the patient has the right to be informed of his medical condition. On the other hand, the duty of being truthful with terminally ill patients, dying patients and patients who are not ready to bear the weight of the truth, requires a lot of discernment and human tact on the part of the medical personnel (24). Hence, it is suggested, that at times it is preferable to tell the patient the truth according to prudent graduality, “over a span of time and not in one shot affair”(25). The Pontifical Council for Pastoral Assistance to Health Care Workers explains this well: There is a need to establish a relationship of trust, receptivity and dialogue with the patient, seeking the appropriate time and words. There is a way of speaking that is discerning and respectful to the patient’s moods and it should be in harmony with these. There is a form of conversation wherein questions are tactfully handled and even provoked; so that the patient is gradually brought to an awareness of his condition. If one tries to be present to the patient and sensitive to his lot, one will find the words and the replies which make it possible to communicate in truth and in charity: “giving the truth in love”(26).

Challenges faced by our Catholic Healthcare Institutions
The outstanding commitment of the Catholic Church to the sick, the suffering and the dying is noteworthy. Throughout the world the Church is known for its healthcare apostolate. From the Church’s earliest days, some Christians as part of their witness to the Faith, committed themselves to the care of the sick. For example, Saints Cosmas and Damian, both physicians, who reached out in care and compassion to the sick, were both martyred for the Faith (27). On the occasion of the 11th World Day of the Sick, Pope John Paul II emphasized that “Catholic Hospitals should be centres of life and hope, where, together with the chaplaincies, ethical committees, the training of lay healthcare staff, the humanization of care and treatment of the sick, care for their families and a special sensitivity towards the poor and the marginalized should also grow. Their professional work should be expressed in a concrete way in an authentic witness of charity, bearing in mind that life is a gift of God, of which man is only the administrator and guarantor”(28).

All those engaging themselves in the healthcare ministry are sharing in Christ’s mission of love. In developing countries like India, there has been a lot of progress in the field of healthcare. There is a steady growth in the number of healthcare professionals and healthcare facilities. However, a majority of the people lack the basic minimum requirements for having good health and quality healthcare. These requirements include food, nutrition, safe drinking water, sanitation. Hence, health for all still seems to be a distant goal (29).

The following are some of the important areas in which our Catholic Healthcare Institutions need to persistently pursue to make themselves relevant in the healthcare apostolate:
To continue reaching out to the marginalized (especially in rural and tribal villages) and providing them with medical care and facilities (such as nutritional support to poor children and expectant mothers)
To continue conducting awareness and outreach programmes for healthcare providers as well as for

26 Pontifical Council for Pastoral Assistance to Health Care Workers, Charter for Health Care Workers, no. 126.
people on various issues in medicine (such as antenatal care, prevention of diabetes, prevention of communicable diseases, HIV/AIDS care to infected children) and issues in preventive health for the communities at the grass root (such as sanitation and water problems)
To continue endeavours to make primary healthcare more accessible and more affordable
To continue providing spiritual care services in our Catholic Healthcare institutions
To continue providing home based care to infants and children and to others where hospitalized care is difficult
To continue training community health care workers to run home based health care
To continue improving our healthcare institutions with telemedicine facilities and training programmes to use these modern methods
To keep on urging our medical professionals to serve in rural areas.
To continue collaborating with the government on various issues of health and make healthcare affordable and accessible
To constantly adhere to and promote the Church’s ethical teaching in its healthcare institutions

Secularization and the Truth of the Gospel
Secularism claims that religion is merely a private matter. Materialism creates a false sense of hope that we alone can fulfill our own needs. And individualism leads to destructive forms of freedom and autonomy (30). Hence, we need to first of all reaffirm the fundamental belief of the Church and our own belief that the key, the center and the purpose of the whole of human history is to be found in Jesus Christ, our Lord and Master (31). Without God, our deepest needs cannot be fulfilled. Without God, who alone bestows upon us what we by ourselves cannot attain (cf. Spe Salvi, 31), our lives are ultimately empty. We need to be constantly remind to cultivate a relationship with Christ who came that we might have life in abundance (cf. Jn 10:10).”(32). Second, we need to commit ourselves to the task of the new evangelization “to find the adequate means to repropose the perennial truth of the Gospel of Christ”. We need to be that leaven where the faith has gone flat and that salt where the faith has lost its zest (33). It is in this way that we become “an instrument of his presence and action in the world”(34).

Joyfully accepting one’s Suffering is the Way to Christian Redemption
Human suffering is a complex phenomenon and an enigma that is not easy to understand. Surely, each of us has undergone suffering in some way or another. Every newspaper, journal, television channel is replete with so many instances of suffering in various forms. Sometimes suffering is so excruciating or painful, either physically or psychologically, that the person undergoing it may unfortunately even question the existence of God. Perhaps the most difficult question about suffering is the question of innocent suffering. There are no easy answers to the why of human suffering.

In today’s secularized world, there are many who cannot bear any pain and still many others who desire to run away from the slightest pain the get. Still others compare their pain and suffering with others and wish they had a lighter cross. Hence, there is a tendency today to eliminate suffering from human experience. This is exactly what Pope John Paul II meant in his Encyclical Evangelium Vitae when he said: “All this is aggravated by a cultural climate which fails to perceive any meaning or value in suffering, but rather considers suffering the epitome of evil, to be eliminated at all costs. This is especially the case in the absence of a religious outlook which could help provide a positive understanding of the mystery of suffering”. According to the Pope, many people wish to resolve the problem of suffering by removing it totally.

The Christian response to the mystery of suffering is one of hope as it is a way that leads to God. The person of Jesus Christ, his suffering, death and resurrection is God’s answer to human suffering. God did not come to eradicate suffering and not even to explain it but to fill it with his presence(35). God does not abandon us in our agonizing moments and times of suffering. He is

31. Second Vatican Ecumenical Council, Gaudium et Spes, no. 10.
34. Congregation for the Doctrine of the Faith, Doctrinal note on some Aspects of Evangelization (December 3, 2007) 1.
35. M.A. Monge, “La sofferenza nella malattia: Alcuni punti chiavi per aiutare gli ammalati a viverla in modo sano”, Dolentium
sensitive to every form of human suffering. It is only faith in God that can help us encounter the reality of suffering. By accepting our suffering, we associate ourselves with the suffering of Christ and in doing so gain redemption. Thus, it is in Christ that all human suffering takes on meaning. In Salvific Doloris, Pope John Paul II puts it quite well: “In bringing about the Redemption through suffering, Christ has also raised human suffering to the level of the Redemption. Thus each man, in his suffering, can also become a sharer in the redemptive suffering of Christ”(36).

Those who are suffering can meet Christ in their suffering and he will give them joy and happiness then never experienced before. Each one of us is invited to experience the meaning and value of our own suffering, and in doing so be able to see the meaning in the suffering of others, especially the terminally ill and dying patients.

Sadly, those who are influenced by secular culture, support doctors to end the life of a patient who is suffering from an incurable disease, by some so called painless procedure. Pope Benedict in his encyclical Spe Salvi observed that “a society unable to accept its suffering members and incapable of helping to share their suffering and to bear it inwardly through ‘compassion’ is a cruel and inhuman society”(37). The assisted dying bill recently discussed in the United Kingdom would allow individuals to participate actively in ending others’ lives. It would allow doctors to supply lethal drugs to people whom they have diagnosed as terminally ill and whom they believe to have 6 months or less to live, so that the drugs could be used for the purposes of suicide. The Supreme Court of India too has recently started debating on euthanasia by issuing notices to state governments for their responses on the validity of mercy killing. The US state of Oregon, on which the England and Wales bill is modeled, has permitted assisted dying since 1997. Last year, 122 dying Oregonians were given life-ending prescriptions; 71 took life-ending medication and died(38). Towards the end of December 2013, Belgium became the first country to allow euthanasia for incurably ill children, namely children afflicted with “constant and unbearable physical suffering” and equipped “with a capacity of discernment”(39). However, the written approval of their parents is needed. Such type of legislations poses a real threat to the ongoing need of end-of-life care and we must work together in solidarity to oppose such threats to human life. Some people in New Zealand too have threatened to reintroduce an end of life choice bill which fell through in the year 2012. It is not acceptable to deliberately put an end to the lives of the disabled, the sick and the vulnerable (40). The Second Vatican Council noted that “euthanasia and willful suicide” are "offenses against life itself" which "poison civilization"; they "debase the perpetrators more than the victims and militate against the honor of the creator"(41). The Catechism of the Catholic Church instructs us that “it is God who remains the sovereign master of life. We are the stewards, not owners of the life God has entrusted to us. It is not ours to dispose of”. Accepting the suffering that comes with illness, old age and the process of dying can render a person more mature, help him to discern in his life what is not essential in order to turn himself to what is more essential. Very often illness provokes a search for God and a return to him (42).

Conclusion
Living today in an age of secularization and technology, the challenge of contemporary medicine is to provide treatment to patients that respect the dignity of the human person. Every human being is created in the image and likeness of God and hence human life is of inestimable value. Each one of us has been given a sublime dignity, based on the intimate bond which unites us to God our Creator. In each of us shines forth a reflection of God himself (43). All those involved in the practice of medicine and research are called to display their human qualities of love, care, compassion, understanding and concern to those under their care. Every human must be treated humanely’. When this is applied to health and health care, it paves the way for the humanization

42. The Second Vatican Council, Gaudium et Spes, The Pastoral Constitution on the Church in the Modern World, no.27.
43. Pope John Paul II, Evangelium Vitae, no. 34.
of health, which constructs at a deep level "that civilization of love and life" without which the existence of individuals and society loses its most authentic human quality (44).

Unfortunately, as a result of scientific and technological advances, many people do not find the need for God in their lives. Due to heavy reliance and dependence on technological devices, gadgets and medical procedures, God is slowly removed from their lives. In such a perspective, unfortunately even people are treated as numbers and as something and not someone with a name and dignity. This phenomenon can lead to a desacralization and dehumanization of the sacred gift of human life. Technology has value in so far as it serves the sick. However, it risks becoming a tool if it limits itself to the service of science (45). Bio-medical progress should not in any way lead to the dehumanization of the health and health care (46). Disrespect for human life leads to the evils of abortion, euthanasia, assisted suicide. God’s hand in all healing can easily be obscured by naturalistic explanations of disease and natural models of care.

The well-being of a patient goes beyond just physical health and should include a holistic interpretation of body and soul, which can only be separated by death. The challenge of healthcare is not only to treat the illness but also to bring about a spiritual transformation of the suffering persons. According to Hippocrates, illness is not only seen “as a physical-chemical event brought about by specific causes but also as a disturbance of the essence of man in his totality” (47). Pope Benedict aptly remarked: It follows that dialogue between science and ethics is of the greatest importance in order to ensure that medical advances are never made at unacceptable human cost. The Church contributes to this dialogue by helping to form consciences in accordance with right reason and in the light of revealed truth. In so doing she seeks, not to impede scientific progress, but on the contrary to guide it in a direction that is truly fruitful and beneficial to humanity (48). Science and technological progress ought to enhance the formation of relationships that support and sustain a person in love and empathy (49). Fostering a culture of life is an imperative, since the Gospel of Life is at the heart of Jesus’ message. The Church is called to proclaim the Gospel of life in love. This vision for a new culture is based on respect for each person as a living image of God. Can we be bold and faithful proclaimers of the Good News of the culture of life?

We must not give into discouragement and not lose hope. Each of us is encouraged to work together to build a “civilization of love” founded on the universal values of peace, solidarity, justice and liberty, in response to the culture of death. May Christ the Divine Physician continue to inspire us, guide us and show us the way, the truth and the life!
Formation of a Catholic Physician
Fr. James Mc. Tavish, MD, FMVD, FRCSEd, STL (Philippines)

Abstract
What makes a physician “Catholic”? Catholic physicians have Jesus as their model - he is both the “Good Doctor” yet present in every patient. However many physicians struggle to meaningfully integrate their practice of faith and medicine. To enjoy their work Catholic physicians should cultivate an interior space for Jesus especially amidst their busy schedules. A medical career without Jesus at the center soon proves to be soulless - “Remain united to me and you will bear much fruit, but cut off from me you can do nothing” (John 15:5). Some Catholic physicians bear much holy fruit yet in our country millions of poor Filipinos still lack access to even basic medical care. Why are we so far from a truly “Catholic” healthcare system despite having so many “Catholic” physicians, nurses and hospital administrators here in the Philippines? Catholic physicians should not only consider their career path and salary but also their prophetic mission to be a powerful voice for change. Physicians living out their Catholicism can be a vital force for good in society especially in working for a more just and accessible health care system.

Slides
1. Christ the good Doctor
2. Christ as patient: I was sick and you healed me (Matthew 25:36)
3. “The ability to cultivate an interior space” (Evangelii gaudium, n. 262)
4. Scottish soup
5. 154 stitches?
6. Key areas... Catholic health system, No Euthanasia ...
7. Bell’s, blended scotch whisky
8. In Scotland, on one day:
   • Alcohol will cost Scotland $160 million in terms of health, violence and crime
   • Alcohol will kill five people
   • 98 people will be admitted to hospital with an alcohol related condition
   • 450 victims of violent crime will perceive their assailant to be under the influence of alcohol.
9. Shout out
10. We have catholic physicians, catholic nurses, catholic patients, catholic hospitals, etc. But we do not have a CATHOLIC healthcare system.
11. St John Paul II: “How can it be that even today there are still people... lacking the most basic medical care?”
12. Dr Philip Nitschke suspended from the medical register for helping a 45yr old man to die. He said “It will make no difference to what I do.”

13. St Paul: “Proclaim the Word in season and out of season” (see 2 Tim 4:1-5)

14. Mother Mary helps us to live out the full dignity and calling of being Catholic. We pray for all Catholic physicians that they can enjoy their vocation to become more and more like Jesus, the “good Doctor”.


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Curriculum Vitae

Fr James McTavish is a Scottish missionary priest with the Verbum Dei Catholic missionaries, an international missionary order, founded in 1963 in Spain by Fr Jaime Bonet. He studied Medicine at Cambridge University, England and qualified as a Medical Doctor aged 24 years old. He worked as a surgeon becoming a Fellow of the Royal College of Surgeons of Edinburgh in 1997. He then specialized in Plastics and Reconstruction although he says his own beauty is natural. In 1999, he heard the call of the Lord to heal the Body of Christ through evangelization? “Give me life by your Word” (Psalm 119). He did his novitiate in Cebu, Philippines and later went on to study Moral Theology and Bioethics in Rome graduating Summa Cum Laude in both before returning to Manila in 2008 to work as Novice Master and teach Morality and Ethics in various universities and theological faculties. He has published over 30 articles in local and international journals and has written two books, one of which “Choose Life!” - theological reflections on current moral issues - is available today.

Formation of a Christian Doctor

*Dr. Etienne Gaisne (France)*

**Abstract**

Christian physicians are facing two important challenges in their professional lives, which arise with the desire to be consistent with the Church’s Doctrine and to be excellent practitioners.

In one hand, because of the lack of anthropological bases during their studies, they may have judgment difficulties whilst applying technical protocols.

In the other hand: because they work a lot and most of the time they are alone, they abandon their deep desire to be Christian doctors. Knowing this, Love & Truth Doctor (Apostolic branch of the Emmanuel Community) has been providing two concrete solutions to overcome these challenges:

1. International annual meetings, targeting medical students, with the objective of:
   - Providing the basis of ethical questions
   - Experiencing the Grace and Mercy of Jesus
   - Sharing their experience about their medical universities.

2. Regular local meetings, with the objective of:
   - Increasing the sharing, both professional and spiritual, between students / young Christians and senior doctors
   - Helping everyone to live as a witness of God
1. Formation of a Catholic Physician - Love and Truth Doctors (Etienne Gaisne, M.D. France)

2-3. This is where the story begins:
   • In France, medical students lack anthropological bases during their studies
     Problem: they may have judgment difficulties whilst applying technical protocols.
   • During the professional life, physicians work a lot, and most of the time they are alone
     Problem: they abandon their deep desire to be Catholic doctors

4. Here are the 2 challenges to overcome
   • How to provide students with a solid Catholic education for the formation of their judgment?
   • How to support physicians to be faithful to their convictions and to the Church Teaching?

5. Our proposition: Love and Truth Doctors
   • Created in 1980
   • Pastoral and apostolic branch of the Emmanuel Community
   • For the benefit of couples, families, and for respect for human life
   • Since 2007, specific activities for doctors, house physicians and medical students, have been organized in the light of reason and of the Catholic faith
     - 24 countries in the world
     - 206 members in Europe (145 in France)

6. Why is L&T Doctors existing for? L&T Doctors support physicians and students:
   • For training & sanctification
   • For service to the sick with human life respect
   • For the health progress in complete respect of human well-being

7-8. To overcome these 2 challenges, L&T Doctors has provided 2 solutions:
   • International activities for students education:
     - International Seminar of Doctors and Medical Students,
     - Participation to the Bioethics Seminars
     - Partnership with FIDESCO (NGO)
   • Local activities for physicians:
     - Regular doctors’ fraternity
     - Punctual pilgrimages and informal meetings

9-15. International activities for students education - Seminars
   • Annual International seminars of Doctors and Medical Students have been organized by L&T Doctors since 2008 in Paray-le-Monial
   • This is a specific place which offers the possibility to:
     - Experience Jesus-Christ merciful
     - Take time to receive the Teaching of the Church
     - Learn from the testimony of others involved in medical activities
   • Paray le Monial France: In the 17th century, St. Marguerite-Marie received revelations from Jesus Christ: «This sacred Heart appeared to me as a shining sun of blinding light whose burning rays fell straight on my heart»
   • How does it work?
     - During 2.5 days
       - Plenary session teaching and discussion
       - Workshop
       - Prayer and praise
       - Testimony
       - Mass and adoration
   • 2008 : Medecine and holiness, is it possible?
   • 2009 : With Christ, all together for the service of life
   • 2010 : Catholic doctors, which guidelines ?
   • 2011: In the footsteps of Christ doctor
   • 2012: How to shape our being as Christian physician
   • 2013. Take care of him (Luke, 10,35)
   • 2014: Who is the Man that You are mindful of him?
15-19. International activities for students education - Seminars: The Virtues
(according to Father Pascal Ide)

- **Intellectual virtues**: - adequate medical practical formation,
  - real scientific interest,
  - excellent formation in medical knowledge
- **Cardinalis virtues** (since Aristote & Platon)
  1) Prudence of healthcare - the universal and the singular
     - ends and means
     - conviction and responsibility
     - deliberation and decision
     - the implementation and fruition
  2) Justice of doctor - Justice to the patient
     - Justice to colleagues
     - Justice to the institution
  3) Temperance, Moderation of passions and desires
  4) Courage
- **Theological virtues**
  1) The faith of the physician: Faith in general, The specific doctor’s faith
  2) The hope of the physician: Human trust, The specific expectation of the physician
  3) The charity of the physician: Charity of Jesus, The specific medical charity

20. International activities for students education – Seminars
- Mass, Workshop, Testimony, Adoration

21-22. International activities for students education - Bioethics
- Participation to the International Seminar of Bioethics
  - Every year Since 2001
  - 3 days in Paray le Monial, 8-10th Nov 2014
  - Loving Life... until what point? In acts and in truth

23. International activities for students education - NGO
- Partnership with FIDESCO, NGO: In India, In Africa

25 (7-8) To overcome these 2 challenges, L&T Doctors has provided 2 solutions:
- International activities for students education:
  - International Seminar of Doctors and Medical Students,
  - Participation to the Bioethics Seminars
  - Partnership with FIDESCO (NGO)
- **Local activities for physicians**:
  - Regular doctors’ fraternity
  - Punctual pilgrimages and informal meetings

26. Challenge 2: How to support physicians to be faithful to their convictions and to the Church teaching? and How to allow young doctorsto stay in touch with established physicians?

27. Doctors’ fraternity
- 6 to 10 physicians (private, public, generalist, specialist, government medical service) animated by 2 members of the Emmanuel community
- Every two months:
  - Evening time
  - Praise and prayer
  - Listening to the Word of the Lord
  - Sharing “what is the word of the Lord in my daily life at work?”
  - How can I share Christ’s joy in my work?

28-30. Doctors’ fraternity – Testimonies: Vincent C, general physician in the south part of France

31-32. Informal meetings
- God’s paternity by a psychiatrist
- So what?
  - Students, young doctors and senior physicians together
- Sharing a time of praise, prayer, intercession and sharing testimony
- Every 6-8 weeks

33-34. Something to take away?
• Fruits from our meetings
  - Joy of being supported and praying together (adoration)
  - Share in trust (compassion)
  - Renewal of the joy of practicing his profession
• Our learnings
  - Diversity in medical practices: private-public, generalist-specialist
  - Being humble with colleagues
  - Learning to pray to Jesus not only during difficulties
  - Desire to invite other doctors (evangelisation)
  - A real Fraternity in CHRIST, The Saviour

35. Thank you for your attention. May God bless you all

Curriculum vitae
French orthopedic surgeon specialised in hand surgery, member of the French Orthopedic and Hand Surgery Societies. Member of the Emmanuel Community since 1982, and active consultant of its Ethics Committee.

IV. Session 2
Medical Education

Medical education in the shadow of ‘stealth euthanasia’ among Catholics: Are we fighting secularism or heresy? (50)
George Isajiw, MD, KM (USA)

Abstract
Experience has shown a rapidly increasing trend towards the acceptance of euthanasia in Catholic health care institutions, which Pope Francis has termed "stealth euthanasia". This is often justified by a false application of the principle of double effect and patient autonomy, as well as an improper interpretation of Church teaching about "ordinary and extra-ordinary" treatments, such as medically assisted nutrition and hydration (MANH). Examining possible causes of this erroneous acceptance of a "choice of death" as a valid clinical decision by both patients and physicians, it is not enough to recognize the influence of secularism to explain it, since it's practice is increasing among those who sincerely consider themselves deeply committed Christians. An analysis based on actual case histories suggests a heretical concept of the meaning of death and life after death. An examination of this question from the perspective of Faith and Science will be presented, based on the firm Christian ethical principle that there can be no conflict between them.

50. The Linacre Quarterly 82 (3) 2015, 210–216. This is a modified version of a paper presented at the XXIV Congress of the World Federation of Catholic Medical Associations (FIAMC), Manila, Philippines, October 2, 2014.
I would like to dedicate this talk to the memory of Dr. Gino Papola, past president of FIAMC, who introduced me to the Catholic Medical Association and was my mentor for forty years. When Gino died in December of 2011 at the age of ninety-one, I felt like an orphan. Dr. Papola loved to teach by discussing case histories, and as those of you who knew him will recall, he often told humorous stories to illustrate his point. One such story was about a physician who died and approached St. Peter at the Pearly Gates, wearing a white coat and a stethoscope around his neck, confident that he had led a good life and would easily enter Heaven. However, St. Peter stops him from entering and directs him to a long line of physicians who are undergoing extensive questioning by a committee of angels. Observing that other souls who are not doctors are entering the Pearly Gates without waiting in line, he asks St. Peter why doctors are being treated differently.

St. Peter answers with a quote from the Gospel of Luke (12:48): “From everyone who has been given much, much will be demanded, and from the one who has been entrusted with more, much more will be asked!” Still awaiting his turn hours later, he suddenly sees an elderly bearded man wearing a shining white coat and a stethoscope around his neck walking right past St. Peter and entering the Pearly Gates. He angrily runs over to St. Peter and demands an explanation. “Oh Him?” answers St. Peter calmly, “I do not have any control over Him. He is God the Father returning from earth where he occasionally goes in order to play doctor!”

Terri Schiavo, also known as “Theresa of the Forgotten”, was martyred by a process called “stealth euthanasia”, or, as our Holy Father Pope Francis refers to it, “covert euthanasia” (Abbott 2013; Bergoglio and Skorka 2013; Colegrove 2013). This form of euthanasia victimizes thousands of patients under the guise of modern so-called “end-of-life care”. My experience, of course, is only in the United States, but it is done all over the world. Terri Schiavo became perhaps the best known case of death by dehydration and starvation. Consider how labels can be lethal: This non-terminally ill, brain damaged woman was classified by modern medicine as being in a “persistent vegetative state.” Terri Schiavo died on March 31, 2005, at forty-one years of age, after fifteen years of being sustained by tube feeding. After tube feeding was stopped, it took thirteen days for Terri to die with excruciating pain and suffering, as was witnessed by Father Frank Pavone of Priests for Life, who was the only nonfamily member permitted to be at her bedside. Unlike most victims of this type, she was not even given morphine to alleviate the pain of dehydration because that would have been inconsistent with the erroneous claim that so called “persistent vegetative state” (PVS) patients are not conscious and cannot feel pain (Terri Schiavo Life & Hope Network).

You might ask why have I singled out Terri’s case when such cases occur daily around the world, especially in elderly patients who have suffered a stroke or have advanced dementia? Her case is legally important in the United States, because when our Supreme Court failed to protect Terri’s life, this form of stealth euthanasia came to be considered a private medical-treatment decision between a physician and a patient. Just as in the abortion ruling in 1973, these patients cannot be protected by the courts.

Committing stealth euthanasia by withholding food and water from patients who are not dying but merely have their ability to eat and swallow impaired, such as victims of stroke, dementia, Parkinsonism, etc., is only the tip of the iceberg. It is often claimed that a PEG (percutaneous endoscopic gastrostomy) tube does not offer any benefit because it does not cure or improve the disease process itself. These patients are inappropriately referred to hospice as if they were, in fact, dying. And of course, it becomes a self-fulfilling prophecy when they die from dehydration and malnutrition. It is claimed that the so-called evidence-based medicine shows that tube feeding does not prolong life, because only 50 percent of the patients in one study survived for more than one year. Of course, that is an oxymoronic conclusion because without the feeding tube, 0 percent would have survived. Those who died did not die from complications caused by the feeding tube, but died from their co-morbidities. However, clinical experience and recently published studies in Israel (Glick and Jotkowitz 2013; Shapiro and Friedmann 2006) have shown stable, thriving patients at three years and beyond. Could it be that the Israelis have more respect for the sanctity of life of their elderly patients than the so-called Christian West?

Another form of stealth euthanasia is commonly seen in the terminal patient, who is, in fact, dying and requires palliative treatment with narcotics and sedatives. Narcotics commonly suppress feelings of thirst and hunger, and the patient becomes dehydrated if there is no provision of intravenous or nasogastric tube supplementation of fluids. Soon the patient suffers more pain and
discomfort from the dehydration itself, and instead of treating with hydration, increasing doses of morphine are given to alleviate these symptoms. In the presence of a low fluid volume, the vasodilating effects of the narcotics cause hypotension, and death is hastened. This is often justified by an erroneous application of the principle of double effect. In a well-hydrated patient, narcotics will not hasten death, and there is no reason why both hydration and narcotic treatment cannot be utilized at the same time. Further, double effect is justified only if there is no other means available to avoid the bad effect, whereas providing fluids is a readily available, ordinary medical treatment.

Another form of stealth euthanasia is common in hospice programs, where the stated principle of care is supposed to be both to avoid prolonging life by extraordinary means and to avoid hastening death. Death is, in fact, often hastened by the denial of ordinary treatments, which, besides withholding hydration, often also include stopping all beneficial medications such as insulin and medications which control congestive heart failure (Mallon 2009; Panzer 2011–13). Perhaps the most egregious form of stealth euthanasia in some hospice centers is the denial of ordinary treatment for readily reversible temporary co-morbidities, such as antibiotics for curable infections and denial of fluid replacement in reversible cases of gastroenteritis.

Now let’s turn to the big question which needs to be confronted: Why is the practice of stealth euthanasia just as common in many Catholic healthcare institutions as it is among secular healthcare providers? Why is the withdrawal and withholding of ordinary medical treatments routinely approved by Catholic ethics committees and justified by many Catholic ethicists and theologians? And what can be done to reverse this trend?

Of course, there may be multiple reasons, but let us assume for the purposes if this discussion that all of these erroneous decisions are made in good faith with a sincere desire to benefit the patient. Other motivations, such as healthcare rationing, reducing costs, and attempts to reduce the burden of care for families and caretakers will not be discussed at this time.

Two case histories from my own experience in a Catholic hospital can give us some insight. A woman on the hospice service with very painful terminal pancreatic cancer was receiving an intravenous morphine drip but without any intravenous hydration. She was experiencing muscle cramps due to dehydration and electrolyte imbalance over and above the pain of the cancer itself. The morphine dose was being increased. I offered to write IV orders, which could have corrected the cramps, but was told that hospice policy did not permit intravenous hydration. It seemed to me that since she already had an intravenous line for the delivery of the morphine, that hydration and correcting electrolyte imbalance would constitute ordinary beneficial treatment, consistent with good palliative care. The charge nurse refused to carry out my order because, in her words, “it would make the patient live longer and thus prolong her suffering.”

In another case, a patient with lung cancer who was not yet in a terminal stage was placed on a ventilator for a reversible bacterial pneumonia, which was improving and successful weaning was anticipated in several days. His wife demanded that his life support be immediately removed because she would rather see him die now than recover from this episode and face a painful death from his cancer in the future. The Catholic ethics committee agreed with her position and justified it by declaring that the ventilator treatment was extra-ordinary care and that the wife had a right to make the decision based on the principle of substituted judgment and the principle of autonomy. In the presence of the authority of a Catholic priest-theologian and a religious nun, my ability to convince the wife otherwise was greatly diminished, and I had to recuses myself from providing further care for this patient.

Again, I believe that the nurse from the first case, and the wife, the priest, and the nun in the second were, in fact, convinced that they were acting in the best interest of their patients. What was going on here? Was I guilty of playing God for trying to prolong the life of these two patients who both had a poor prognosis due to untreatable cancer, or were the nurse and the ethics committee guilty of stealth euthanasia? Remember that along with the Church’s strong condemnation of all forms of euthanasia, put forward in the Declaration on Euthanasia in 1980 (CDF 1980), is the recognition that euthanasia decisions are often made for sincerely compassionate reasons and with good intentions. And yet the prohibition against any form of euthanasia, regardless of good intent, is one of the strongest and uncompromisingly absolute teachings of the Church, equal to the prohibition against abortion.

Here again, is where Dr. Gino Papola has given me some insight. He presented a case history of an elderly woman who was brain damaged as a result of a stroke, who could not talk, received tube feedings, and appeared to be unconscious most of the time. Just like in the case of Terri Schiavo,
there was much talk about whether the feeding tube had become “extra-ordinary” treatment and whether it could be discontinued. One day, when Gino was making rounds, this Italian woman suddenly sat up, cried out “Deo Mio”, went into cardiac arrest, and died. It was a moment of revelation for Dr. Papola. It appeared to him that this was the moment that this elderly woman had “made her peace” with God. What if, Gino would say, this woman had died prior to “making her peace with God,” and what effect could that have on her individual salvation? Especially what if her death was precipitated by the intentional will of her doctor, rather than the Will of God? Would not that be exactly what is meant by the expression “physician playing god?”

Well if we analyze this case through the eyes of faith—we have to ask this question: if, through the workings of Divine Providence, this woman’s road to heaven required her to be in this prolonged state of diminished consciousness before her soul was ready to depart to face a favorable final judgment—would the outcome of that individual judgment have been altered by hastening her death through an act of stealth euthanasia? Would an intentional act to hasten her death have prevented unnecessary suffering, or could it actually add to her suffering? Of course, we cannot answer that question based on any scientific “evidence-based medicine,” but we can look at the teachings of the Church and draw certain conclusions. But first, we must admit that there also is no scientific “evidence-based medicine” which disproves the possibility of suffering after death. Through the eyes of Revelation there exists the possibility that any attempt on our part, no matter how well intentioned, to shorten our patients’ suffering by hastening their death may actually have the unintended consequence of increasing the possibility of their suffering after death.

Let me quote from Canon XXX, Session VI, of the Council of Trent, January 13, 1547: “If anyone says that after the reception of the grace of justification the guilt is so remitted and the debt of eternal punishment so blotted out to every repentant sinner, that no debt of temporal punishment remains to be discharged, either in this world or in Purgatory, before the gates of Heaven can be opened, let him be anathema” (Schouppe 1986, vi).

Most importantly, this canon applies to those who have received the “grace of justification” — those who have, in fact, been redeemed and are on their way to eternal life.

The sixteenth-century language here makes it difficult to comprehend, but here is how I interpret it, applying it to my own inevitable future. There is abundant “evidence-based medicine” that death is part of my prognosis. I also know that part of my road to redemption is the necessity to atone for my sins before I can merit eternal Salvation and the resurrection of the body. This atonement can be achieved in many ways while I am alive, and I sincerely hope that is how it happens. However, if I should die before my atonement is fully achieved, I will need to complete this atonement in Purgatory, which, if you read Fr. Schouppe’s (1986, vi) book, is a pretty scary place. So, I pray that the Lord gives me the Grace to complete whatever suffering I need on this side of the Great Divide of physical death, in the presence of people who love me and pray for me, rather than on the other side of that divide, where I may be all alone and long forgotten by others. What if God grants me that Grace, but someone else, for instance, my family or my doctor, decide, with perfectly good intentions, to alleviate my suffering by hastening my death? Will that lessen my net sum of the atonement necessary to achieve eternal salvation? God’s will is unchangeable, it will simply find another way of being expressed. As a matter of fact, it may actually increase my suffering. St. Catherine of Genoa, who received revelations about purgatory and documented them in her “Treatise on Purgatory,” writes the following, and I quote,

“He who purifies himself of his faults in this present life satisfies with a penny a debt of a thousand ducats, and he who waits until the other life to discharge his debts, consents to pay a thousand ducats for that which he might before have paid with a penny” (Schouppe 1986, xxx).

Well, in order to avoid it, we must be clear as what the definition of stealth euthanasia actually is. We know that it is sometimes perfectly legitimate to withdraw or withhold medical treatment, including life support, in patients for whom these treatments have become extra-ordinary, that is, their burden outweighs their benefit, and death will occur regardless of whether the treatment is continued. The hallmark of stealth euthanasia is the withholding or withdrawing of ordinary treatment—treatment that has continued benefit and does not itself add to the patient’s suffering. As our Holy Father Pope Saint John Paul II stated in 2004, nutrition and hydration — even if delivered by artificial means such as a PEG tube, nasogastric tube, or intravenously — is always ordinary treatment, and, I quote:

"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... consists in providing
We must remember, that without nutrition and hydration, death is a certain outcome for anyone, even the healthiest among us. It is not always easy to distinguish between ordinary and extraordinary treatments, and it is easy to fall into the trappings of making decisions based on emotion, rather than clinical reality. For instance, how often do we hear such expressions as “he has suffered enough, he is ready to die,” or “grandmom has lived a good life, I’m sure that she will go right to Heaven,” or, in the case of unconscious patients, statements such as “he is already gone, it is only his body that remains behind.”

We hear a lot today about the need for the New Evangelization. In the context of combating euthanasia, we usually think of it as a battle against secularization. St. Luke (6:42) says, “how can you say to your neighbor, ‘Friend, let me take out the speck in your eye,’ when you yourself do not see the log in your own eye?” I believe that removing the log of “stealth euthanasia” from the eyes of our own Catholic brothers and sisters may be an even more difficult task than converting our secular adversaries, precisely because they are acting in good faith. For an example of this, I invite you to read over “To Peg or Not to Peg” (Isajiw 2009), which involved a truly religious, practicing Catholic family. The patient’s son who opposed placing the PEG tube is a Catholic physician. Please pay special attention to the son’s objections, quoted in his own words (51). Unexpected grace was evident in the results of our persistent efforts. Once he saw the benefits provided by the tube feedings, he not only changed his mind, but also joined the Catholic Medical Association and continues to be an active member. Furthermore, as a result of the public discussion on this subject, Deacon Peter Gummere, an ethicist who previously opposed using PEG tubes in elderly, demented patients, has completely changed his mind (Howland and Gummere 2014). When a professional ethicist changes his mind on a controversial subject, it is truly a miracle!

The fact is, however, that successes in reversing the trend towards stealth euthanasia among Catholics are few and far between, which brings us to the prayer for the beatification of Terri Schiavo (52). I invite you to include it in your own daily prayers. If persistence in this kind of intercessory prayer results in miracles leading to the canonization of Terri as a Holy Innocent martyr, that will have a much more widespread effect of conversion than our individual efforts. Let us pray that it may be so.

Given today’s secular trend towards overt euthanasia and physician assisted suicide, prayer is the first and foremost resource to stem the tide of stealth euthanasia. However, in our own practices and educational endeavors we must utilize available resources such as the clinical “decision tree” delineating the indications for assisted nutrition and hydration recently published in The Linacre Quarterly (Ad Hoc PEG Study Group 2012), authored by a group of fifteen Catholic practitioners, representing multiple clinical practices and specialties, including primary care, gastroenterology, neurology, ethics, theology, nursing, and nutritional sciences.

We must persist in our individual efforts, especially for the benefit of our patients. We can expect criticism and even accusations of lacking compassion. We have to be willing to make those sacrifices for the sake of the truth. St. Alphonsus Liguori, quoting St. Gregory the Great, writes: “He truly believes, who by his works, practices what he believes.”

God asks us to be faithful, and he himself will decide whether we will be successful. When we inevitably face our own awesome and terrible final judgment, we will not be asked whether we achieved, but whether we tried. And perhaps, as a result, when the time comes for us to approach the Pearly Gates, Dr. Gino Papola will whisper in St. Peter’s ear, and we may be given a priority pass to the head of that long, slow moving line of doctors.

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51. Isajiw (2009, 214): PEG is invasive, not easily reversible, often painful / uncomfortable, and can be hugely depressing to sensitive, cultured patients, such as Mom, as it can be smelly, unsightly, leaky, and cause skin irritation, not to mention the patient’s concern that it might fall out or get stuck or whatever; and many have interrupted sleep with “startle” due to subconscious fear of lying on tube... is futility of care and may increase suffering w/o hope/benefit of reversal of the underlying condition, namely ordinary aging (no reversible/treatable disease has been diagnosed here). A PEG tube is potentially harmful in terms of procedural morbidity and patient dignity.

52. Prayer for the Beatification of Terry Schiavo, Prayer for the cause of Theresa of the Forgotten:

“Merciful Lord, you filled the heart of Terri Schindler Schiavo with a spirit of profound sacrifice for love of neighbor. She became a holocaust offered to your Heart for the end of the culture of death. Through her excruciating agony and death we plead for a change of heart in all who have compromised or failed the cause of life. In life Terri would say, ‘Where there is life, there is hope’. Bring hope to my cause that seems hopeless. May I have unbounded trust in Jesus, Most Merciful (here mention your petition). My sins render me unworthy of your mercy, but be mindful of Terri’s sacrifice of love. I offer this prayer to your glory, and confident of your help”. Amen
References


Curriculum vitae

A board certified internist in private practice in Lansdowne, Pennsylvania, USA, has been an attending physician on the teaching service at Mercy Catholic Medical Center in Darby, Pennsylvania for 38 years. He is an active member of the Philadelphia Guild of the Catholic Medical Association (USA), involved in Catholic medical student formation programs sponsored by the Philadelphia Guild and the National CMA. He is a 1970 graduate of Thomas Jefferson Medical College in Philadelphia. Dr. Isajiw is a past president of the USA Catholic Medical Association (1993), and was the Program Chairman of the World Congress of FIAMC in New York City in 1998. He served as vice-president of FIAMC from 2002 to 2006. Dr. Isajiw is a contributor to the Linacre Quarterly Journal of the CMA and co-author of the landmark article "When to Recommend a PEG Tube: A Decision Tree for Clinicians From a Catholic Perspective" (February, 2012), a reprint of which will be provided for Congress participants. Dr. Isajiw is a Knight of Malta and currently serves as Board Chair of Mothers' Home in Darby, Pennsylvania (USA), a full service maternity residence for women with crisis pregnancies.

Experience in the Education of Medical Ethics to Medical Students & Physicians in a Korean Catholic University

Prof. Young Seong Hong, MD, PhD, Professor of Medical Oncology, Department of Internal Medicine, Seoul St. Mary’s Hospital, The Catholic University of Korea

Slides

2-3. Background

I. A steady stream of literature has insisted on the importance of ethics education and the need to establish an adequate ethics curriculum within medical schools (Academic Medicine
28

2002;77:432-437).

2. Concerns that ethics curricula often fail to address the stage specific needs of students.
3. Increased social issues on bioethics in Korea.
   e.g) embryonic stem cell research, withdrawal of futile treatment
4. Some contents of lectures may serve to inhibit students’ moral growth to the direction which Catholic church recommends to go.
5. Jesus Christ gave us a Mission to have special concerns on the patients in agony, and to care and cure them.
6. Restoring human dignity, destroyed by the diseases of body and soul, is also our Mission.

4-5 • 1. Education of medical ethics for medical students

1) Since 2009
2) Omnibus: Latin, "to all men" in the first Corinthians of the Bible
3) Medical humanities and social science

6. Purpose of education (Medical ethics): Train physicians with Catholic identity
   Calling, Ability, Leadership
   1-2 Year: Understanding of holistic medicine based on Catholic spirit and medical humanities

7. Table 1. Examples of medical humanities segments in the OMNIBUS curriculum at the College of Medicine, The Catholic University of Korea

<table>
<thead>
<tr>
<th>Year</th>
<th>Titles</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Foundation</td>
<td>Introduction of the OMNIBUS curriculum</td>
</tr>
<tr>
<td></td>
<td>Medicine and Humanities I</td>
<td>Holistic understanding of the human and medicine</td>
</tr>
<tr>
<td>2</td>
<td>Community Outreach Holistic understanding and practice to Program</td>
<td>address human disease, suffering, and treatment</td>
</tr>
<tr>
<td></td>
<td>Medicine and Humanities II</td>
<td>Holistic understanding of the human and medicine</td>
</tr>
<tr>
<td></td>
<td>Leadership Training</td>
<td>Self-management and development of self-efficacy based on self-understanding</td>
</tr>
<tr>
<td></td>
<td>Medicine and Humanities III</td>
<td>Holistic understanding of the human and medicine</td>
</tr>
<tr>
<td>3</td>
<td>Medical professionalism</td>
<td>Develop competencies and attitudes of physicians</td>
</tr>
<tr>
<td></td>
<td>Medical ethics</td>
<td>Develop high standards of ethics in research and medicine</td>
</tr>
<tr>
<td></td>
<td>Medicine and Society I</td>
<td>Develop leadership skills with social responsibility</td>
</tr>
<tr>
<td></td>
<td>Medicine and Society II</td>
<td>Develop leadership skills with social responsibility</td>
</tr>
<tr>
<td>4</td>
<td>Medical Law and Research Ethics</td>
<td>Develop skills to make ethical judgments</td>
</tr>
<tr>
<td></td>
<td>Planning for the Future: Career and Research Interests</td>
<td>Teamwork for enrichment and career development</td>
</tr>
</tbody>
</table>

8. Learning Objectives
Upon completing the study of medical ethics, students should be able to
1. Describe the definition, history, and principles of biomedical ethics
2. Understand and identify ethical issues related to "beginning of life" and "end of life"
3. Apply ethical theories to identify, clarify, and analyze clinical ethical issues with the emphasis on patient care as top priority
4. Deepen core competencies through mock hospital ethics committee
   • 1) empathy • 2) moral sensitivity • 3) moral reasoning • 4) rational judgment
9. Lecture schedule

<table>
<thead>
<tr>
<th>Session 1</th>
<th>8/19 (Mon)</th>
<th>Session 2</th>
<th>8/20 (Tue)</th>
<th>Session 3</th>
<th>8/21 (Wed)</th>
<th>Session 4</th>
<th>8/22 (Thu)</th>
<th>Session 5</th>
<th>8/23 (Fri)</th>
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<tbody>
<tr>
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<td>09:40</td>
<td></td>
<td>10:35</td>
<td></td>
<td>11:30</td>
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</table>

10. Subjects of lecture

<table>
<thead>
<tr>
<th>Subject</th>
<th>Session No.</th>
<th>Lecturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navigation</td>
<td>1</td>
<td>Leader of subject</td>
</tr>
<tr>
<td>Module 1: History, views of bioethics</td>
<td>4</td>
<td>Bioethicist</td>
</tr>
<tr>
<td>Module 2: variable topics in bioethics</td>
<td>3</td>
<td>Professor of medical humanities (MD)</td>
</tr>
<tr>
<td>Module 3: beginning of life</td>
<td>2</td>
<td>Professor of medical humanities (MD, PhD)</td>
</tr>
<tr>
<td>Clinical experiences in beginning of life</td>
<td>3</td>
<td>Gynecologist</td>
</tr>
<tr>
<td>Module 4: end of life</td>
<td>3</td>
<td>Professor of medical humanities</td>
</tr>
<tr>
<td>Clinical experiences in end of life</td>
<td>2</td>
<td>Medical Oncologist</td>
</tr>
<tr>
<td>Roll play</td>
<td>3</td>
<td>All</td>
</tr>
<tr>
<td>General review</td>
<td>2</td>
<td>Leader of subject</td>
</tr>
</tbody>
</table>

11-12. Mock hospital Ethics Committee

- Students are given four clinical cases involved with different ethical issues
- Students compose hospital ethics committee with appropriate roles and members according to given situation
- Each student plays a particular role in the hospital ethics committee and present her or his position according to her or his given role
- Professors provide feedback and comments in order to encourage students’ moral sensitivity and to promote both medical and ethical understanding
13. Satisfaction of the students, 2013 (5 point Likert scale)

<table>
<thead>
<tr>
<th>Curriculum</th>
<th>4.13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment methods</td>
<td>4.10</td>
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<tr>
<td>Participated Professors</td>
<td>4.16</td>
</tr>
<tr>
<td>Examination</td>
<td>4.18</td>
</tr>
<tr>
<td>Teaching methods</td>
<td>4.12</td>
</tr>
<tr>
<td>Total</td>
<td>4.14</td>
</tr>
</tbody>
</table>

14. Feedback from students
- It was a good chance to think about ‘life.
- It provided a good opportunity to broaden my thoughts
- I became more considerate about ethical values of medical profession.
- This curriculum provided me with the opportunity to appreciate "the doctor-patient relationship" and the importance of physicians’ attitudes.
- I am satisfied with teaching methods and strategy to induce students interests and participation
- It was helpful for moral understanding to be presented with several clinical cases.
- I learned that there are necessary core moral competencies as well as medical skills and knowledge for medical profession

15. Feedbacks from students regarding the activity
- I could understand others’ position and viewpoints more through role-play.
- I could recognize the needs, roles and duties of hospital ethics committee.
- I can appreciate more other positions through the process of preparation and exercise of mock hospital ethics committee with my peers.
- Now I became interested in medical ethics.

16. Conclusion
- Catholicism, as a hidden part of the curriculum, helped the students to explore their ethical and professional identity, as well as to learn various perspectives of the “good doctor”.
- Role play was very much effective in deepening students’ understanding of the value of medical ethics.
- Students were in agreement that Catholicism did not appear to be emphasized regularly in courses, but they were able to identify a "hidden curriculum" of Catholic value.

17-18. • 2. Education of Medical Ethics for Physicians
1) Since 2013
2) Education for the newly assigned assistant professors in hospitals of the Catholic University of Korea

19. • 1. Purpose of education
• 1. Reinforcement of hospital ethics committee in the changing medical circumstances and society: Need to be fully aware of clear guideline for the ethical debates
• 2. Establishment of the Catholic hospital identity through the practical understanding and application of clinical medical ethics
• 3. Fulfillment of need for the clinical medical ethics education through case based learning

20. • 2. Who teaches?
21 & 25. • 3. Contents of education

22. • 4. Time table

23-24. Education of medical ethics for physicians
• Methods
  - Problem Based Learning
  - Team Based Learning
  - Role Play
26. Example
- III. Clinical bioethics at the end of life
  - 1. Accepting death - Purpose of Education
  - Sympathize with the suffering of terminal patents and realize the ethical aspects of the issues such as futile treatment and brain death
  - Understand the medical basis of medical futility of treatments in the view point of Catholic church

27. Example
- III-1-1 Decision of death - Study goals
  - Can list variable criteria of death
  - Can make a statement on the meaning of death which patient and family recognize
  - Can make a statement on the teaching of Catholic church about death

28-29. Example: Case
A 25 year old young man, Mr. G
Massive Intracerebral hemorrhage due to trauma by snow board à brain death
Parents of Mr. G refused to accept their son’s death
How can the doctors convince the family to accept their son’s death?

• A. Points of ethical debate
  1. What is the criteria for decision of death?
  2. What is brain death?
  3. What should be cared for in deciding the brain-death?
  4. Can you suggest organ donation the parents who do not accept the brain death of their son?

• B. Explanation for the points of ethical debate
  1. Criteria for decision of death
  2. What is brain death
  3. What should be cared for in deciding the brain death?
  4. Can you suggest organ donation the parents who do not accept brain death of their son?

• C. Opinion of the Catholic church: Summary

30. Survey before and after the course for the physicians attended medical ethics education.
• Characteristics: 84 assistant professors
  - Mean age : 38
  - M / F = 52 / 32
  - Religion: Catholic 40 / None 22 / Protestant 17 / Buddhism 2 / No response 3

31. Change of attitude on the beginning of life issues

<table>
<thead>
<tr>
<th>Issues</th>
<th>Proportion of agreement before</th>
<th>Proportion of agreement after</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality of Human Embryo</td>
<td>38%</td>
<td>86%</td>
</tr>
<tr>
<td>Prescribing Oral Contraceptives</td>
<td>37%</td>
<td>22%</td>
</tr>
<tr>
<td>Abortion</td>
<td>80%</td>
<td>27%</td>
</tr>
<tr>
<td>IVF</td>
<td>87%</td>
<td>35%</td>
</tr>
</tbody>
</table>
32. Change of attitude on the end of life issues

<table>
<thead>
<tr>
<th>Issues</th>
<th>Proportion of agreement before</th>
<th>Proportion of agreement after</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary Active Euthanasia</td>
<td>8%</td>
<td>1%</td>
</tr>
<tr>
<td>Physician assisted suicide</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>Withdrawal of life sustaining treatment</td>
<td>54%</td>
<td>74%</td>
</tr>
<tr>
<td>Terminal sedation</td>
<td>45%</td>
<td>50%</td>
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33. Conclusion
- Medical ethics education was expected to be very useful in helping newly assigned professors.
- And a large proportion of physicians has changed their attitude to the direction which Catholic church recommends to go.
- This education for physicians is a valuable starting point of medical ethics education in the Catholic University of Korea, and for whole Catholic hospitals in Korea as well.

34. Thank you for your attention!

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**Curriculum vitae**

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- **Major Social and Academic Societies**
  - 09/12-present, President of Seoul Catholic Medical Association
  - 03/12-present, full-time referee in HIRA (Health Insurance Review & Assessment Service)
  - 12/11-12/12, President of the Korean Society for Hospice & Palliative Care
  - 09/11-08/13, Dean of Graduate School of Healthcare Management and Policy
  - 09/09-08/11, President of Seoul St. Mary’s Hospital, The Catholic University, Seoul, Korea
  - 03/08-03/11, Representative of Peace Makers (a social welfare foundation), The Catholic Education Foundation
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  - 09/07-09/09, Chairman of Asia Pacific Hospice Palliative Care Network
  - 03/07-08/09, Spokesman of the Catholic Medical Center, the Catholic University of Korea
  - 6/05-present, Member of the bioethics research committee, Korean Bishops’ Council
  - 6/06-present, Member of the Board of directors, the Korean Association of Clinical Oncology
  - 5/05-08/07, Vice-chairman of Asia Pacific Hospice Palliative Care Network 7/04-06/07, Chairman of Board of Directors, The Korean Society for Hospice & Palliative Care
  - 7/02-present, Chief of International affairs committee & Board of Directors, The Korean Society for Hospice & Palliative Care
V. Session 3
Prayer in the Life of the Catholic Physician

1. Prayer in the life of a catholic physician

Msgr. Jacques Suaudeau, MD (Vatican City)

Text
“A catholic, without prayer? It is the same as a soldier without arms” (Saint Josemaria Escriva, Furrow, n°453).

Every faithful man and woman, whatever his/her religion, agrees on the fact that prayer is basic. One cannot go on pretending to be a believer, if one does not pray. Of course there are many different ways of praying throughout the world, and one does not pray the same if he/she is a Moslem, a Buddhist, or an animist. And the way men pray may also have changed throughout the centuries. But, at the basis of prayer, there is always the same longing which expresses itself through the different forms of prayers, from contemplation to vocal prayer: a longing to be with God, a longing to feel oneself in God, in harmony with God. This is what indeed tells us the Document Gaudium et Spes of the Second Vatican Council, when it says:

“Now, man … plunges into the depths of reality whenever he enters into his own heart; God, Who probes the heart(7), awaits him there; there he discerns his proper destiny beneath the eyes of God.” (Second Vatican Council, Pastoral Constitution Gaudium et Spes, chapter I, n°14)

Prayer of the laity in the tradition of the Church

The Bible does not teach us how to pray, but give us, continuously, examples of prayer, prayer of request and prayers of thanksgiving, prayers for reaching God, and prayers of confidence and trust, prayers of distress and anguish, and prayers of recovered strength and hope. We see the People of God in a state of continuous pilgrimage, seeking God, seeking the god of Abraham, Isaac and Jacob, the god of the armies also, who give victory, the rock on which the People of God can rest, and in which he find support and strength. We see the People of God on the seaside of the Red Sea, rising cries of Joy and thanksgiving toward God, liberator and saviour. We see the queen Esther in full distress and anguish, rising her spirit toward God to seek protection, support, strength and wisdom. We see the young Tobit and his wife Sarah reaching to God for asking his benediction on their union, which they want full and holy, in accordance with the will of God. We
see Job, asking God to enter in a contest with him, requesting urgently from Him an explanation for all his misfortunes and miseries, and protesting of his innocence. But it is in the psalms that the prayer of Israel reaches its apex, the psalms in which the man of the Bible enters in dialogue with his creator, master, and father from all eternity. Thus, the man of the Bible does not limit himself to prayers of request or even to prayers of thanksgiving, but does not fear to enter into a dialogue with his creator, a dialogue often vehement, impassioned, even reproachful, before ending on always in a serene, hopeful tone.

What the Gospel adds to this prayer in the Bible is the prayer of Jesus, the way Jesus prayed, the prayer of the son toward the Father, a prayer of confidence, and trust, a prayer in which Our Lord draw his strength and energy. The prayer of Jesus is a prayer of contemplation and dialogue. It is a time of life with the Father, in the Father, a time in which Jesus rest in God, find support in God, reconstitutes his energies, find light for his mission. “Abba”, Father: this is the word that Jesus gave us as a key to prayer, “Abba”, “Our father”. The Apostles learn to pray as Jesus did. While they continue Israel’s tradition of pilgrimage, of going to the Temple on feastdays, of praying in a collective way, in the synagogue, they also learn how to stop their activities, give time for God, especially before every important decision. The community of Christians is a community which pray, in the “Ecclesia”, in community, but also at home, in this “domestic church” which is the Christian family.

All along its history, the Catholic Church has always invited the faithful to prayer, indicating in particular the recitation or singing of the psalms, alone or in community, as an optimum way for praying. However, with the development of the religious orders, of the contemplating orders in particular, a kind of split in the People of God seemed to open up, at least in the western part of Christianity, with, on one side, the religious, the “professional of prayer”, unceasingly seeking God through vocal or silent prayer and, on then other side, the lay people, whose job was to work and raise families. Lay people were certainly not excluded from prayer, but they did not received a particular, specific attention in that field.

The real novelty in the attention of the Church toward the prayer of lay people came with the ecclesiastical assistance given to princes, kings, nobility, in order to help them keeping a life Enlightened by God through the practice of prayer. They were busy, they needed to attend to the affairs of this world, to fulfill the duties of their state. So they had to be helped on praying. This “spiritual direction” of the powerful gave some wonderful fruits, like in King Louis IX, “Saint Louis” who was able to combine a deep life of prayer, and a very efficacious government.

It is this practice of the “spiritual direction” which inspired afterward all the movement to offer to lay people a way of praying adapted to secular life. It started with the “Imitation of Christ”, flowered through Saint Francis of Sales, reached us through persons of prayer and action like Saint Don Bosco, to offered in our times, to lay people, the way to combine prayer and active, professional life, prayer nurturing, directing, action. They were busy professionals, mothers of families, young people starting in active professional life or engaging into demanding studies. And they learn to pray, despite their many secular activities. The Jesuits, the Catholic Action, and then many orders have developed in our times programs, plan of life, days of retreat, specific spiritual direction, all adapted to the busy life of ordinary faithful. Constant preoccupation has been in this regard not to transform lay people in religious, with a model of prayer inspired by religious life in convents or religious congregations, but to give to lay people the spirituality they need in order to be active, coherent Christians in the world. In our times, the whole life of saint JoseMaría Escriva, has been dedicated to such an aim: to give the means to lay people, fully inserted in the world, busy, with families and children, not only to have a consequent life of prayer, but to keep alive the inner fire of faith without which there is no apostolate. These lay people, supported that way, were to become the modern apostles of our time, colleague to colleague, bringing that way Christ in the middle of an ever more secularized world.

**What is prayer for a lay Christian?**

For a monks, or a member of a contemplative religious community, daily life is made of an alternance of times of manual work or of study and times of prayer, either vocal prayers in the community, or private times of prayer in the silence of one’s own room. This is perfectly fitting with their vocation.

For a lay person, whose vocation is that of professional work and family life, it cannot be the same. The time consecrated actually, specifically, to prayer cannot be but limited. Profession, family life and even social life come first in the timetable of the day, and it has to be that way.
We all know some persons, certainly pious and of good will, who sometimes after a strong spiritual experience in their life, start spending hours at Church or touring monasteries, while neglecting more and more their professional duties and even their families. And we realize rightly that this is not balanced, that these persons are giving even a bad idea of Christians around them.

However, on the other hand a Christian who prays little or does not pray at all is also an unbalanced person, this time neglecting his spiritual needs. With the passing of years, he/she will grow cold toward our Lord, and, at best, turn into a tepid Christian. Saint Augustine call them “silent souls”, “those who have fallen silents”. They are cold inside, they have no more desire of God, no more words of love and trust toward God: this is the “silence of the heart”: "If you cease to desire than you will have fallen silent in your prayer. Who are those who have fallen silent? ...The freezing of love is the silence of the heart” (In ps. 37, 13-14; CCL 38, 391-2).

With this “silence of the heart”, faith becomes a dull part of one’s individuality, linked more with a sense of obligation, duty, than with a sense of joy, hope, fulfilment of the soul. Quite often such a person who does not pray, and who had gone cold in his/her heart do not realize the gravity of his/her state of spiritual dereliction, which makes things worse. Of course, he/she is unable to do any apostolate, unable even to transmit faith to his/her children. He/she has become “a dead branch” of the Church, a dead weight instead of an active member.

On the contrary, the person who his able, despite an heavy schedule, to keep in touch with God throughout the day, have all chances to stay or to become an alive Christian, joyful and serene, with hope and light in his/her heart, and irradiating hope and light all around him. He is that tree planted by the water of whom speak the psalms and the prophets: “And he shall be like a tree planted by the rivers of water, that bringeth forth his fruit in his season; his leaf also shall not wither; and whatsoever he doeth shall prosper” (Psalm I,3). Jeremiah 17:

“They will be like a tree planted by the water, that sends out its roots by the stream. It does not fear when heat comes; its leaves are always green. It has no worries in a year of drought and never fails to bear fruit.”

But, in the concrete, practical way, how can such a busy person save times for prayer, times with God and in God, in his/her schedule? How can prayer fit in the life of the ordinary, busy, and responsible christian?

The answer to this apparent dilemmas stays in a better understanding of what is prayer. The Acts of the Apostles tell us that, after the resurrection of Christ and His ascension to the Father, in the waiting for the coming down on us of the Holy Spirit, the eleven apostles, with Mary, in the “upper room”, that is the Cenacle, were “praying continuously”. And indeed the word which seems to characterize best this early community of Christians is that of this “continuous prayer”. But, can we imitate such an example? This “praying continuously” seems at first hand, something impossible, incompatible with ordinary, daily life. How is it possible? We cannot spent day and night at church. Everybody has his own job and daily tasks, a family to attend, children to educate, house to keep in order. Saint Augustine, commenting this “praying continuously” of the Holy Scriptures, has given us a precious teaching on it.

He says: «How can we pray continuously? Can we be always bending the knee, prostrating the body, or lifting up our hands, Is that what (the Apostle) says by telling “Pray without ceasing? If that what prayer means when I say that we cannot do it without ceasing?». No, there is one another way of praying, answers Saint Augustine. «There is another inward kind of prayer without ceasing, which is the desire of the heart. Whatever activity you happen to be engaged in, if you only long for that Sabbath then you do not cease to pray. If you do not want to pause in prayer then never pause in your longing. Your continuous desire is your continuous prayer».

In other words: if we keep our hearts driven toward God, if we keep running the inner music of our hearts toward Him, with hymns of joy, thanksgiving, praise, confidence all along our days, then we can turn our whole day into a continuous prayer. And Saint Augustine adds: “For that very desire of your heart is your prayer; and if your desire continues uninterrupted, then so does your prayer. It was not in vain that the Apostle said Pray without ceasing.” (In ps. 37, 13-14; CCL 38, 391-2)

If we follow this teaching of Saint Augustine, we realize that prayer do take place whenever we turn to God, either in a specific time of the day, through vocal prayer or contemplation, or all along the day, when we keep our hearts towards God through inner acts of trust and love, This “cry of the heart” advised by Saint Augustine can be done in fact in many different ways, glancing time to
times to some representation of our Lord or of our Lady, or expressing inside us chosen few words of thanks, trust or adoration, or keeping alive in our heart some religious song which we like, or keeping in our pocket a little cross or a rosary which we press in our hand times to times, whatever. But the essential is to keep this sense of the “presence of God” which enlighten all our day and can turn it into a continuous prayer, if we will.

This is what Saint Josemaria Escriva, the “saint of our times” called “to be contemplative souls in the middle of the world”

“Let us work. Let us work a lot and work well, without forgetting that prayer is our best weapon. That is why I will never tire of repeating that we have to be contemplative souls in the middle of the world, who try to convert their work into prayer.”(Furrow, n° 497)

So, prayer does not has “to fit in” into our schedule. It is the whole day’s occupations which can be turned into a continous prayer, by keeping the presence of God. It is not an idealistic proposition, an impossible goal. It can be done.

Answering one day to one of the young professionals he was helping spiritually, Saint Jose Maria Escriva observed:

«When you started your ordinary work again, something like a groan of complaint escaped you: “It's always the same!” . And I told you: «Yes, it's always the same. But that ordinary job —which is the same one your fellow workers do — has to be a constant prayer for you. It has the same lovable words, but a different tune each day.»

«It is very much our mission to transform the prose of this life into poetry, into heroic verse.» (Furrow, 500)

Now, Keeping the “presence of God” naturally, throughout the day, without any artificiality, is difficult if it has not been preceded by a time-period fully given to God, a specific time of inner dialogue with God through meditation and vocal prayer. The prayer of early morning kindles the desire of the heart, our inner fire while anticipating our tasks of the day. The prayer of the evening sustain the heart, while examining what has happened during the day, asking pardon for our failures, thanking God for our moments with Him and for the help He gave us. What is essential to make fruitful these times dedicated specifically to prayer is to pull away, at the onset of the exercise, all distractions and preoccupations which would otherwise occupy our minds and make useless our gift of time to God.

**The prayer of the Catholic Physician**

All these remarks about the prayer of the ordinary catholic lay professional apply to the particular question of the prayer of the catholic physician. In what pertains to prayer, the situation of the catholic physician is first of all the situation of a busy lay professional Christian, with responsibilities at work and in his/her family. But being a physician adds a new dimension in this perspective of prayer. I would say the “Hippocratic dimension”. What does that means?

Hippocrates has given to the practice of Medicine its founding moral values, and this has been true up to our times. The “Hippocratic oath” contains indeed most of the ethical precepts that are expressed in today’s bioethics. And it exhorts the physician to live a "pure" life, that is to say to live according to the ethics of virtues.

The teaching given by Hippocrates was certainly very remarkable. According to him, the practice of medicine was inscribed in a triangular relation \(^{53}\), with, on one hand, the patient, on one another hand the illness, governed by natural laws, and between the two the physician who helps nature and is servant of the medical art. The physician must therefore be concerned above all by the patient, as a person.

Hippocrates recommended wisdom, the reserve, the modesty, the decency, the generosity, the frankness. Later on, the stoicism introduced in the "corpus Hippocraticum" an insistence on duty, compassion \(^{54}\), a friendly and even loving attitude towards the patient.

During the Middle Ages (500 to 1500 AD) the ideals of Hippocrates to which were added the Christian teachings formed the basis of medical ethics \(^{55}\). The physicians were considered as men of religion. Christian writers like St. Thomas of Aquin in the XIIIth century, or Jewish writers like Moses Maimonides, in the twelfth century, considered the practice of medicine as the

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most elevated ideal. The goal of medicine was to serve the patient in order to serve God.

Thus, Hippocratic medicine places at the heart of its preoccupations the relationship between the physician and the patient, between the one who takes care of and the one who needs to be cared. Now, for a Christian physician, this Hippocratic duty towards the patient rises to a higher level: for it is Christ himself that the catholic physician serves when he/she serves his/her patient. This teaching comes from the Gospel itself, with, at its center, the parable of the Good Samaritan (LK, 10, 29-37), and the Chapter XXV of Saint Matthew (Matthew 25, 31-36) on the last Judgment with the separation of the sheep from the goats: “Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me”

All these considerations on Hippocratic oath, Hippocratic tradition, and Christian teaching about serving the patient as serving Christ have a great importance in medical ethics and the catholic physician has to be in the forefront of their application in his/her practice. But would they have some implications in the prayer life of this catholic physician? Would the teaching of Christ about the service of the sick go beyond the mere fact of trying to apply it well in daily practice of medicine?

The answer is:”Yes”.

We have seen indeed that prayer cannot be dissociated from daily life and daily occupations, and that professional life should be integrated in prayer through the keeping of the presence of God all along the exercises of the profession – the “prose” of daily life turned into the “Alexandrine” of prayer. Prayer, seeking God, seeking to be in God, does not start from an ideal condition far above the ground. It starts from what we are, what we do, our everyday preoccupations, the everyday fulfilling of the duties of our state – that is of our profession. The Hippocratic oath, with all its dimensions, has to be present in the prayer life of the catholic physician. This is why, for a catholic physician, can be part of his prayer: - keeping up to date the quality of the care he is delivering,
- being attentive to all new developments in his/her field, taking advantage of all proposals for continuous post doc education,
- delivering a high quality care to all patients, with no preferences and no discriminations, whatever the age, the social position and the economic affluence of the patient,
- never letting oneself fall into a less-than perfect job because of tiredness, displeasure with the patient, lack of time or sense of futility,

In the same way, can also be integrated in prayer life of the catholic physicians
- his attentive and caring attitude toward his patient,
- the time he spend explaining to patients all what is about their case, and helping them to take proper decisions,
- his welcoming attitude toward the family of the patient, when things are not going well and the family show distress, anguish, and needs confort and clear explanations.

However, the professional competence of the physician, the quality of the care he is delivering, the time he spend with the patient and the families, will remain at the level of ethics, professional qualities and competence, human qualities and virtues, and will not be integrated in prayer life if the catholic physician do not consecrate a time to a dialogue with God, in a specific time of prayer. The effort he will make to secure this time in his daily timetable, and the efforts he will make to keep it despite inevitable difficulties, throughout his whole life, can also be considered as prayer.

Prayer cannot be dissociated from life and job. And the ideal for the Christian in general, and for the medical doctor in particular, must be that of unity of life, living an equilibrated, balanced life, even if one is very busy, even if one finishes late and starts early. The will of the medical doctor to spare a specific time to silent prayer, at home, at the beginning of the day, will kindle in his/her heart this longing for God, this desire to be with God, which may transform in turn, throughout the day, all his activities in prayer, in the continuity of the actual prayer started in the morning.

Prayer life, life in the presence of God, finding support and hope in God, will encompass all this, in one unit, the unity of life, as a permanent offering of one’s life to God, which is the essence of being Christian. And our physician will truly walk, that way, in the footsteps of Christ.
When I was the ecclesiastical adviser of CPGP, we often asked this question: What are the most important virtues for you, a Catholic physician? The recurring answer: respectfulness, compassion, truthfulness, humility and prayerfulness. In various rankings, prayerfulness was always there.

Let us reflect on "Prayer in the Life of a Catholic Physician." We develop the topic by pointing out some essential elements of a prayerful life. First, we speak on our need and obligation to pray; second, on the nature and the kinds of prayer; third, on methods of prayer, and fourth, on the fruits of prayer.

1. Prayer: need and obligation

We all need to pray. We are creatures of God. We are God's children, baptized in the Blessed Trinity. We are weak and needy: "Beggars of God" (St. Augustine). "Apart from me": Jesus says, "you can do nothing" (Jn 15:5). The motto of CPGP puts it well: "A Deo est omnis medela" (all help comes from the God). Prayer - one of my students writes - "is a must, and it is the source of our strength (like boosters and medicines)." We need to pray especially today: there is too much action and noise and too many words...!

We are body-soul. Our bodies need food - physical food - to live and stay strong. Our souls need food - spiritual food - to be alive in God. To those who followed Jesus expecting physical food - bread and fish -, He tells them: "Do not work for the food that perishes but for the food which lasts, and which gives eternal life..." (Jn 6: 25-27).

We are obliged to pray always. We believe in God, hope in him and love him and, therefore, we have to pray: faith, hope and love pray! Jesus tells us: "Pray always and never lose heart" (Lk 18:1). After the Ascension of our Lord, the apostles, together with some women including Mary our Mother, went to the upper room to pray: "With one heart all these joined constantly in prayer" (Ac 1: 12-14). In our hurried life, we all need to go to the upper room to pray. St. Paul repeats to us: "Pray constantly" (I Thes 5:17). The Lord asks us to pray always, that is to pray daily: actually or virtually, and externally or internally. "In faith, hope and charity, the constant desire of love makes us pray continually" (St. Augustine); "desire, without ceasing, the blessed life, which is none other than eternal life"(St. Augustine, Letter to Proba; in Office of Readings, III, 29th Monday). Praying ceaselessly is the actual or virtual desire of charity and consequently, the constant intention of doing all things for the glory of God (1 Cor 10:31; St. Thomas Aquinas, II—II, 93, 14). For the Russian Pilgrim, praying ceaselessly means to have the remembrance of God in all times and places and circumstances.

Jesus was a prayerful person. As we see in the Gospels, He prayed always, and especially when He had to make an important decision or celebrate an important event: before encountering the scribes and Pharisee (Lk 5:16); before He chose the twelve apostles; before Peter's confession (Lk 9:28); before He taught his disciples to pray (Lk 11:1). Mary was very prayerful: she kept everything that happened around Jesus in her heart, meditating it. All the saints are prayerful persons. St. Dominic talked always with God or of God: "Never asking for reward, he just talks about the Lord."

We need to pray. We are obliged to pray. How do we learn to pray? Blessed Mother Teresa of Calcutta answers us: "By praying." Saint Padre Pio of Pietrelchina's answer: "By praying always."
Is it difficult to practice prayer, contemplation? The Master of Novices answered a novice by giving him the two great laws of contemplation: the first law is to pray; and the second is to keep at it."

2. Nature and kinds of prayer

**Prayer** is "one thing that can conquer God" (Tertullian). It is "the lifting up of mind and heart to God" (St. John Damascene). It is like the breathing of the soul, feeling God's presence in our lives and communicating with him. Prayer is the language of the heart in love with God. St. Teresa of Avila, still an incomparable master of prayer, defines prayer as "A dialogue of friendship, being alone (silently) many times (frequently) with the One we know that loves us." She could not understand why the whole world does not try to approach God through this particular friendship. **Prayer is personal and communitarian.** We need both: we are persons and social beings, individuals and children of God. We belong to God's Family. Communitarian prayer per excellence: *The celebration of the Holy Eucharist* in which we take communion at two tables - the table of the Word and the table of the Eucharist; it is sacrifice and sacrament, act of thanksgiving, worship, petition and atonement for sins. The first Christians were asked; "Why do you celebrate the Breaking of the Bread when you know that if caught you will be sent to jail?" Their answer: "We are Christians. We cannot live without the Eucharist." For them the Eucharist was a mystical experience, the experience of the sweetness of God. The Sunday Eucharist may be an experience of God!

**Prayer is vocal and mental, external or internal, with words or in silence.** What matters in prayer is that it is done well. Hence, we need to be aware of who is talking; to whom is he talking; and what is he saying (St. Teresa of Avila); to be aware of God and of oneself; of God's love and our poverty. God says to St. Catherine: "I am He-who-is, you are she-who-is not." All prayer: talking and listening - mostly listening. (Story: A boy was asked: "Do you pray to God?" The boy: "Yes, every night." "What do you ask from Him?" Boy: "I ask Him if I can help Him in anyway.") **Prayer is addressed to God, to Jesus, to Mary, to the saints** (cf. CCC 2664-2672). Above all, to God: prayer and devotion are the two main acts of the virtue of religion through which we relate to and unite with God. All prayers are Trinitarian prayers: "Through Christ our Lord, in the Spirit, to God the Father." Like devotion is primarily devotion to God and secondarily to the saints; prayer is first to God. (We pray to the saints so that they will join their prayers to ours). We recall St. Teresa's words: "Few devotions and much devotion." She had a few devotions herself, that aided her much (especially the devotion to our Lady and to Saint Joseph), but cautioned against useless devotions: "From silly devotions deliver us Lord," she says. As Christians, we ought to have a special devotion to Mary, who is also our Mother and the disciple of disciples. (How about praying to the souls in purgatory? Traditional answer: we pray for them, but not to them for they do not enjoy as yet the vision of God - see II—II, 83, 4 and 3. Some modern theologians however answer in the positive, like K. Rahner).

**Prayer is universal.** Christian love is not selective, but solidarity with all, our brothers and sisters in Christ. We pray for all: for our Church and our communities, and our families, for sinners, for the souls in purgatory; and for our enemies, "for those who maltreat us" (Lk 6:27-28; Lk 23:24).

**Our prayer is very often intercessory prayer.** We are sinners and needy, so we ask for God's help - for ourselves and for others. We ask God, too, for health of mind and body. The well-known saying "mens sana in corpore sano," is not just that but: "Orandum est ut sit mens sana in corpore sano " (Juvenal): We pray to have a sound mind in a sound body (Juan Manuel de Prada, ABC September 8, 2013).

3. Notes on some methods of prayer

(When I participated in seminars of bioethics, organized by CPGP, throughout the Philippines, the first thing the doctors asked at hotel desk: Where is the nearest Church? This also happened in Macau! Indeed, Catholic doctors pray!)

**No time to pray?** The doctor is really very busy. There is always the temptation to use this reality as an excuse not to pray: What matters here is not quantity - a long time praying -, but quality: quality time with the Lord. Prayer time is restful time. Also doctors ought to take seriously the words of Jesus to the apostles: "Come away to some lonely place all by yourselves and rest for a while" (Mk 6:31). We do not forget that God also needed to rest: "He rested on the seventh day after all the work He has been doing" (Gen 22). The famous Christin doctor Paul Tournier (who had an hour of silent meditation everyday) says that silence helped him much in coming closer to God.; prayer helped him realize deeply that two things go into the making of a doctor:
competence and compassion.

**We have to pray daily - doctors too.** We pray today, now, this moment, which is the only thing in our hands. The Zen Master says: "The past is unreal; the future is unreal too; only the moment is real. Life is a series of moments, either lived or lost." Indeed, *life is a series of moments either lived or lost!* Hence, our prayer is not yesterday or tomorrow but today: "If today you hear his voice, harden not your heart" (Ps 95:7-8).

**A simple recipe for daily prayer:** Start the day in God's presence: "In the name of the father and of the Son and of the Holy Spirit." Place the day in God's hands: "Into your hands, Lord, I commend my spirit." Ask God's help: "Give us this day our daily bread." Feel God's presence in your daily chores and work: in particular, in your patients in whom the Lord is present in a very special way: "I was sick and you visited me" (Mt 25:36). Say a silent prayer here and there - for your family, for your patients, for your colleagues:... *Our Father, Hail Mary, Glory be...* Say "Hello" to the Blessed Sacrament when you can. At the end of the day tell the Lord: "Thank you, Lord," "Sorry, Lord," "Love you, Lord," and ask him: "Give us a tranquil night and a good end." *In the name of the Father and of the Son and of the Holy Spirit*

**There are different methods of prayer.** What is the best method? Any method or kind of prayer is good as long as the result is good: increase in love of God and neighbor. Which is the best method? The one suited to each one of us. We know these useful methods: Pray with the Bible (read, reflect, and respond); Pray with Mary (the Rosary, the Angelus); Zen-type (with mantra) silent prayer; pray like the Russian pilgrim (repeating: "Lord Jesus Christ, have mercy on me a sinner"), Lectio Divina, etc.

**Lectio Divina** is still very popular in many places throughout the world - and not only for monks, priests and religious men and women, but also for lay faithful, including physicians. It is still for many of our brothers and sisters today an attractive and fruitful method of prayer. Its four parts make this prayer very rich: Reading (attentive spiritual reading, especially the Holy Scriptures); meditation (reflective thinking: what is the meaning for me?); prayer of the heart (dialogue with God: giving thanks, asking for forgiveness, petition, and praise); and contemplation (silence, love, adoration), and consequent good deeds. One more part is made explicit today: action (good deeds).

In our fast-pace world, however, for many of us time is - at times, unfortunately - what we do not have, particularly for long periods of contemplative prayer. So I also suggest a shorter and seemingly very fruitful kind of contemplative prayer: silent, personal and private (secret) prayer.

Praying is a journey of life and hopefully we pray better as we go along from one kind of prayer to another. The classical process is this: from vocal prayer we grow into mental prayer, and from mental prayer into contemplative prayer. As we move up by the ladder of prayer, we realize deeply than the main obstacle to prayer is our selfishness; hence the continuing need of "unselfing." As we mature in prayer we move from self-centered prayer to God-centered prayer, from petitionary prayer to prayer of adoration, thanksgiving and praise. (Cf. Simon Chan, o.c, p. 133) Usually, different kinds of prayer live together in our lives - and may be helpful.

St. John of the Cross invites us to go back to our interior home, where the Beloved lives. Each one of us needs to cultivate the interior space and therefore to pray silently. **How long for individual prayer?** Up to each one of us: ten, fifteen, twenty, thirty minutes? What is essential is to be faithful to it, daily, so that we may acquire the good habit - prayerfulness - and will never leave it. How do we do it? One easy way: Sit comfortably; close your eyes; feel your breath; experience the presence of God through faith; listen to him; repeat perhaps - like a mantra - a word, a wonderful word: "Jesus." Repeat "Jesus" slowly, slowly, time and again, "breath" Jesus (the Jesus of Advent, of Christmas, of Lent, of Easter... the Crucified and Risen Lord). Meanwhile try hard to expel from your heart - a sort of "bracketing" them out - the thoughts of an always fertile imagination ("the crazy one of the house," according to St. Teresa). Do not force things; relax; keep quiet; listen to the Holy Spirit; say what comes to you: "Sorry, Lord," "help me Lord," "I love you Lord," "thank you, Lord." Above all, keep silent; meet God at the depth of your soul, of your being. Try and try and try - always; listen to God's sounds of silence. Never get discouraged: our effort is a prayer. We search for God, we long for him: "Like a parched land, my soul thirsts for you" (Ps 143:6).

A modern mystic advises us: "I sit silently before God; I let God look at me and I look at him. As I look at God, I forget myself. I feel loved; just that" (Anselm Grun). St. John Vianney, the saintly Cure of Ars, saw daily an old man praying after Mass: he did not move his lips; his eyes were on the altar. The holy priest asked him: What do you do kneeling at the rear of the Church every day.
The old man answered: "I talk to God." "And what do you say?" Old man: "Nothing. I just look at him and he looks at me!" We all must have a place for God in our heart, for with him "your heart will rejoice and your limbs regain vigor like the grass" (Is 66:14). We need silence in our hurried life and we need to listen to "the sounds of silence (cf. Lk 10:38-42). "I will be silent and let God speak within" (Meister Eckhart). I keep encouraging myself to make pauses of silence - besides a longer one - daily. These may help us experience God in a sunset, or the smile of a child, in the poor beggar, in the suffering patient, in our copilgrims on the journey of life. Do not rush, smell the flowers on the way and contemplate the tenderness of God.

Pope Francis - who is busier than physicians and priests, than any of us - sums up his preferred prayer life as follows: "I pray the breviary every morning. I like to pray with the psalms. Then, later, I celebrate Mass. I pray the Rosary. What I really prefer is adoration in the evening, even when I get distracted and think of other things, or even fall asleep praying. In the evening between seven and eight o'clock. I stay in front of the Blessed Sacrament for an hour in adoration. But I pray mentally even when I am waiting at the dentist or at other times of the day." (Interview by Antonio Spadaro. SJ. Editor. Civiltà Cattolica, Rome: August 2013)

4. The fruits of prayer

In his Diary of a Country Priest, author Georges Bernanos puts these words in the lips of the main character, a young humble, poor, good priest: "When has any man of prayer told us that prayer has failed him?" Never! Prayer cannot fail, although we can pray the wrong way or ask for the wrong things.

Why at times you or I do not seem to receive from God what we ask for? Jesus tells us a parable "on the necessity of praying always and not losing heart," the parable of the corrupt judge and the persistent widow: if the corrupt judge listened to the persistent widow how much more God the Father will listen to us? We have the promise of Jesus: "Anything you ask from the Father, he will grant in my name...; ask and you will receive" (Jn 16:23-24; cf. Mt 7:7). He did not say, maybe you will receive, but you will receive what you asked for. The promise of Jesus refers primarily to the "giving of the Holy Spirit" (in Jn), the granting of good things (in Mt). "We are quite confident that if we ask him for anything, and it is in accordance with his will, he will hear us" (I Jn 5:14); "Whatever we ask him, we shall receive, because we keep his commandments, and live the kind of life that he wants" (1 Jn 3:22). Certainly, God always answers. However, his answers may not be our answers as his ways are not our ways (Is 55:8; cf. CCC 2736-2737).

God our Father in heaven knows best what is good for us not just today or tomorrow, but throughout our lives (cf. Lk 18:1-8; cf. Mt 7:7-12; Mk 11:23-24; I Jn 5:14). St. Basil affirms that "If you asked and did not receive it is because you asked for something that is not good; or you asked for it without faith, or it is not convenient for you; or you did not persevere in asking" (see St. Thomas, II-II, 83, 15). When we ask something from God, we must say - like Jesus - "your will be done", not our will. Faith assures us that God always gives us strength.

Jesus said: "By their fruits you will know them." The goodness of prayer comes not from thinking much or saying many prayers, but from loving much. Prayer is a humanizing and divinizing process: a process to change the silky caterpillar of our soul into the white butterfly of God. (St. Teresa, Interior Castle: M5, 2, 4).

Good prayer necessarily leads to a growing rejection of sin. Fruit of prayer is our firmer resolve to say no to sin! "One cannot sit the contraries, God and sin, at the same table" (St. Teresa). Moreover, prayer is especially helpful against temptation: "Watch and pray" (Mk 14:38).

The practice of virtues is the fruit of prayer. Prayer, indeed, is the mother of all virtues (St. Catherine of Siena). Prayer strengthens the doctor to practice and defend basic values such as life, truth, freedom, justice and solidarity. It helps the physician to acquire the virtues that helps him/her practice the basic ethical principles of good medical practice, such as respect for every human being, informed consent, stewardship, totality, non-maleficence and beneficence, truthfulness, confidentiality, totality, stewardship, conscientious objection. Prayer encourages the doctor to promote human life from the moment of conception (against abortion) to natural death (against euthanasia and the death penalty).

Above all, fruit of genuine prayer is the practice of love, the virtue of virtues: "Put love where there is none, and you will reap love"; "In the evening, you will be examined on love" (St. John of the Cross). Prayer issues good deeds, deeds of love. Prayer helps us love our neighbors, in particular the poor and wounded neighbor. St. Vincent de Paul says that "Looking after the sick is praying." True prayer is necessarily linked to compassion: Prayer together with almsgiving can furnish us with countless good things from above; they can quench the fire of sin in our souls and can give
us great freedom" (St. John Chrysostom, The Seventh Baptismal Instruction). Throughout history, doctors in general are compassionate with poor patients. Prayer strengthens and enriches this marvelous trait of physicians.

Prayer is a source of courage to carry our cross. Prayer with love makes our cross bearable and even joyful. Prayer helps every Christian to carry out the duties of his/her vocation.

Prayer leads to good work. Work needs the breathing of prayer to become a prayer, and certainly prayer time is never wasted time: "We need this deep connection with God in our daily life. How can we obtain it? By prayer" (Blessed Mother Teresa of Calcutta; cf. Benedict XVI, DCE, 36).

Prayer gives meaning to our work and to all our activities. Pope Francis tells us: "Pray and work..." On one hand, "prayer, interior space, prolonged moments of adoration, prayerful encounter with the word, sincere conversation with the Lord" - all are needed so that "our words do not become meaningless" (EG 262). Prayer must not replace work, but animate, purify, improve our work, including our professional work. If we are prayerful, our work becomes a prayer: our work is our participation in God's creation, and therefore our work must be competent work, the mission of a true vocation, as a passion of love. Prayer helps us love our work and the people we work with. K. Gibran says that those who work without loving their work should not work, but ask for alms at the entrance of the temple.

How come, we ask, that my prayer does not produce those fruits? It appears that often our prayer does not seem to be that helpful and does not make us better. Perhaps, we do not follow the recipe! Jesus the Lord tells us not to pray like the hypocrites who pray to be seen and applauded (cf. Mt 6:5); not like those who are too talkative before God, who multiply words to be heard (cf. Mt 6:7). We pray as Jesus taught us: "Our Father who art in heaven..." (Mt 6:9-13).

St. Thomas Aquinas points out that the benefits of prayer are: remedy of evils, attainment of what we desire, and establishment of friendship with God. To obtain these benefits, however, certain conditions are required, namely: confidence, rectitude, order, devoutness, and humility (cf. The Aquinas Catechism, "On the Lord's Prayer." Manchester, New Hampshire: Sophia Institute Press, 2000).

What our attitude should be when we pray? When we pray, we are collected, recollected, not scattered. Prayer time is God's time, our quality time with God.

We are humbly present before God. Prayer is the language of humility. Without humility, progress in prayer is not possible (cf. St. Teresa of Avila, Interior Castle, 7M 4, 8). In the actual presence of God, we are humble. We are sinners like the publican (Mt 6:5-6). We are humbly penitent. "Lord, I am sorry," and ask his forgiveness, and forgive (Mt 6:14-15). "Pardon your neighbor any wrong done to you, and when you pray your sins will be forgiven" (Si 28:20).

Prayer involves total trust in God. He is our Father. He loves us. We are his children and work hard - like St. Therese of the Child Jesus - to be child-like, not childish. Prayer is an effective medicine against pride, and "a holier and wiser than thou" attitude.

In another classic of Spiritual theology, The Way of the Pilgrim (no. 6), the anonymous Russian author tells us that prayer to be true "should be offered with a pure mind and heart, with burning zeal, with close attention, with fear and reverence and with the deepest humility."

5. Conclusion

We do not leave prayer, only in an emergency of love! Joseph Cardinal Bernardin: Jesus' work, at times, interfered with his sleep, but never with his prayer" (The Gift of Peace, 1197). "Never leave prayer, St. Teresa of Avila advises us, "there is always remedy for those who pray," "prayer is the royal road to heaven."

We pray always. We are theological people; thus, faith prays, and hope prays, and charity prays. We are sinners. We ask God's forgiveness. Prayer leads to penance; and the virtue of penance, to the Sacrament of Penance. Prayer is the best way to purification, to change, to renewal, that is, to fidelity to one's vocation. We persevere in prayer, even (and especially) when we go through the desert of life.

Prayer leads to personal and community or family change. Many things are wrong in society; also, perhaps, in our own personal and community lives. We can ask others to change; but, unless we change, we cannot truly expect change. The story of a great Muslim mystic: as a young man he prayed every night: 'God make me a revolutionary to change the world,' but no change! As an adult: "Help me change my family and those around you," but again no perceptible change! As a mature person: "God, help me to change myself. Only then, he began to change himself, his family and others, and the world.

We pray often the prayer of prayers: the Our Father (cf. CCC Part Four, Section Two). This is how
you are going to pray, Jesus said, and taught them the Our Father, the prayer (Mt. 6:9-13). Let us close this reflection on prayer by praying **The Prayer:** The Lord's Prayer:

*Our Father who art in heaven,*
*hallowed be thy name,*
*thy Kingdom come,*
*thy will be done on earth as it is in heaven.*
*Give us this day our daily bread,*
*and forgive us our trespasses as we forgive those who trespass against us,*
*and lead us not into temptation,*
*but deliver us from evil.*
*Amen.*

◊
Saturday 3 October 2014

VI. Dr. Mariano M. Alimurung Memorial Lecture

1. "Strengthening One's Identity as a Catholic Physician in the Age of Globalization"
   Angeles Tan-Alora, MD (Philippines)

Abstract

The objective is to share insights from readings and observations about the Catholic Physician today. The presentation will explore the meaning of a Catholic Physician identity; how it is manifest in caring about those who are poor in Body, Spirit, or Material Assets; how this identity is strengthened in oneself and others through Prayer, Practice and Witness.

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Slides

2. Objectives
   • Share insights from readings and observations about the Catholic Physician in the Age of Globalization
   • Invite you to be one

3. Outline
   • One's identity as a Catholic Physician
   • Manifest in caring about the poor in Body, spirit, material assets
   • Strengthen this identity in the age of Globalization: Self and others, Prayer and witness

4. Identity
   • As Catholics Made to the image and likeness of God
     - Nearness to and intimacy with God
     - Openness and total giving to others
   • As Catholic Physicians
     - Same as Christ the Divine Physician
     - Practice as Christ would
     - Extend His healing mission

5. Manifest Care about the poor
   • As a person with needs that touch
     - Logical left brain,
     - Tender right brain,
     - Warm heart

6. The poor we serve: Body, Spirit, Material assets

7. Caring about the poor body
   • Body
   • Require Technical competence, Ethical sensitivity

8. Technical competence: Balance theory, research, and experience
9. Ethical Sensitivity
   • From what can be done to what ought to be done
   • Consider Consequences, Principles, Virtue
10. **Ethical Sensitivity: Consequences**: Patient, Family, community, and Society, Self

11. **Ethical Sensitivity: Principles**
   - Do no harm (Non-maleficence)
   - Do good (Beneficence)
   - Respect person
   - Justice

12. **Principles: Do no harm / Wrong**
   - Maintain sacredness and dignity of person and human life
   - Do not kill: "I do not perform abortions!"
   - Do not destroy integrity
   - Do no unsupervised care of inexperienced
   - Do not reveal secrets
   - Do not disregard family and cultural values

13. **Principles: Do good**
   - Treat as end: seek best interest first
   - Benefits outweigh harms in specific case
   - Patient's interest > self interest: Earning, Learning, Research

14. **Principles: Respect for Person**
   - Regard as someone of value: Do no harm, Do good, Deal with gentility
   - Explain truth to understanding "the Catholic physician is patient and perseveres in repeating his explanations"
   - Support free choices

15. **Principles: Justice**
   - Give due
     - Standard healthcare service and supplies
     - Accurate account and impartial recompense for injury
   - "Fair to those in need and fair to those who give"

16. **Ethical Sensitivity: Virtue**
   - From knowing to doing and being
   - Traits of character or habits of disposition under rational control,
   - To consistently think and act in ways that are good.

17. **Virtues for the Catholic Physician**: Fidelity, Courage, Humility, Compassion

18. **Virtues for the Catholic Physician**
   - Faithfulness to trust and promise: Seek what is best always
   - "It takes a huge leap of faith to risk my life and health to a complete stranger. If I cannot trust my doctor, how can I bare my body and soul? (Patient)

19. **Virtues for the Catholic Physician**
   - Humility: Contentment: accept reality
     - Moderation: simple life
     - Willingness to serve

20. **Virtues for the Catholic Physician**
   - Courage: Choosing not what is easy but what is right
     - Doing it without undue fear

21. **Virtues for the Catholic Physician**
   - Compassion: Feel for patient's suffering:
     - Move to serve in her turf
     - Individualized care
     - Attentive presence
   - "The best present my doctor can give me is his presence" (Patient)

22. **Caring about the poor in spirit**
   - Saint : Spirituality. Love that tends to the spirit
     - The vulnerable, fragile patient
     - "I realize that there is a god, and it is not me!"
23. Caring about the poor in spirit
- Feed the hunger for God
- Medical care is spiritual work
- True health is a restored fellowship with God
- Give Meaning, Hope, Love
- A God who is always present even if He is silent.

24. Poor in material assets
- No medicine
- Unequal healthcare
- Recognize responsibility - Work for minimum standard, equally available healthcare for all
- From our plenty to their need
- Influence reform and legislation

25. Strengthening our identity: Prayer, Witness

26. Prayer
- Expresses and shapes who we are
- We pray daily and fervently to forge our Christian selves

27. Morning Prayer
- Father, I adore you
- Thank you for your gifts.
- I am sorry for my sins and will try to sin no more.
- I renew my commitment to your healing ministry
- Make me always seek You in my work, in my life and in myself.
- Give me strength to face today's stresses, to be less selfish, more patient, more forgiving, tougher against temptation,
- Touch me with your Spirit so that every patient and person I come in contact with may feel your presence.
- Dwell in me, Bless me and make me a blessing to others.

28. Evening Prayer
- Lord I adore you.
- Guide me as I ask myself - "What could I have done better today?"
- "Did my patients see the healing Christ in me?"
- "Am I the person You created me to be?"
- I see my failures, weakness and flaws and I am sorry,
- Take my inadequacies into your hand.
- Fortify my resolve to become the best version of myself.
- Give me the courage to change.
- Thank You for Your grace and love.
- To you I commend myself.

29. Witness
- A Eucharist which does not pass over into concrete practice of love is intrinsically fragmented "
- From prayer to a prayerful life
- Exemplify what is right and true

30. Witness: "Today's world is in great need of witnesses, not so much of teachers, but rather of witnesses. It's not so much about speaking, but rather speaking with our whole lives" (Pope Francis, May 18, 2013)

31. Witness
- Awaken their awareness of God
- See moving and firm witnesses - In conformity with God's law
- Teach the Catholic norm
- Serve the less fortunate
- Pray for and with patients
- Love and pass God's love
- Joyful
- Lead so others follow
32. Conclusion: The First Catholic Physician's Guild
Objectives: To foster
• The Catholic physician's faith and relationship with God and His church
• The physician's knowledge and practice of moral and ethical principles
• The solidarity among its members

33. Conclusion: After 102 years...
• Does our faith and relationship with God and his Church manifest in the way we live?
• Is our practice Christ-like? governed by moral and ethical principles?
• Are we in solidarity with each other? passing on the love given to us?

34. Conclusion: Let us:
• live our catholic identity
• build the body of Christ
• be worthy of His trust
• delight in His service

35. Catholic Physician Identity: Thank you

36. Abstract
• The objective is to Share insights from readings And observations about the Catholic physician
  Today.
• The Presentation will explore the meaning of a Catholic Physician's identity; how it is manifest in
caring about those who are poor in Body, Spirit, or Material Assets; how this identity is
strengthened in oneself and others through Prayer and Witness.

Curriculum vitae
Chair, National Ethics Committee, Dept. of Health — Executive Director, Southeast Asian Center for
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Response : Strengthening one's identity
as a Catholic physician in the age of globalization
Vincent N Alimurung, MD

Text
What an honor it is to be with you today after Dr. Angeles Tan-Alora's lecture commemorating my
late grandfather, Dr. Mariano M Alimurung. On behalf of the Alimurung family, I would like to
extend our appreciation and gratitude to the organizing committee of this 24th World Congress of
the Federation hitemationales des Associations Medicales Catholiques chaired by Dr. Jocelyn
Yambao-Franco that has made this event possible.
I am not that familiar with Dr. Mariano's involvement with such distinguished Catholic medical
associations, but I am sure that he would have been delighted and honored to be among you today
as he has been with several audiences throughout his medical life.
Today we honor the physician as a Catholic in the process of international integration arising from the interchange of world views, products, ideas, and other aspects of culture. Dr. Alora's presentation has shared with us insights on exploring the meaning of a Catholic physician identity; how it is manifest in caring about those who are poor in body, spirit, or material assets; how this identity is strengthened in oneself and others through prayer, practice, and witness. In tune with the healing ministry of Christ, Catholicism has shaped many physicians around the world.

For many Catholics, a career in medicine is a calling from God, looking to a tradition that describes Christ as the Divine Physician who came to heal a wounded humanity. This implies an obligation to care for the least of our brothers and sisters. Meanwhile, over the course of history, philosophy, religion, language, the arts, and other aspects of culture spread and mixed as nations exchanged products and ideas. Global movement of people, goods, and ideas have expanded significantly while the advent of electronic communications, most notably mobile phones and the internet have connected billions of people in new ways.

How then would a Catholic physician respond to challenges posed by globalization; where does one align himself/herself vis-a-vis technological progress where the humanities, social, and natural sciences are forced to confront one another. As Dr. Alora mentioned, the ethical sensitivity of Catholic physicians is therefore challenged, how are its consequences, principles, and virtues brought to light in this era.

In the recent GOP response to US President Barack Obama's State of the Union address, "No challenge is too great and no dream is too big."

We must confront the challenges posed by globalization where the transformations of culture as well as by cultural differences give humanity opportunities (at Pope John Paul IPs urging) to become a single family, built on the values of justice, equity and solidarity.

The physician's alignment to the Catholic faith can be summed up in an address to the 2001 General Assembly of the Pontifical Academy of Social Sciences on "Globalization and the Common Humanity: Ethical and Institutional Concerns"; for to be effective in the world, we must try to understand the constancy of change and the obligation to be concerned with what is going forward in the world today, the phenomena collectively known as globalization.

In view of the enlightening presentation just delivered by Dr. Alora, let me delve into the context that provides the very challenge towards strengthening one's identity as a Catholic physician. Only by understanding the different elements that define globalization can one align the self or reconcile identity with his/her religious faith, whether Catholic or otherwise.

Globalization encompasses four aspects: trade and transactions, capital and investment flow, migration and movement of people, and the dissemination of knowledge; all processes of change which underpin a transformation in the organization of human affairs by linking together and expanding human activity across regions and continents.

Just to share some figures on the global Catholic population (source: Pew Research Center)... Catholics comprise 50 percent of all Christians worldwide and 16 percent of the world's total population; a number that has more than tripled in the past century. As of 2010, there is at least one Catholic among every six people in the world (from 291 million to 1.1 billion)

Of Asia's 4.3 billion inhabitants (60% of global population), the Philippines at 100.3 million strong checks in with the 12th highest in the world, 81% (2010) of whom are Catholics. This majority accounts for much of the Asia-Pacific region where only 3% are Catholics. I do not know how many Catholic physicians exist but you can extrapolate the figures and do the math to determine the potential impact a Catholic physician in the Philippines would have on the global population.

As we look at the four aspects that shape globalization, technological developments, which are defined as the socialized knowledge of producing goods and services, are conceived as the driving force behind most of these globalization processes. There are five important elements which give this driving force a socio-political role in the world: production, knowledge, instruments, possession, change. We must therefore ask how does a Catholic physician's view of these elements shape his identity.

Technology has something to do with production (of goods and services) for it improves our capacity to produce. Technology has something to do with knowledge for it is the result of intellectual activities developed through research and development institutions. Technology has
something to do with instruments for it indicates the usage of instruments as extensions of the human body. Technology has something to do with possession for those people who possess technology also control it in the form of patents, transfers, and protection of intellectual rights. And most importantly, technology has something to do with change for innovations from such technological advances have very important effects on the lives of peoples of the world.

In theology one learns about the progressive revelation of Christ which refers to the idea and teaching that God revealed various aspects of His will and overall plan for humanity over different periods of time. In technological progress we witness Christ's progressive revelation. It sheds new light on the physician's view of the world, of the impact of science on human nature. Doctors started using more tools as their understanding of the body increased. It also means that we must keep scientific advance and healthcare in conformity with God's law, ultimately treating a given patient as an end and not a means.

As such, today's standard of care will not be tomorrow's standard. Just over half a century ago, the world was not much aware about the contribution of genetic factors towards human diseases. The Human Genome Project (primary goal: to map and identify both physically and functionally, the approximately 20,000-25,000 genes of the human genome) was initiated to better understand the human DNA. Its completion in 2003 has unleashed different research perspectives towards establishing new strategies for medical diagnosis, treatment, and prevention. Furthermore, it specifically aimed to have all data generated to be freely and rapidly available on the internet so that the medical sciences could prosper around the globe. To date, the HGP has aided the discovery of more than 1800 disease genes, enabled probing of genotype-phenotype relationships, paved the way for over 1,000 genetic tests for various human diseases/conditions, resulted in developing 350 biotechnology-based products, and laid the foundation for the HapMap catalog of common patterns of genetic variation.

Looking back at history: "Before the stethoscope, access to a disease was a story told by the patient, but afterwards the doctor trusted much more the technology or the apparatus." notes Bjorn Hofmann, a philosopher of medicine at the Dartmouth Center for Health Care and Delivery Science. Hark back to the early 19th century when Alexander Fleming gave birth to the modern age of antibiotics and three decades later Watson and Crick (and Wilkins) unveiling DNA as the blueprint of life - the structure whose novel features are of considerable biological interest. Thus solving a moral problem with a technological solution repeats itself throughout history and the church has always understood that great transformations such as globalization are phases always passing away rather than culminations.

And as Pope John Paul II noted, "the Christian cannot limit himself to analyzing historical processes as they happen, maintaining a passive attitude, as if they were beyond his capacity to intervene, as if we were led by blind and impersonal forces."

Physicians the world over come from a variety of backgrounds, traditions and levels of commitment to religious belief come with a diverse set of understandings about what it means to be Catholic, what the church teaches and whether being Catholic has relevance to their lives as physicians. Not everyone finds church teaching congenial on matters like abortion, embryonal stem cell research, assisted suicide, or the role of medically assisted nutrition and hydration for persons in persistent vegetative states.

Moreover, the processes which underpin globalization have brought about a paradigm shift towards shared decision making and individualized medicine based on the plethora of information that continues to accumulate beyond what we can even comprehend. It raises the question: What does this do to the physician - does the doctor become a coach, a servant, or an adviser - what will the new role become? And where amidst all this does the Catholic physician find himself, developing and growing in ways that fully reveal what it means to be human. There is a spiritual component to human life that is as real and perhaps more important than what can be measured, seen or manipulated.

I always believed that the doctor-patient relationship transcends the four walls of the clinic and the hospital setting; a sacred space akin to a person's communion with God through genuine interaction taking into account the forces that shape the world today.

God bless you and God bless the Philippines.
VII. Session 4
The Practicing Catholic Physician

A Catholic Physician in a Non-Catholic Setting
Josef Glasa, PD, PhD (Slovakia)
Institute of Pharmacology, Clinical and Experimental Pharmacology, Institute of Health Care Ethics, Slovak Medical University; Institute of Medical Ethics and Bioethics n. f.; Bratislava

Abstract
A catholic physician is practicing his profession nowadays mostly in a non-catholic settings. Be it in a public or private hospital, research or clinical institute, university – medical faculty, industry, municipal structures, managerial posts within a health care system, and/or in different executive or legislation power structures. Concrete attitudes, convictions, cultural/moral ‘atmospheres’, interpersonal relationships and communications within these various working environments differ a lot within a broad spectrum, running from an open hatred and/or oppression, or even threats of physical elimination – up till explicit appreciation of somewhat unique contributions a catholic physician/health care professional is bringing to that particular milieu, when practicing his/her profession alongside the ethical/moral avenues consistent with his/her Christian–Catholic convictions.

Indeed, the present marked secularization of the society at large, and of the health care systems/provision in particular, may bring about situations, when witnessing, in an appropriate manner – more in deeds than in words, about one’s religious reasons for his/her good actions prepared to go beyond mere professional obligations, may be perceived as an interesting, even welcome departure from the “normal”, everyday’s routine behaviour or ‘discourse’ at the bedside, or in the outpatient office. Professional excellence, appropriate mastering of the ‘science and art’ of one’s medicine/health care profession, of course, is the condition sine qua non for any credible moral testimony. A special challenge may sometimes be presented by the religious, Christian, but non-catholic settings, marked today by considerable differences in practical dealings with concrete ethical issues in the health care practice/provision (e.g. contraception, abortion, assisted reproduction, some end-of-life care decisions, euthanasia etc.). These challenges are posed to be even greater in the religious, but non-Christian settings (e.g. Muslim, Hindu etc.), where such differences are deepened by, sometimes fundamental, divergences in understanding of the basic anthropological questions about the human nature, origin and (ultimate) destiny, including those about the roles and positions of the male/female members of the society/family/tribe/societal group, that are resulting in much divergent moral (ethical) attitudes and reasoning.

Dealing with those numerous challenges, a catholic physician/health professional is invited to find effective communication manners when entering into a friendly, collegial dialogue with his/her co-workers within the concrete health care practice environment, as well as with his/her patients/clients of very much different worldviews. In those encounters, a catholic health care professional is to maintain and deepen his/her personal (including moral) identity and integrity, albeit not necessarily revealing in the first place, or even imposing his/her views, convictions, or critical moral considerations to/upon his/her fellow citizens – colleagues, or patients/clients. Especially not by mere highhandedly “preaching” or criticising. It is important, of course, if possible, to express himself/herself in defence and effective support of innocent human beings, his/her patients, especially those who are impoverished, marginalised, stigmatized, displaced, or abandoned because of their untoward social, economical or other vulnerable situations prone to abuse, oppression or an unjust, even brutal exploitation. His/her is the profession exemplified by the deeds and attitudes of the “merciful Samaritan” from the paradigmatic Jesus’ parable. This almost universally understandable story, now about two millennia old, is remaining us in an impressive, almost graphic, and unforgettable manner about who is indeed our real, ‘un-bypass-able’ neighbour, relative, our true brother or sister.

As the witnessing to our Christian – Catholic faith and hope in today’s secular world (and health care milieus, as said) is far from being easy, neither it is free of danger, suffering and powerful temptations, it is more than ever necessary to lay oneself upon the Divine help of our Master – Jesus the Healer, the best Doctor of all times, drawing into the rich resources provided by Him to us in our Christian brothers and
sisters in His Church, including those being our colleagues in our difficult, but formidable health profession/s. In this respect, a necessary renewal of vivid catholic professional communities of faith and prayer may again prove its value, strength, and multiple benefits. This Christian associations’ work, nowadays in worrisome crisis in many angles of the World, may hopefully benefit from a good use of the novel communication possibilities and other managerial and communication improvements. But it will probably for ever be based mainly on a personal encounter, devotion and friendly, brotherly/sisterly sharing of the joys, difficulties, and also troubles of our unique and common ways to our Lord in heaven – and those to our fellow brothers and sisters, Christians and non-Christians, still needy pilgrims in this World, to whom we are sent to care for, to understand, to support, and even to heal.

References

Curriculum vitae
Physician and clinical researcher, teaches clinical pharmacology, hepatology and medical ethics/bioethics at the Slovak Medical University (SMU) in Bratislava. Deputy head, Institute of Pharmacology, Clinical and Experimental Pharmacology SMU; head, Institute of Health Care Ethics SMU. President, Slovak Society of Clinical Pharmacology; Scientific secretary, Slovak Society of Hepatology; Director, Institute of Medical Ethics and Bioethics n.f.; Founding Editor, Medical Ethics & Bioethics; Past chairman, Member, Ethics Committee, Ministry of Health, Slovak Republic; 2nd Vice-President, Slovak Medical Association (SMA), Chairman, SMA Commission on Bioethics; Member, DH-BIO (former CDBI, CoE, Strasbourg); Member-past, European Group on Ethics (EGE, EC; Brussels). Founding secretary, Member, Subcommittee on Bioethics, Theological Committee of the Slovak Catholic Bishops Conference; Board member, European Federation of the Catholic Physicians Associations (FEAMC), Corresponding member, Pontifical Academy for Life.

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A Catholic Physician Treating a Non-Catholic Patient

Jasenka Markeljevic, MD, PhD (Croatia)

Abstract
Analysis of most aspects of a Catholic physician treating a non-Catholic patient from the individual and institutional point of view requires a comprehensive approach that includes an analysis of the religious, cultural, intellectual and economic characteristics of a society, including the possibility for education and practicing religious orientation of both of them. The basic standards of the medical profession, the Hippocratic Oath, formulated almost 2500 years ago, represent the historical continuity of ancient-Christian tradition. In its original form it indicates how important it always is to continue ethical principles in a spirit of responsibility towards temptations and risks of the medical profession, respecting scientific researches, particularly now, at the beginning of the 21st century. Today, the dominance of technological, scientific oriented civilization, deprived of religious views of reality, fulfils our every day life with personal imperatives of understanding eternity, constantly emphasizing the spiritual insecurity and loss of inner harmony. The biomedical approach to health, the biopolitics and the rapid development of science, allow us the use of new achievements in the field of biotechnology, genetic engineering and nanoscience promoting research aimed at human cloning, IVF procedure, pre-natal and post-natal euthanasia. In these circumstances, both Catholic physicians and non-Catholic patients are concerned about the same reality, only from different points of view. They both are faced with human disablility, pain, fear and share the same fascination with mystery of life and suffering. A Catholic physician believes
that life and dignity of human being is a gift, created in the image and likeness of God (Imago Dei), and must be respected and protected from conception to natural death. The reality of Absolute truth of creation and its creator arises out of the same human capacity for knowing factual reality and spirituality. Human being exists as an expression of absolute truth that is imprinted in our dignity, life, consciousness, conscience and heart. It is important to listen to the voice of conscience and to be aware of the Absolute. A Catholic physician are faced with different medical guidelines, the "gold standard" which entails absolutely, reference truth about the ethical and professional aspects of individual procedures in medicine, that define the international professional associations. In such circumstances, questions of how to respect different religious or non-religious beliefs of non-Catholic patient are inevitably raised? How to implement the right to conscientious objector guaranteed by Resolution of EU Parliament? How to ignore the so-called "cost / benefit" principle, the influence of "linguistic engineering" and ethical relativism on non-Catholic patients? A personal contact with a non Catholic patient is essential since suffering opens the possibility to realize the spiritual/religious dimension of life and recognize the authentic truth of the existence. Special attention has to be paid to the role of Christian hospitals and care centres for dying and the elderly as well as handicapped and abandoned children, and the disabled. Such places should be environments in which the pain and suffering in their human and Christian sense should be recognized and interpreted.

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**Curriculum vitae**

Assistant Professor, PhD, specialist in internal medicine, subspecialist in clinical immunology and allergology, Department of Medicine, School of Medicine, University of Zagreb, Division of Clinical Immunology and Rheumatology, Zagreb Clinical Hospital Center, Kispaticeva 12, Zagreb, Croatia

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**A Catholic Physician Dealing with Laws Contrary to the Catholic Faith**

Fr. Joseph Tham, LC, B.Sc, MD, B.Phil, STL, MBe, PhD (China)

**Abstract**

There has been disturbing news in different parts of the world regarding laws that made it difficult for Catholics and Christians to practice medicine according their faith. This talk will first look at the nature of law according to St. Thomas Aquinas. All human laws are derivable ultimately from the law inscribed in nature that human beings can discover. In this sense, any law is unjust because it is contrary to natural law primarily before it is contrary to the divine law. This distinction is important because otherwise, laws contrary to the Catholic faith are just applicable to Catholics and not to everyone else. Thus our resistance and objection would be seen as sectarian, and our attempt to change the unjust law would be an imposition of the Catholic beliefs on the general public. Thus, according to Catholic teaching, the rationality of human laws are derived primarily from reason rather than from faith. Hence, all unjust laws are no law at all, and Catholics and all religious groups should resist them and appeal to objection of conscience. At the same time, there is increasing protection of religious views from the perspective of human rights and international laws. Hence from a practical point of view, appeal to religious exemption are more effective and better defined than appeal to objection of conscience. Some practical points on how to protect oneself and to change the laws are given, as well as some principles regarding cooperation with evil in our duties.

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**Slides**

1. A Catholic physician dealing with laws contrary to the Catholic faith: Fr. Joseph Tham, LC, MD, PhD, Dean, School of Bioethics, Ateneo Pontificio Regina Apostolorum, Rome, Italy.

2. Recent headlines: Obama Care: Hobby lobby — College of Physicians and Surgeons of Ontario:
Physicians and the Ontario Human Rights Code — Polish Prime Minister Says Doctors Must Perform Abortions Despite Conscience Objection

3-4. **Natural Law**: Not physical law — We can discover in our hearts (murder is wrong) — Must be reason based, logos — Common and accessible to all humans — Do good and avoid evil — Not divine positive laws — Conscience CCC 1778 -- Law written in our hearts. Rom 1

5. **Divine Law**: Eternal salvation needs God’s revelation — Sin clouded out intellect and will, need Church to enlighten us — Law only judge external behavior, not interior motives — OT and NT

6. **Human Law**: Reasonable, Common good, Authority, Promulgated, Political, Consensus, Majority, Follows practice, Critical mass

7-8 & 13. **Unjust law is no law at all**: Natural Law (Conscience objection), Divine Law (Religious objection), Unjust Human laws, Eternal Law

9. **Conscientious objection**: Cooperation with evil: Formal, Material (Proximate, Remote), Degree of heroicity — Doctors, nurses, pharmacists, investigators

10. **Unjust laws**: Laws follows practice: Abortion, IVF, contraception, same sex marriage, etc. — EV 74 regarding modification of unjust laws

11. **Human rights and international laws**
   • Council of Europe, Resolution1763 (2010), UK Equality Act 2010, Laws on abortion

12. **Practical advices**
   • Know the laws in your country regarding conscientious or religious objection
   • Clear statements from religious authorities
   • Change culture, critical mass, change laws
   • Undercover or full disclosure? Wise as serpents and innocent as doves: prudence.

14. **References**
   • *Summa theologiae*, I-II, q.90-108.
   • *Evangelium Vitae*

15. **School of Bioethics, Pontificio Ateneo Regina Apostolorum, Rome**
   • info.bioetica@upra.org - www.upra.org

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**Curriculum vitae**

Dean, School of Bioethics, Regina Apostolorum Pontifical university, Via degli Aldobrandeschi 190 - 00163 - Roma - Italy - Tel: (+39) 06 66527654 - Fax: (+39) 06 66527814 - <jtham@legionaries.org>

Fr. S. Joseph Tham was born in Hong Kong and immigrated to Canada at the age of fifteen. At the University of Toronto, he first majored in Mathematical Sciences and then graduated from Medical School. After several years of work as a family physician, he entered the seminary of the Legionaries of Christ and was ordained a priest in 2004. As a part of this preparation, he has obtained his degrees in philosophy and theology at Rome’s Regina Apostolorum Pontifical university, where he also completed his post-graduate studies in bioethics. He successfully defended his doctoral dissertation with high honours on “The Secularization of Bioethics—A Critical History” under the direction of Dr. Edmund Pellegrino, former Chairman of the President’s Council on Bioethics. He is School Dean and presently teaches bioethics in Regina Apostolorum. He is the Editorial Coordinator of the journal Studia Bioetica, and a Fellow of the UNESCO Chair in Bioethics and Human Rights. He is the author of The Missing Cornerstone (2004), The Secularization of Bioethics (2007) and Bioetica al Futuro [Bioethics of the Future] (2010) and Religious Perspectives on Human Vulnerability in Bioethics (2014).
VIII. Session 5
The Catholic Physician and the Cry of the Poor

The Catholic Physician and the Cry of the Poor
Sr. Eva Fidela Maamo, SPC, MD

Slides
2-7. Tboli tribe, Ubo tribe, Manobo tribe, Muslim tribe, Bilaan tribe, Kalagan tribe
9-10. Lake Sebu, Surallah, south Cotabato (November 10, 1974)
12. Clinic, Lake Sabu, Surallah, South Cotabato
14-17. 3 prevalent factors contributing to the illness of the people: Poverty, Malnutrition, Ignorance
20. Statistics (Sta. Cruz Mission Clinic Statistics, Lake Sebu Surallah South Cotabato)

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22. Foundation of Our Lady of Peace Mission, Inc.

23. Vision - Mission: A non-governmental organization committed to the upliftment of the underprivileged individuals, families, and communities towards a sustainable total human development.
24-27. 1) Health Program:
• Our Lady of Peace Hospital, The Hospital for the Poor, Coastal Rd., Brgy. San Dionisio, Parañaque City
• Surgical, Medical, and Dental Mission
• Tribal Barefoot Doctors’ Training, Now serving their communities! (Batches 1 to 7)
• Supplemental Feeding – 12 Feeding Centers: Back of Lorenzana Compound, Parañaque City - Villa Coastal Madrigal, Las Piñas City - Villa Coastal Lopez, Las Piñas City - Paco Manila - Sto. Niño, Navotas - Wawa, Longos, Bacoor, Cavite - Sitio Putting Bato, Navotas - Gala, Zambales - Sta. Ana, Manila

28-35. 2) Livelihood Program:
• Urban poor livelihood: Micro-lending, Pedicab, Peanut Butter Making, Soap Making, Dried Mango and Dried Banana
• Sari-sari Store: Fish Vending, Vegetable Vending, Food Vending
• Aeta Resettlement Area Livelihood, Diversified Hog Raising: Piggery, Poultry, Goat, Tilapia Farming, Carabao Dispersal
• Weaving, Sewing, Cloth Dyeing
• Handicrafts, Basket Weaving, Pottery, Fruit Preservation
• Organic Farming, Tree Planting, Pedicab, Mango Production,
• E-Pondo (Cooperative Store) Project
• 8 Day Care Centers

36-37. 3) Scholarships:
• High School, College
• Functional Literacy

38-41. 4) Street Children Program (Angels’Home):
• The Angels
• Formal Schooling: Tutoring, Catechism, Pilgrimage
• Livelihood Training, Rosary Making
• Family Day

42. 5) Program for the Elderly

43-44. 6) Spiritual and Values Formation Program:
• Retreats and Recollections, Marriage Encounter, Counselling & Basic Ecclesial Community
• Mass Baptism, Mass Wedding Children’s Catechism, Eucharistic Celebrations

45. 7) Culture Preservation of Tribal Communities

49. Surgical mission

52. Salamat po!

Curriculum vitae
IX. Session 6

The catholic physician under siege: personal witnessing

The Catholic Physician under siege: Personal witnessing, Asian experience
Peter Au Yeung, MD (Hongkong, China)

Abstract

As a Hong Kong doctor trained to the specialist level in England, parts of my personal witnessing happened in the UK. Having checked with Dr Blin, I have decided to share my experiences in England at this point to supplement his European report, before embarking on remarks about Hong Kong and China. The hostile attitude to opposed to abortion (and also contraception as well) in the UK was quite apparent by the 1980s. After all, in the 1970s an obstetrician refusing to perform abortions had to leave because all doors were closed to him. That experience led him to talk about a Marshall plan for mothers at the last Congress as well as floating the idea of a training institute where obstetricians and gynaecologists who conscientiously object to abortion (+/- contraception) can get qualify in the specialty. By the late 1980s, some GP trainees were threatened with being unable to complete training if they did not acquiesce and participate in contraceptive services. I was part of a subcommittee of the English Guild, working with Dr Paddy Linehan of beloved memory, to help out individuals as well as formulating a plan for junior trainees.

A year or two later, I was personally bullied by a barrister and his wife, as the duty obstetric anaesthetist in Labour Ward, to help with an epidural placed for pain relief for aborting a 20 week old foetus which had just been seen on ultrasound to suffer from the hare lip/cleft palate syndrome. I stood my ground, refused involvement and, as a result, got a 4-page letter of complaint alleging all sorts of inappropriate behaviour when all I did was to assert my rights to conscientious objection as protected by Law. Luckily the department was understanding and the matter was resolved.

Returning to Hong Kong as a visiting university lecturer, I was able to navigate my way through the work schedule to avoid anaesthetizing for abortions and sterilizations. This was partly through working more in intensive care. Yet I have heard anecdotes about interns and trainees forced to prescribe medication for abortions, obtain consent etc. and various hospitals chaplains have repeated more of the same, though when the Hong Kong Guild tried to quantify the problem, no systematic breach of freedom of conscience was properly identifiable. Yet the individual cases still keep surfacing. Although pro-life lawyers have talked about drafting some form for healthcare workers to declare their conscientious objection to the management, it can be seen that these moves may not be actually helpful on the ground in helping to people concerned (usually of a junior rank) being pressurized to do things they consider wrong.

So far there has not been a training requirement for obstetrician and gynaecologists in Hong Kong to need to induce abortions or be involved in sterilizations and contraception as a mandatory part of training. Whether it would come to this (like say in England) is hard to say, but the march of hard secularism in Hong Kong is proceeding in a similar fashion as in Western countries, so it would not surprise at all, if this would eventuate. But besides the usual minefields of abortion and contraception, the spectre of advancing LGBT rights can bring problems to other specialties such as psychiatry and reconstructive surgery.

Back to contraception, paradoxically the tide might be starting to turn as interest in Natural Family Planning is increasing, though not for spacing children, but rather as aids in conceiving. There also seems to be a demand for NaPro technology, though with no recognition of this alternative to artificial reproductive technology by the medical authorities, gathering a critical mass to launch and promote this alternative is some way off. As to other areas of conscientious objection, the awareness relating to use of vaccines made from illicit biological material is just beginning, and there is still some way to go before proper campaigning for ethical vaccines can start.

As for Mainland China, although the "One Child Policy" does not operate in Hong Kong due to the “One Country Two Systems” Model, the fact that the policy employs large scale forced abortion and forced sterilizations to achieve its aims is common knowledge in the SAR well before it became internationally
well known. Tales of such breaches of human rights make their way from time to time into the local newspapers. Some individuals (even ones connected with pro-life organizations) in Hong Kong are loath to criticize, whilst others are more forthright. There can be absolutely no doubt that religion is considered officially in Mainland China as something private between one and one’s Maker, but something that could never be allowed to affect one’s life as seen in public, so there can be no question of allowing conscientious objection to doing abortions or sterilizations. There are claims that Church teachings relating to bioethics in general and abortion, contraception and sterilization in particular are censored or otherwise rendered inaccessible. The recent announcement that the Mainland authorities are considering developing a form of Christian theology supportive of Government policies is certainly further cause for concern.

Of course the recent political developments in Hong Kong, intimating Mainland China reneging on the "One Country Two Systems" Model and enforcing Mainland style rule is worrying, given the propensity of the ruling Communist Party to give scant regards to a broad range of human rights. One can only pray that this would not come to pass soon.

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Text

I would beg the indulgence of the Congress and change the scope of my presentation to include my experience in the United Kingdom. I studied and spent my first years as a junior doctor in England, where there were hostile attitudes towards those who would not do certain procedures because of their religious beliefs. Participants at these Congresses would know Prof. Robert Walley, being an obstetrician and gynaecologist refusing to do abortions, who was left with no option but to leave the UK. Having had a successful career in Canada, he founded MaterCare International, to help improve maternal health in Africa and to tackle the neglected problem of obstetric fistula there. MaterCare is now part of our FIAMC family.

Another problem some years later concerned doctors training to become general practitioners (otherwise known as GP trainees). There was trouble over contraception training requirements as well as handling the statutory paperwork relating to abortion. There was a specific doctor involved and her case was taken up by the UK Guild. As a result of this, the UK Guild set up a working group to explore the problem of junior doctors as well as GP trainees in relation to conscientious objection in the course of their training as well as to provide general advice on how to minimize problems. I had the great privilege of working with the late Dr TP (Paddy) Linehan (formerly President of the FIAMC) on this important project.

It was within this contest that my personal witnessing took place. I was the duty anaesthetist for Labour Ward on that day, when a barrister and his wife came in for the abortion of an 18-20 week old foetus found suffering from hare lip/cleft palate syndrome by ultrasound scan at this relatively late stage of pregnancy. An epidural was requested and as it was to the anaesthetic department, I conveyed the message and reminded them that I would not participate on the grounds of conscientious objection. A colleague soon came and performed the procedure. However, things did not go smooth and various other attendances were needed. Soon they directly demanded that I came to attend to them. It was something like a top-up and the pregnant lady was never in any danger, but they were adamant that they got immediate medical attention (arrangements had been already made for someone to come). Somehow they got to know that the duty anaesthetist (ie me) would not participate because of conscientious objection and demanded to see me immediately. After politely explaining to them that I would not get involved, the husband started to bully me to force me to attend to the patient, asserting that I had an absolute duty to intervene. At this point I firmly said that the Law afforded me protection in my conscientious objection and I would not comply. Of course things got downhill from there. My colleague did come and intervene and I just got on with the other parturient ladies as needed.

Months later, the consultant obstetric anaesthetist talked to me in a semi-formal manner. He was well aware of my position and was sympathetic. He showed me the very long (4 pages of A4) and vitriolic letter, commenting that he did not believe that I have behaved in the manner described in the letter of complaint. I explained that as he had known me in the months I had worked in the department, my objection to participating in abortion (and sterilizations) had always been communicated discreetly to other members of the department on a “need to know” basis, and that I had neither been targeting the couple nor denouncing them in front of the whole Labour Ward. In the end, we went through the letter and I was able to convince my consultant that I had behaved
I later return to Hong Kong where I was a Visiting Lecturer in Anaesthesia and Intensive Care at the younger of the 2 medical schools. There the lecturers were channeled to either Intensive Care or Obstetrics and since I had trained in Internal Medicine and was a member of the Royal College of Physicians, I naturally was directed to the Intensive Care stream. Thus I managed to stay clear of abortion (and sterilizations), but I was unsure about situation for others whilst there. There was however concerns from priests, one of whom mentioned his concerns at a Guild AGM, that junior doctors and nurses at different hospitals had been forced to participate in various ways in abortions. As far as the bosses and seniors members of the departments are concerned, there were no problems although the juniors tell different story. However further enquiries did not lead to any concrete data, so with no data, there can be no lobbying. There is also an ongoing initiative from lawyers, about preparing a form for doctors and nurses to declare conscientious objection to their hospital or department, but it seems unlikely to help as there is statutory “protection” already. In any case, pressure to conform can always be in the form of peer or senior pressure and in such cases, neither a declaration form nor statutory protection is of much use.

Apart from the aforementioned, there are other areas of concern. As yet there is, unlike in the United Kingdom, no requirement in training for Obstetrics and Gynaecology yet to perform abortion procedures. Contraception is less of a problem in Hong Kong because the contraceptive pill is available over the counter, and does not need a doctor’s prescription. As contraception training is also not required for family medicine training, there have not been any reports of problems encountered. Further concerns relate to the anticipated problems for psychiatrists and surgeons over the emerging LGBT agenda as well as the problem of vaccines made from illicit biological materials.

As for Natural Family Planning (NFP) and contraception, the former is not really recognized as part of birth regulation, but there is increasing interest in NFP, less for delaying or spacing children, but as a means of trying to conceive for subfertile couples. In this respect, there is increasing interest in NaPro Technology, although this is not established yet in Hong Kong.

Turning to mainland China, it is run by basically a totalitarian government emphasizing rule by law rather than the Rule of Law. Religion is highly restricted, and one is not expected to live out one’s religion in one’s daily lives. There is state control of Churches, with party political control over church affairs and even teachings. As far as the Catholic Church is concerned, teachings contrary to government edicts are banned, and the relevant parts of the Catechism does not get official government approval. The Chinese government is recently reported even to be exploring its own brand of theology. For some 35 years, China has been pursuing the One Child Policy, using voluntary and forced abortion and sterilization as the main tools and punitive fines as well as the denial of registration of persons (which affect everything from education, jobs to pensions) as backup. The stories of abuses have been reported in HK for many years, well before international concern started. The preference for male heirs led to gendercide (via selective abortion and infanticide of females) leading to very serious sex imbalance. Its effects are felt in Hong Kong, as pregnant women swarming to Hong Kong to give birth, partly to escape One Child Policy, as well as for the (much more generous) rights and benefits of persons born in Hong Kong, creating much tension in the city.

In conclusion, there have been some harassment and coercion in Hong Kong, but no evidence of systematic denial of rights to conscience relating to abortion can be found. The insecure totalitarian regime on Mainland maintains a tight control of religion as well as speech and thought in their society. It cannot be expected and there is indeed no room for conscientious objection there.

Curriculum vitae

Dr Au-Yeung joined the Guild of Catholic Doctors in the UK as a junior medical student and got into the habit of attending their Annual Symposia. Voted in as a student observer to the National Council in the
Challenges to Catholic Health Care in the United States
Kevin J. Murrell, MD (USA)

Abstract

As challenges to basic human and U.S. Constitutional freedoms increase in the United States, Catholic health care comes under attack. Last year’s annual CMA conference addressed many of these challenges and pointed to the importance of Catholic Social Teaching as a foundation for the exercise of many of the freedoms we enjoy in society.

These challenges, such as the HHS mandate on provision of contraceptives by all health care programs, including Catholic organizations, are being met by lawsuits against the government and a strong commitment by the Catholic Bishops and the Catholic Medical Association, as well as other Christian associations, to fight these restrictions on basic human and Constitutional freedoms.

This year’s CMA conference is titled “Courage in Medicine: Defending and Proclaiming the Faith in the New Evangelization”. The conference chairman, Dr. Peter Morrow, writes: “The 2014 conference will begin by exploring the grave threats posed by a radical and progressive secularization of society and its impact on the profession of medicine. It will highlight the fact that health care professionals are on the front lines of a battle between good and evil, a battle that has been going on throughout all of salvation history and one that is played out daily in the choices we make as Catholic physicians. It will then proceed to examine moral courage and the pivotal role it plays in enabling medical professionals to remain consistent in pursuing the good; and steadfast and firm in the face of opposition and difficulty. In these challenging times, those in the profession of medicine will require ‘courage to contradict the prevailing mindset… and the courage to stand firm in the truth’ (Pope Benedict XVI). Finally, we will consider the mission of health care professionals to re-evangelize not only the medical profession but also the very culture itself by joyfully and courageously defending and proclaiming the truths of the Faith in our daily lives and in the practice of medicine.”

These challenges are coming from a new progressivism in politics that is secular and utilitarian in nature and willing to sacrifice the foundational precepts of the U.S. Constitution which declare basic rights of the people to be inalienable and not dependent on the prevailing political ideology. These challenges are also awakening a new fervor in Christians to fight for these rights and contributing to a new ecumenism as the Body of Christ recognizes its need to come together in commitment to Christ and the Gospel. “In the depths of his conscience, man detects a law which he does not impose upon himself, but which holds him to obedience. Always summoning him to love good and avoid evil, the voice of conscience when necessary speaks to his heart: do this, shun that. For man has in his heart a law written by God; to obey it is the very dignity of man; according to it he will be judged. (9) Conscience is the most secret core and sanctuary of a man. There he is alone with God, whose voice echoes in his depths.” (Gaudium et spes, #16)

Curriculum vitae

Dr. Murrell entered medical school several years after serving in the U.S. Army as a helicopter pilot. He
became interested in medicine while flying medical evacuation missions in Vietnam. Dr. Murrell graduated from the Medical College of Georgia in 1977 with an M.D. He is Board Certified in Psychiatry. He worked in General Psychiatry in Community mental health clinics, has been on the Psychiatry faculty at the Medical College of Georgia, worked at the Veterans Affairs Medical Center and continues to work part time back in Community mental health. He was Chairman of the Ethics Committee at the Medical College of Georgia Hospital and Clinics and Director of the Psychiatry Clerkship at MCG. Dr. Murrell is a past-president of the Catholic Medical Association (USA), a former Delegate to FIAMC from North America and former Treasurer of FIAMC. He and his wife, Karen, have been married almost 48 years and have 5 children and 19 grandchildren.

Challenges the catholic doctors have to face.
European experience, personal witnessing
Francois Blin, MD, President of FEAMC (France)

Abstract

The challenges to the catholic medical associations in Europe come from several sources:

1. The European organizations:
   • The Council of Europe (based in Strasbourg, France). It regroups all the countries in Europe (47 countries, including Russia). It is the preferred organization for the protection of human rights and dignity of man in Europe. Among its several structures are the Parliamentary Assembly, and the European Court of Human Rights.
   • The European Union (based mainly in Brussels) regroups only 28 countries (17 are from western Europe). Bioethical issues were recently discussed in structures: The European Commission, and the European Parliament.
   • The WHO Regional Office for Europe (based in Copenhagen, Denmark) published in 2011 a quite unacceptable document on "Standards for sexuality education in Europe”.

2. The laws of the different countries. A few examples:
   • Euthanasia has been legalized for several years now in Netherlands, Belgium, and Luxembourg, and assisted suicide in Switzerland
   • There are serious difficulties for conscientious objection in several countries (Poland, Norway...)
   • In France, laws authorizing same sex marriage, research on embryos, and creating a "right to abortion" were recently voted through. End of life issues are still being discussed.

3. The different religions in Europe: The great majority of Europeans are Christian (approx. 800 millions). There are:
   • A Catholic majority in Italy, Spain, Portugal, France, Belgium, Austria, Bavaria (South Germany), Hungary, Poland, Lithuania, Slovakia, Slovenia, Croatia. But the influence of the Church, and regular attendance to Mass are declining. Example in France: 87% of the population said they were catholic in 1972, 75% in 1980, and 64% in 2009. And among them, the percentage going to mass every Sunday dropped from 20% in 1970 to less than 5% in 2006.
   • A Protestant majority: in United Kingdom, north of Germany, Scandinavia.
   • An Orthodox majority in Greece, Cyprus, and the eastern part of Europe (Serbia, Montenegro, Macedonia, Moldavia, Romania, Bulgaria, Belarus, and Russia). There is great spiritual theological closeness with the Orthodox; the greatest theological difficulty relates to the Primacy.
   • Islam is only a majority in the old parts of the Ottoman Empire (Turkey, Albania, Bosnia-Herzegovina, Kosovo), but the new fact is the growing presence of Moslems, because of migratory phenomena: 12 million in 1991, around 35 millions now (among which 5 millions in France).
   • No religion is mentioned for 18% of the European population, and it is already a majority in Czech Republic, Netherlands, and Estonia.

FEAMC had its first Congress in 1964 in Malta with the countries of western Europe. The Fall of the Iron
Curtain in 1989 nearly doubled the number of member-Associations (22 in 2014). A few associations disappeared (Malta, Luxembourg), some are in a difficult position (Spain [except Catalonia], Austria, Lithuania, Netherlands...), in others the average age is rising up, while the number of members is declining, some are still in a good position (Italy, Croatia, Poland, Portugal).

• FEAMC holds a Congress every 4 years. The last Congresses were in Gdansk (Poland), in September 2008 "Natural law and statutory law in contemporary european medicine", and in Rome in November 2012 "Bioethics and Christian Europe".

• The board members meet twice a year in different places (10 to 18 countries are usually represented). The last board meetings were held in:
  - Strasbourg (France) in April 2009 (Visit of the Council of Europe and discussion with the bioethical authorities of it, reception of the church representatives to the Council of Europe and to the European Union);
  - Lviv (Ukraine) in October 2009 (oriental liturgy);
  - Lourdes (France) in May 2010 (short meeting, during the last world Congress);
  - Bratislava in October 2010 (preparation of the Brussels meeting);
  - Berlin in May 2011 (discussion on "WHO Standards for Sexuality Education in Europe");
  - Brussels in October 2011 (Symposium inside the European Parliament on "Sense and nonsense of Human fragility in contemporary European society");
  - Dublin in May 2012 (Preparation of the next Congress in Rome);
  - Zagreb in May 2013 (Study of the CoE "Guide on the decision-making process regarding medical treatment in end-of-life situations" - Comments were sent to the Committee on Bioethics [DH-BIO] of the Council of Europe);
  - Bari (Italy) in October 2013 (ecumenical meeting with an orthodox doctor, specialized in palliative care, and sent by Moscow Patriarchate);
  - Bratislava in June 2014 (Important meeting with the Slovakian Episcopal Conference, in the presence of Mgr Zimowski, president of the Pontifical Council)

• FEAMC has edited a Biannual Bulletin since 1969, and had a website (www.feamc.eu) for more than ten years. Among the member-associations: 12 publish regularly a Bulletin and 18 have a website.

Conclusion: The crisis in Europe is more moral than financial. Values recognized as universal and which are the strength of our society are under threat (respect for life [1], meaning of marriage...) so that our civilization is facing a risk of decadence. If solidarity with the weakest is more than ever the sense of the Gospel, it is also important - for us doctors - to be extremely vigilant in the field of bioethics.

[1] Dr Albert Schweitzer (Nobel Peace Prize 1952) would have said "Reverence for life"

Text

In Europe, the catholic doctors have to face two kinds of challenges:

1 - External challenges

a) The Council of Europe is located in Strasbourg, France. It regroups 47 countries in Europe, including Russia (Belarus, the last communist country in Europe, is still not member), and 5 observer countries: Vatican, USA, Canada, Japan, and Mexico. It is the preferred organization for the protection of human rights and dignity of man in Europe. Among its several structures, the Steering Committee on Bioethics, CDBI (which became in 2012 the Committee on Bioethics, DH-BIO), prepared some remarkable texts, among which The Oviedo Convention, published in 1997 ("Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine"), and further important texts.

But,

• In the Parliamentary Assembly, were rejected after difficult debates:
  - and one willing to limit the right to conscientious objection for healthcare professionals (McCafferty draft resolution in 2010)

• The European Court of Human Rights tends now - according to recent decisions - to allow assisted suicide, to approve the right to abortion, and to authorize surrogate motherhood.

b) The European Union has its offices mainly located in Brussels, Belgium. It regroups only 28 countries, united by treaties (17 from western Europe, and 11 from eastern Europe, and has several structures. Inside it:

• The European Commission recently opposed its veto to a legal European Citizen Initiative called "One of us", and which aimed to prohibit funding for embryo destructive research. This Citizen Initiative could have been accepted if it had more than 1 million signatures, but though it had
1,721,000, coming from the 28 member-countries of the European Union, it was not accepted!

- The European Parliament happily rejected, in December 2013, the Estrela report "on Sexual and Reproductive Health and Rights", wanting to get recognized a universal right to abortion.

- The WHO Regional Office for Europe, located in Copenhagen, Denmark, published in 2011 a document on "Standards for sexuality education in Europe". The conceptions of "sexual health" and "sexual rights" in this text being quite unacceptable, FEAMC published in May 2011 a statement against it.

2. The laws of the different countries are the 2nd of the external challenges

- Euthanasia has been legalized in the Netherlands, Belgium, and Luxembourg, and assisted suicide in Switzerland.

- Conscientious objection meets serious difficulties in several countries, such as Poland, and Norway...

- In France were legalized a few months ago: same sex marriage, research on embryos, and "right to abortion" on the simple decision of the woman. Assisted suicide, and euthanasia (even without patient's consent!) are still being discussed.

3. The different religions in Europe are the 3rd of the external challenges

The great majority of the Europeans are Christian (approx. 800 millions), but:

- a) 18% of the European population, do not mention any religion. They are already a majority in a few countries such as Czech Republic, Netherlands, or Estonia.

- b) Islam is only a majority in the old parts of the Ottoman Empire (Turkey, and a few countries in the Balkans, such as Albania, Bosnia-Herzegovina, and Kosovo). The new fact is the growing presence of Moslems in many countries, because of migratory phenomena: 12 millions in 1991, and now around 35 millions (among which 5 millions in France).

- There are structures of dialogue.

- c) There is an Orthodox majority in the Eastern part of Europe (Belarus, Bulgaria, Estonia, Greece, Latvia, Montenegro, Macedonia, Moldavia, Romania, Russia, and Serbia).

- In countries such as France, Protestants and catholics very often work together on bioethical issues

II - Internal challenges

1. The difficulties of the Catholic Church

There is a Catholic majority in Western Europe (Austria, Bavaria, Belgium, Croatia, Czech Republic, France, Hungary, Italy, Poland, Portugal, Slovakia, Slovenia, Spain). But the influence of the Church is declining.

In France, the percentage of the population saying they were catholic, from 87% in 1972, decreased to 75% in 1980, and 64% in 2009. And the percentage of the catholic going to mass every Sunday decreased from 20% in 1970 to 5% in 2006. The number of priests is declining, and Humanae vitae (1968) was badly accepted by many Catholics

2. The difficulties of our associations

Around 22 national associations are member of FEAMC. These associations are the witness of the catholic medical world from the different countries. Among them 17 have a website, 11 publish regularly a Bulletin.

The number of their members seems stable in a few countries (Italy, Croatia, Poland, Portugal), but in others it is declining, while the average age is rising up (in France the association had 5 000 members in 1950, but less than 500 members were remaining in 2010). Some are in a difficult position (Lithuania, Netherlands). Three disappeared (Luxembourg 1998, Malta 1999, Austria 2005).

Some Regional Catholic Medical groups are not members of their National Association. The Catholic medical students often do not become members of the National Association of Physicians, and the creation of "Diocesan Pastoral of Healthcare workers" may have reduced the need for doctors to be put together in an association (?)

3. What the European Federation of the Catholic Medical Associations ( FEAMC) is trying to
The first Congress of FEAMC took place in Malta in 1964 with the countries of western Europe. In the following years after the fall of the Berlin wall (1989), nine new Associations from Eastern Europe came to FEAMC. Since then a few associations disappeared (Malta, Luxembourg, Austria), some have been in a difficult position (Lithuania, Netherlands...), in others the average age is rising up, while the number of members is declining. Some are still in a good position (Italy, Croatia, Poland, Portugal).

Since 1972, a Congress has been held every 4 years. The last Congresses were in Gdansk (Poland), in September 2008 on "Natural law and statutory law in contemporary european medicine", and in Rome in November 2012 on "Bioethics and Christian Europe". Were notably discussed the Christian roots and the conception of bioethics in Europe, the problems at the beginning and the end of life, the question of an equitable division of resources for health, and there was a roundtable on conscientious objection.

FEAMC Board meets twice a year in different european cities, and 10 to 18 associations are usually represented at every meeting. The last board meetings took place in:
- Strasbourg (France) in April 2009 (Visit of the Council of Europe and discussion with the bioethical authorities of it, reception of the church representatives to the Council of Europe and to the European Union);
- Lviv (Ukraine) in October 2009 (oriental liturgy);
- Lourdes (France) in May 2010 (short meeting, during the last world Congress);
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- Bari (Italy) in October 2013 (ecumenical meeting with an orthodox doctor, specialized in palliative care, and sent by Moscow Patriarchate);
- Bratislava in June 2014 (Important meeting with the Slovakian Episcopal Conference, in the presence of Mgr Zimowski, president of the Pontifical Council)

Here are the themes of a few recent Board meetings
- In April 2009, in Strasbourg (France), we visited the Council of Europe and could discuss very kindly for 2 hours with Mr. Carlos de Sola (in charge of the bioethical questions), then meet Mgr Aldo Giordano (representative of the Holy See to the Council of Europe), and Mgr Christian Kratz, (French delegate to the COMECE).
- In October 2011, in Brussels, our meeting took place inside the COMECE office, and was followed by a Symposium inside the European Parliament on "Sense and nonsense of Human fragility in the contemporary European society". It was attended by more than 350 participants.
- In October 2013, in Bari (South of Italy), was held an Ecumenical meeting with an orthodox doctor sent by Moscow Patriarchate, while the Istanbul Patriarchate sent us a very friendly letter of support.
- In June 2014, in Bratislava, our meeting was preceded by an International Conference on "Contemporary Biomedicine, HealthCare and Human Dignity", organized by the Slovakian Episcopal Conference, and in the presence of Mgr Zimowski, President of the Pontifical Council. FEAMC has edited a biannual Bulletin since 1969, and has had a Website since 2004: www.feamc.eu. Among the member-associations: 12 publish regularly a Bulletin and 18 have a website.

III - Conclusion

"I would like to mention in a particular way the Loss of Europe's Christian memory and heritage, accompanied by a kind of practical agnosticism and religious indifference... many Europeans give the impression of living without spiritual roots and somewhat like heirs who have squandered a patrimony entrusted to them by history".
"Living one's faith in Jesus becomes increasingly difficult in a social and cultural setting in which
that faith is constantly challenged and threatened. In many social settings it is easier to be identified as an agnostic than a believer".

"Today's Europe... at the very moment it is in the process of strengthening and enlarging its economic and political union, seems to suffer from a profound crisis of values".

2. Signs of Hope

- **Preamble of the Statute of the Council of Europe (London 1949)**
  "The Governments of ... reaffirm their devotion to the spiritual and moral values which are the common heritage of their peoples and the true source of individual freedom, political liberty, and the rule of law, principles which form the basis of all genuine democracy..."

- **Ecclesia in Europa (John-Paul II, 2003)**:
  "We joyfully recognize the growing openness of peoples to one another, the reconciliation between countries which have been hostile... with each other for a long time"...
  "We welcome with satisfaction all that has been done to safeguard the conditions and ways to respect human rights".
  "Finally... we sincerely hope that, in creative fidelity to the humanist and Christian traditions of our continent, there will be a guarantee of the primacy of ethical and spiritual values".

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**Curriculum vitae**


◊

**Latin American Experience**

*Pilar Vigil, MD (Chile)*

◊

**The catholic physician under siege**

**African experience (Nigeria)**

*Henrietta Williams, MD, FCMC, FC, BA Divinity,*

*Medical Director, Fertility Care services of Nigeria.*

**Abstract**

The recent Ebola Epidemic in West Africa where doctors and health workers died to maintain the health AND LIVES of their patients constitute the latest challenge to the African Catholic Physician under Siege. Dr Stella Ameyo Adadevoh’s heroic efforts as a Catholic Physician in a Catholic owned private hospital made it possible for the disease to be contained in Nigeria. She lost her life but saved thousands of human lives.
The Physician's Oath, Declaration of Geneva was adopted in 1948 and amended in 1968, 1984, 1994, 2005 and 2006. The original declaration that a doctor would respect human life "from the time of conception," was removed. "The health" of a patient is now the doctor's first consideration compared to the "health and life", to free the medical profession from extending life at all cost. The violation of "human rights and civil liberties", replaces "the laws of humanity" as a forbidden use of medical knowledge.

The African Experience of challenges to the Catholic Physician is neo colonisation or the "new slaveries", by the international global agencies determined to forcefully entrench their anti-life, anti-family, and anti-African values into medical practice by domiciling the Maputo Protocol into the Health care Systems of African countries and promoting population control by contraception and forceful sterilisation, euthanasia, trafficking in human eggs and sperms from the In Vitro Fertilization programs, and same sex "marriages"...etc.

A global post modern cultural revolution with a new global ethics, values, and agenda, rooted in Western apostasy and driven by powerful minorities at the rudder of governance since 1989 with new words, paradigms, norms, values, lifestyles, educational methods and governance processes entrenched in organisations like the United Nations, WHO, UNICEF, UNESCO, UNDP, IMF, World Bank, Planned Parenthood, etc... globally rule the world cultures, with majority of intellectuals and decision makers following the new norms.

Ebola Haemorrhagic Virus Disease has been known for over thirty years, yet only when hundreds of millions of dollars from these organisations, and their agencies were released, recently, did the drugs and vaccines appear. The value of human life has to give way to the "god of money and profit for the few" at the expense of the lives of millions.

In response to significant economic intrusion from managed care, the “patient-physician covenant” of the Catholic Doctor makes it clear that the fulcrum of medical practice must lie like Christ’s at the patient-doctor relationship. “For God so loved the world that He gave His only begotten son, so that whoever believes in Him, should not perish but have everlasting life.”John 3;15. Christ died that we may live.

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Curriculum vitae

Born in Lagos, Nigeria, on the 19th July 1950, Dr. (Mrs.) Henrietta’s passion in life is integrating the harmonious unity of faith into medical science to provide holistic and culturally acceptable medical services that will improve the quality of life of African women and their families.

Medicine was at the University College, London, Lagos University Teaching Hospital, the Institute of Obstetrics and Gynaecology of the Royal Postgraduate Medical School London. In 2003, she graduated in theology at the Maryvale Institute in Birmingham, United Kingdom, and proceeded to the Pope Paul VI Institute for the Study of Human Reproduction in Omaha Nebraska, USA, to qualify in 2004 as the first African certified Fertility Care Medical Consultant in Naprotechnology which provides Creighton Model natural family planning and infertility treatment which respects human life from conception to natural death. In 2009, she completed Management studies at the Lagos Business School.

She is the current National President of The Association of Catholic Medical Practitioners of Nigeria, (ACMPN), the Nigerian Program Director for the postgraduate training of doctors and midwives in Naprotechnology, and President of Fertility Care Centres of Africa. (FCCAf).

She serves in various capacities on several organisations:
- The Family and Human Life Unit of the Catholic Secretariat of the Catholic Bishops Conference of Nigeria and of Lagos Archdiocese.
- International Federation of Catholic Medical Associations (FIAMC)
- The International Organisation of Catholic Gynaecologists ( Matercare)
- The Fertility Care Centres International (FCCI)

She has been married to Chief Ladi Rotimi-Williams for 43 years, and they have 4 children and 3 grandsons.
The catholic physician under siege
Australia and New Zealand Experience
Elvis I. Seman, MD (Australia)

Abstract

Recent examples will be presented:
2. Tasmania’s Reproductive Health (Access to Terminations) Bill 2013 & it’s exclusion zone’ restricting freedom of speech.
4. Medical Board complaint against private pathology provider in Queensland 2014.

Putting a more positive spin on the title:
1. Blessings of the late Australian Senator, Brian Harradine
2. Personal examples of clinical problems & their management
3. MaterCare – it’s vision & achievements.

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Slides

1. Title

2. Recent examples will be presented:
   1) Anonymous Medical Board complaint against private pathology provider in Queensland 2014.
   2) Victoria’s Abortion Law Reform Act 2008 – 3 examples of implications.
   3) Tasmania’s Reproductive Health (Access to Terminations) Bill 2013 & it’s ‘exclusion zone’.
   4) Euthanasia: deluge of attempts to legalise medicalised killing.
   5) NSW parliament passes Zoe’s law Nov 2013.

3. 1) Anonymous Medical Board complaint against private pathology provider in Queensland 2014.
   a] Australian Health Practitioner Regulation Authority (AHPRA) notification
   b] Website statement on company standards
   c] Response
   d] AHPRA’s verdict

4-5. 1a] AHPRA Notice
Dear Doctor,
Notification about your conduct. On 5 May 2014 AHPRA received a notification from an anonymous source about you under the Health Practitioner Regulation National Law as in force in each state & territory. A summary of the notification is as follows: concerns are raised that you have breached Good Medical Practice: A Code of Conduct for Doctors in Australia by expressing personal beliefs on your website which may exploit the vulnerability of patients or cause them distress (section 8.2.3).
The board will now conduct an assessment of this notification to decide whether or not further action is required.
You are invited to provide a written response to the notification and any information you consider relevant by no later than 30 May 2014.
Dear Doctor,

Notice of Committee decision to take no further action

On 27 August 2014, the Queensland Notifications Committee of the Medical Board of Australia decided to take no further action under section 8.2.3.

The Committee reasonably believes that the complaint is lacking in substance.

The Committee decided this because:

- The complainant alleges that you are ‘practicing contrary to AHPRA & AMA’s code of ethics, in particular the ethics section on the website’ (cited).
- The submission provided by the CEO on your behalf states that you are not primarily responsible for the website & the information provided on the website is ‘primarily for doctors who refer or might refer specimens from their patients. We never see patients directly, & never discuss histology reports with patients directly.’
- The committee notes that XYZ Pathology provides a private diagnostic service. All practitioners have the choice of whether or not they engage this particular pathology service.
- The Committee believes that this is a private diagnostic service & therefore not under the remit of the Committee as the guiding principle of the Committee is to ensure the health & safety of the public.
- The committee further believes that your health, conduct or performance is not in question in this instance & therefore considers it appropriate that no action be taken against you.
- The Board recognizes that being the subject of a complaint can be stressful. This matter is now closed.

12-20. 2) Victoria’s Abortion Law Reform Act 2008 – 3 examples of implications.

- **Example 1: Dr Mark Hobart, GP**
  - 2013 Headline: Victoria, Australia:
  - Melbourne GP may be struck off after refusing abortion referral
  - This Melbourne GP was investigated by the Medical Board of Victoria for allegedly refusing to refer a couple for an abortion.
  - The couple had decided to abort their healthy 19-week baby girl, because they wanted a boy.
  - This case highlights the likelihood of coercion of doctors under Section 8 of Victoria’s Abortion Law Reform Act 2008.
  - Under its provisions Dr Hobart could face suspension or be deregistered, losing his livelihood.
  - Dr Hobart, 55, has practised as a GP in the Melbourne suburb of Sunshine for 27 years.
  - Section 8 of Victoria’s abortion law requires a doctor with a conscientious objection to abortion to refer a woman seeking an abortion or advice on an abortion to another doctor who he/she knows does not have a conscientious objection.
  - The Medical Board of Victoria launched its investigation of him after he had disclosed to Melbourne’s Herald Sun in April, 2013 that a couple had asked him for a gender-selective abortion.
  - Three weeks after his comments appeared, he received a letter from the Australian Health Practitioners Regulation Agency (AHPRA), advising him that the board had initiated an inquiry into
  - “your professional conduct, following receipt of information that indicates you may have… failed in your obligation to refer a female patient seeking treatment or advice on abortion to a non-objecting practitioner”.
  - AHPRA informed Dr Hobart that some unidentified board members initiated the “Own Motion” against him at a meeting on May 9, with the support of a majority of members who were present.
  - In Dr Hobart’s case there was no complaint by a patient nor any allegation of harm to a patient.
  - He was investigated by the board solely for refusing to refer a woman for a gender-selective
abortion of a healthy baby.
- Polls consistently show most Australians are opposed to sex-selective abortion.
- Miranda Devine, writing in Melbourne’s Herald Sun (October 5, 2013), remarked:
  “The irony is that Victoria’s abortion laws, among the most extreme in the world, were driven by
  a bipartisan feminist agenda. Yet now those laws are being used to punish a doctor who refused to
  participate in the sort of selective abortion of female foetuses which has made girl babies an
  endangered species in India and other patriarchal societies.”
- Dr Hobart told the Herald Sun that he doesn’t know any doctor who would agree to abort a
  healthy baby because of its gender.
  “The general response from my colleagues is disbelief and revulsion.”

21-22. Problems with Section 8

Section 8 contravenes Section 14 of the Victorian Charter of Human Rights and Responsibilities
Act 2006, which states: “14(1) Every person has the right to freedom of thought, conscience,
religion and belief.”

Section 8 creates the anomalous situation in which medical and health professionals are denied
the freedom of conscience guaranteed to all other Victorians by Section 14 of the state’s charter.
Section 8, by denying doctors the right to freely exercise their professional judgement and by
interfering with their obligation to act and give advice in the best interests and for the welfare of
their patients, can have far-reaching consequences.
Under Section 8, a doctor with a conscientious objection is not allowed to ask questions to
exclude underlying depression, coercion or partner violence.
Section 8 breaks down the doctor/patient relationship and the trust and confidence of both doctor
and patient.

23-29. Depression, Coercion & Partner violence
- Often, a woman presents to a doctor with her boyfriend, husband, partner or family members.
  Sometimes it’s one of these other parties asking for the woman to be referred for an abortion.
- There are many recorded instances in which the pregnant woman is being coerced into the
  abortion, as is recognised by Women’s Health Victoria (WHV), which led the campaign for the
  2008 abortion act.
- In its 10-Point Plan for Victorian Women’s Health 2010-14, WHV says that “studies in Australia
  and internationally consistently indicate an emphatic association between partner violence and
  abortion”.
- One of the largest studies of this kind was the 2007 La Trobe University investigation by Dr
  Angela Taft and Dr Lyndsey Watson.
- From surveys of over 24,000 women aged 18-27 they found that “partner violence is a strong
  predictor of termination and other reproductive outcomes among young Australian women”.
- The researchers concluded that, as these women had a much higher incidence of depression, any
  strategy to reduce depression among women must involve “prevention and reduction of partner
  violence [which] may reduce the rate of unwanted pregnancy”.
- Therefore symptoms of depression in a woman asking for an abortion referral, particularly if it’s
  her partner or family members pushing for the abortion, is an indicator of a possible abusive
  relationship.
- In such a situation, a doctor needs to be able to assess if the woman is depressed, and if her
  depression is impairing her ability to make a free choice.
- The doctor needs to assess if the first priority is to refer the patient for the treatment of her
  depression (rather than for an abortion), so that she can make a free decision about her pregnancy.
- The doctor also needs to assess if the patient is being coerced into an abortion and take
  appropriate action, depending on the level of abuse.
- If the young woman is also under the age of consent, a doctor has added reason to be concerned.

30-35. Section 8 also breaks down the doctor/patient relationship and the trust and confidence of
both doctor and patient.
- Take, for example, if a woman’s usual doctor, who may have been her doctor most or all of her
  life, has a conscientious objection to abortion.
- The law requires her to be referred to a doctor with no such objection, a doctor she may never
  have met and whom she had not originally chosen to seek advice from.
- In this way, the law operates to deny women their right to consult the doctor of their choice.
- Why have these two doctors been the subjects of investigation for breaching the technical requirements of Section 8?
- It would appear to have less to do with standards of medical care and protection of patients from harm than with over-zealous and bureaucratic monitoring of Section 8 to ensure no conscientious objector escapes the letter of its coercive requirements, even if there was no patient complaint and no harm is suffered by any patient.
- The only ones to suffer harm in these instances were the doctors with a conscientious objection who found themselves under investigation by the Medical Board of Victoria.
- The law should uphold the right of medical professionals to act according to their conscience and to provide the best medical care to women.

36. • Example 2
- Earlier in 2013 another doctor reported that he had been cautioned by the Medical Board of Victoria for comments he had made about Section 8 in an online “conversation” with colleagues, one of whom complained to the board.
- He was investigated, cautioned and warned that if he came before the board again the matter would be regarded very seriously.

37–38. • Example 3
- As a result of section 8, one Victorian paediatrician limited his private practice to patients < 12yo.
- He remained concerned about the prospect of being asked to refer for termination after diagnosing an unexpected pregnancy during his public work (eg during a work up for drug overdose or abdominal pain) & that medical defence wouldn’t cover him if he refused.
- He moved to SA in 2009 where his practice now includes patients up to 18yo.

- Tasmania has joined the Australian Capital Territory (ACT) and Victoria in decriminalising and greatly increasing the scope for abortion.
- After new laws were passed by Tasmania’s parliament in November 2013, women in Tasmania can now abort their pregnancies at up to 16 weeks after getting approval from only one doctor (not two, as previously).
- Included is an additional clause which makes it illegal for people to protest, even silently and non-obstructively, within 150 metres of an abortion facility.
- Anybody protesting within the exclusion zone can be fined up to $9,750 or face imprisonment for up to 12 months.
- Tasmania’s new laws have overridden the right of doctors to exercise their right of conscientious objection to abortion.
- Any Tasmanian doctor who declines to refer a woman seeking a termination of pregnancy to an abortionist can face deregistration.
- Tony Mulder APM MLC, an independent member of Tasmania’s upper house and a former Commander of the Tasmania Police, has pointed out that, while the Tasmanian bill decriminalises abortion, it simultaneously criminalises well-grounded medical or conscientious objection to the destruction of unborn human babies.
- The Catholic Archbishop of Hobart, Julian Porteous, has similarly observed: “This bill has decriminalised abortion, but criminalised opposition to abortion. It puts Catholic hospitals and all Catholic medical practitioners in an invidious position…”.
- In April 2013 a study team, headed by a “pro-choice” New Zealand researcher Dr David Fergusson, published findings that showed that abortion significantly increases the risk of subsequent mental health problems for women, including anxiety disorders, substance abuse and suicidal thoughts, compared with carrying an unwanted pregnancy to term.
- In July 2013, Carlo V. Bellieni and Giuseppe Buonocore published a study in the journal, Psychiatry and Clinical Neurosciences, which confirmed these findings.
- They said: “When comparing abortion and unplanned pregnancies that ended in delivery, four studies found a higher risk for loss of self-esteem, anxiety disorders, depression, suicide ideation, and substance abuse disorder or substance abuse rate in the abortion groups.”
- The bill was originally moved by Michelle O’Byrne, Tasmania state Minister for Health and...
Children in the Labor-Greens state government headed by Lara Giddings. Both Ms O’Byrne and Premier Giddings are prominent identities in Emily’s List, the pro-abortion feminist faction in the ALP. Ms O’Byrne has been a “national co-convener of Emily’s List”.

49. 4) Euthanasia: deluge of attempts to legalise medicalised killing.

50-52. 5) NSW parliament passes Zoe’s law Nov 2013.
- Zoe’s Law recognises for the first time the crime of grievous bodily harm against an unborn child.
- The legislation was prompted by the death of Brodie Donegan’s daughter, Zoe, who was stillborn after Mrs Donegan was hit by a drug-affected motorist on Christmas Day in 2009 while she 36 weeks pregnant.
- MPs from both side of NSW’s lower house, including some pro-abortion MPs, voted for the bill, which was passed by 63 votes to 26.
- The bill was supported by Liberal Premier Barry O’Farrell, but opposed by his government’s Minister for Women, Pru Goward, a former Australian federal Sex Discrimination Commissioner.

53. Conclusion:
1) Anonymous Medical Board complaint against private pathology provider in Queensland 2014.
2) Victoria’s Abortion Law Reform Act 2008 – 3 examples of implications.
3) Tasmania’s Reproductive Health (Access to Terminations) Bill 2013 & its ‘exclusion zone’.
4) Euthanasia: deluge of attempts to legalise medicalised killing
5) NSW parliament passes Zoe’s law Nov 2013.

Curriculum vitae


Elvis believes in the integration of faith in family life & medical practice. He treasures his roles as a husband & father, minister of the Eucharist, prayer group participant, & pro-life gynaecologist. He has a special interest in maternal care in the developing world, urogynaecology, & teaching laparoscopic suturing. He enjoys swimming, walking his dog, music, & most of all, time with his extended family & friends.

Indian Experience
Fr. Mathew Abraham Puthenchirayil, C.Ss.R, MD, Health Secretary, CBCI (India)

Abstract
India is a land of diversity and richness; but also a land of contradictions. As is so often said whatever is true of India, the opposite is also true. India has some of the richest people and most of the poorest. Scientific, software, engineering brains and also illiteracy abounds. A steadily growing hub of medical tourism and yet huge communities have no access to basic healthcare.

What is the role of the Catholic Physician in this context? Is he/she carrying out that role? Is the commercialization of the sector suffocating his/her good intentions and the Healing Mission of Christ
falling by the wayside? Is the Industry taking over the Ministry? With over 10 years of studying and working with the Christian Healthcare Mission and talking to hundreds of people working in the ministry and in the industry, it is right to conclude that the Physician is truly under siege; the Catholic Physician even more so. This scenario in India can be grouped into 5 areas that are core to the idea of Christian healthcare mission:

1. Humanized / Compassionate care
2. Affordable care
3. Rational Care
4. Practice of Christian Ethics and
5. Reaching a huge majority that has limited or no access to essential health care

However, there is hope. In India, although the Christian population is less than 2%, the contribution of Christians to the field of Education and Healthcare is enormous, far beyond proportion. The Christian healthcare network is said to be the second largest healthcare network in India after the Government. Recognizing this goldmine of resources, different Christian networks (Catholic, Protestant, and Evangelical) are realizing the need to collaborate to deal with the emerging scenario in healthcare. Over the past two years, focus has been on collaboration and strengthening of existing resources, networks and goodwill. Leveraging this combined strength, the Catholic Physician can be provided the impetus and a conducive environment that allows him/her to practice the healing mission of Jesus and reach out to those who desperately need basic and essential healthcare.

Curriculum vitae

I am a Medical doctor who happened to experience Jesus in a very personal way. As I grew in relationship with Jesus I discovered a sense of mission, that led me into Community Medicine, Holistic health and eventually chose to become a Redemptorist priest. My Mission includes promotion of Humanized, Affordable, Rational and Quality Care as well as Positive Health (HARC+), in collaboration with health care and other professionals, institutions as well as communities. I am a happy and content Catholic priest and health care professional.

X. Session 7
Lessons from the History

History of FIAMC
Francois Blin, MD (France)

Abstract

In 1884, following an appeal of Pope Leo XIII (Encyclical Humanum genus), Dr Le Bèle, a surgeon from Le Mans (France), founded a Society of St-Luke, St-Cosmas, and St-Damian, which developed rapidly (600 members in 1895, and 1,200 in 1911). Among them were up to 70 foreign members from several countries in Europe (Belgium, Switzerland, Denmark, Italy, Luxembourg, Portugal, Spain), and America (Canada, USA, Brazil). Other societies were founded before 1914: Barcelona 1884, Milan 1897, Rome 1904, Netherlands, Denmark, Rio-de-Janeiro, Brussels, London, New-York and Boston 1910, and Québec 1912. In 1904 an international medical Pilgrimage to Rome gathered more than 200 doctors from Europe (Belgium, France, Italy, Luxemburg, Netherlands, Spain), and Canada, who were received in audience by Pope Pius X. An International Federation was created, and its statutes in eight points were unanimously adopted, but it died as soon as it was born. After WW 1, the French St-Luke Society kept on growing and had more than 3,000 members in 1939. In 1924, Dr Octave Pasteau (its president from 1922 to 1937) created an "International Secretariat of the National Associations of Catholic Doctors", with the approval of the Holy See. The first International
Congress of Catholic Doctors was held in 1935 in Brussels. It gathered 200 participants from Europe and America. The second International Congress took place in 1936 in Vienna. Its main theme was "Eugenics and sterilisation". Racist theories were rejected by the 300 participants. A 3rd Congress had been planned for Easter 1937 in Rome on the Holy Father's suggestion, but it was canceled because of his health problems. In 1938, immediately after the Anschluss, because of its positions at the last Congress, the Austrian Association was forbidden by the Nazi regime, and several of its members deported in concentration camps.

After WW II, Pax Romana (a World Student Association founded in 1921 in Fribourg, Switzerland), held its Congress in Rome in April 1947, and decided to divide into two branches: IMCS (International Movement of Catholic students), and ICMICA (International Catholic Movement for Intellectual and Cultural Affairs which already included secretariats of engineers, lawyers, pharmacists, teachers, writers, artists, economists, and scientists). An International Medical Secretariat was created, and its presidency entrusted to AMCI (Associazione Medici Cattolici Italiani, founded in 1944 and chaired by Prof. Luigi Gedda). Prof. Gedda was then de facto, until 1966, the president of this "international secretariat", which gradually became independent.

In June 1947, the 3rd International Congress in Lisbon was the first occasion of reunion after the war, and gathered more than 400 physicians of 16 European countries and Canada, Brazil, and Chile. The following Congresses were held in Rome 1949, Paris 1951, Dublin 1954, The Hague 1956, Brussels 1958, Munich (Germany) 1960, and London 1962. Popes Pius XII (who wrote more than 80 speeches on medical issues), and John XXIII, directly or indirectly expressed their support for each of the Congresses. In November 1966, the XI International Congress took place in Manila. FIAMC - having just received its statutes approved by the Holy See - became then a democratic federation, and its first regularly elected president was Dr. Mariano M. Alimurung.


A few Congresses on topical subjects were held in association with the Pontifical Academy for Life: on "Vegetative state" (Rome 2004), "Stem Cells" (Rome 2006, and Monaco 2009), and "Organ donation" (Rome 2008); and in association with the Pontifical Academy of Sciences on "Trafficking in human beings" (Rome 2013).

In accordance with its statutes, FIAMC is divided into six regions.

- In Africa, a dozen of countries had - for a variable period - an association of Catholic doctors member of FIAMC, but the sustainability of these associations has been conditioned by the problems of political stability.
- In Asia, the AFCMA (Asian Federation of Catholic Medical Associations) was the first constituted Regional Federation of FIAMC. Its first Congress was held in Manila 1960, and the 16th one will take place in Kyoto in 2016. Thirteen Associations are now members of AFCMA: Hong-Kong, India, Indonesia, Japan, Korea, Malaysia, Pakistan, Philippines, Sri Lanka, Singapore, Taiwan, Thailand, and Oman. Viet-Nam, Australia, and New-Zealand sent observers.
- In Oceania, there are or have been Catholic Medical Associations in several states of Australia. An Association has existed in New Zealand until 2002.
- In Europe, the first Congress of FEAMC (Fédération Européenne des Associations de Médecins Catholiques) took place only in 1964 in Malta, and the 13th one will take place in Porto in 2016. More than 20 Associations are now members of FEAMC: Belgium, Britain, France, Germany, Ireland, Italy, Netherlands, Portugal, Scandinavia, Spain, Switzerland, and since the fall of the Berlin wall in 1989: Croatia, Czech Republic, Hungary, Lithuania, Poland, Romania, Slovenia, Slovakia, Ukraine (Austria, Malta, and Luxembourg disappeared).
- In North America, the National Federation of Catholic Physicians Guilds (NFCPG) was created in USA in 1932. It became the Catholic Medical Association (CMA) in 1997, authorizing individual membership. A "Canadian Federation of Catholic Physicians' Societies" now regroups Medical Associations from British Colombia, Alberta, Ontario, Quebec, and Nova-Scotia. A "Jamaica Association of Catholic Doctors", founded in 1989, was a member of FIAMC until 2002.
- In Latin America, the first Congress of the Federation de Asociaciones Medica de Medicos Catolicos Latino-Americanas (FAMCLAM) took place in 1992 in Santo-Domingo, and the 5th one in Buenos-Aires in 2009. The following are members of FAMCLAM: Argentina, Brazil, Chile, Colombia, Cuba, Honduras, Mexico, Panama, Paraguay, Peru, Dominican Republic, Uruguay, Venezuela, and Trinidad & Tobago were members of FIAMC too a few years ago.

In conclusion, around 60 national Associations are members of FIAMC, which has had since 1997 a "Special consultative status" at the United Nations Economic and Social Council (ECOSOC). A participative status near other international bodies such as UNESCO, WHO, and the Council of Europe... might be claimed for FIAMC could then make its voice better heard.

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**Text Until 1884**

- Since the middle ages, numerous places of worship dedicated to Sts Cosmas and Damian in Europe (Austria, Belgium, England, France [53 places], Germany, Italy [43 places], Spain,
The Netherlands, Poland, Czech Republic, Russia, Switzerland) and the Near East (Egypt, Syria, Holy Land...) are places of pilgrimage.

• The foundation of the first catholic medical schools in Europe begins in the X Century: Salerno, Schola Medica Salernitana (South Italy) - 1088: Bologna (Italy), Surgery - 1208: Palencia (Spain) - 1218: Salamanca (Spain) - 1150: Montpellier (South France) - 1240: Siena (Italy) - 1271 Paris - 1290: Coimbra (Portugal), ... The teachers must speak latin, and report directly to the Pope.

• 1215, Rome: The IV Lateran Council forbids priests to shed blood. It leads to the distinction between the roles of physician and surgeon.

• Until 1452 in France doctors are bound to celibacy, except in Montpellier, where - since 1309 - teachers and students are authorized by Pope Clement V to marry.

• Confraternities of Catholic physicians and/or surgeons are created in France, Spain... Most of them disappear during the wave of de-Christianization of the XVIII and XIX centuries, despite some attempts at restoration (e.g: France 1801 and 1840).

From 1884 to WW 1

• 20 April 1884: The Encyclical Humanum genus (Pope Leo XIII) asks Catholics to unite against rationalism and atheistic materialism.

• 26 September 1884: Dr. Jules Le Bèle (1820-1903), a surgeon from Le Mans (France), following the success of a local subscription for the realization of a chapel dedicated to the saint doctors in the Sacred Heart Basilica of Montmartre in Paris, founds ("restores") a "Medical Society of St-Luke, St-Cosmas, and St-Damian". It develops rapidly:
  = 600 members in 1895, and 1 200 in 1911;
  = up to 70 foreign members from Europe (Belgium, Denmark, Italy, Luxembourg, Portugal, Spain, Switzerland), and America (Canada, USA, Brazil).


• March 1904, Rome: Foundation of the "Società medica italiana di San Luca evangelista".

• 7-12 April 1904, Rome: International medical Pilgrimage. Pope Pius X receives in audience more than 200 doctors, from Europe (Belgium, France, Italy, Luxembourg, Netherlands, Spain), and from Canada. Statutes in 8 points for the creation of an international federation are proposed by Dr Le Bec and unanimously adopted:
  = Art. 1: Catholic doctors intend to establish among themselves a fraternal union and to promote in all countries the foundation of a Society under the patronage of Saints Doctors, Luke, Cosmas, and Damian in order to revive the ancient Christian traditions.
  = Art. 2: This Society proposes:
    - The application of Christian virtues in the practice of medicine.
    - The study of all medical issues related to faith, morals and ethics, in absolute submission to ecclesiastical authority.
  = Art. 3: The Society prohibits any political issue.
  = Art. 4: The Society adopts as the feast day St. Luke's day.
  = Art. 5: Societies established in all countries are autonomous and independent. To promote the dissemination of scientific reports, colleagues can match through their respective presidents.
  = Art. 6: When organizing international general meetings, the presidency will alternately be given to all presidents.
  = Art. 7: General meetings shall be convened whenever possible in Rome, center of Christianity.
  = Art. 8: Colleagues of Rome are invited to correspond with all societies, to provide any information and explanations that may be of interest.

But this Federation dies as soon as it is born.

• Until 1914, other societies are founded: Barcelona (Spain) in October 1884; Milan in 1897; Rome in 1904, London, Brussels, Netherlands, Denmark, New-York and Boston, Rio-de-Janeiro in
1910; and Québec in 1912.

**From WW 1 to WW 2**

Dr. Octave Pasteau, Founder of the International Secretariat of the National Associations of Catholic Doctors 1924

- The French Society keeps on growing (more than 3,000 members in 1939).
- **1924**: Dr. Octave Pasteau - its president from 1922 to 1937 - after a letter of approval by Cardinal Pietro Gasparri, Secretary of State (30 April 1924) creates an "International Secretariat of the National Associations of Catholic Doctors" which maintains a regular correspondence with the already existing groups in Europe (Austria, Belgium, Denmark, Great Britain, Hungary, Italy, Luxembourg, Netherlands, Poland, Switzerland, Czechoslovakia), and outside Europe (USA, Argentina, China, Tunisia).
- **30 May 1935 Brussels: 1st International Congress** of Catholic Doctors, on "The role of physicians and associations of catholic physicians in the Christian rebuilding of society" - 200 participants from Europe and America.
- **29 May 1936 Vienna, 2nd International Congress**, on "Eugenics and sterilisation" - Racist theories are rejected - 300 participants from 12 European countries. - A 3rd Congress, scheduled for Easter 1937 in Rome, is canceled because of the Holy Father's health problems. - The Austrian Association, because of its positions at the last Congress, is forbidden by the Nazi regime in March 1938 (immediately after the Anschluss), and several of its members are deported into concentration camps.

**After WW II**

Prof. Luigi Gedda, President of the International Medical Secretariat of Pax Romana 1947-1966

- **April 1947, Rome: Pax Romana**, a World Student Association founded in July 1921 in Fribourg (Switzerland), holds its Congress, and decides to split into 2 branches: = the International Movement of Catholic Students (IMCS), = and the International Catholic Movement for Intellectual and Cultural Affairs (ICMICA), which already includes secretariats of engineers, lawyers, pharmacists, teachers, writers, artists, economists, and scientists.

An **International Medical Secretariat**, inside ICMICA, is created, and its presidency entrusted to the Associazione Medici Cattolici Italiani (AMCI), founded 1944 and chaired by Prof. Luigi Gedda, who remains then "de facto", until 1966, the president of this "International Medical Secretariat" gradually aiming at its independence.
Following International Meetings
(All in Europe, no elections)

- **June 1947 Lisbon, 3rd Congress**, on "Individual and Collective Medicine" - Message from Mgr Montini - More than 400 physicians from 16 European countries, Canada, Brazil, and Chile.

- **Sept. 1949 Rome, 4th Congress**, on "The respect of the human being in medicine" - Audience and speech of the Holy Father Pius XII in Castel Gandolfo - More than 400 participants from 30 countries. — The International Medical Secretariat meets in April 1950 in Geneva, and March 1951 in Fribourg (Switzerland).

- **July 1951 Paris, 5th Congress**, on "The forming of the conscience in children" - Opening of the Congress by the Apostolic Nuncio Mgr Roncalli - More than 400 participants from 18 countries. - The International Medical Secretariat meets in March 1952 in Fribourg (Switzerland), Nov. 1952 in Paris, and March 1953 in Rome - Dr. Raymond Verly (Belgium) is secretary General until 1966.

- **June 1954 Dublin, 6th Congress**, on "Demography and its medical incidence" - Telegram from Mgr Montini - 361 participants from 19 countries.


- **July 1958 Brussels, 8th Congress (1st World Catholic Health Conference)**, on "Christianity and Health" - TV message of the Holy Father Pius XII - 3 000 participants from over 40 countries across seven medical and paramedical disciplines.

- **July 1960 Munich (Germany), 9th Congress**, on "The physician in the technological world" - Message from the Holy Father John XXIII - 400 participants from 24 countries.

- **July 1962 London, 10th Congress**, on "The Catholic Physician in societies in evolution" - Message from the Holy Father John XXIII - The "International Medical Secretariat" becomes the "Fédération Internationale des Associations de Médecins Catholiques" / "International Federation of Catholic Medical Associations" (FIAMC), though no statutes have been adopted yet - 700 participants from 34 countries from all continents.

  — > Popes Pius XII (who wrote more than 80 speeches on medical issues), and John XXIII, directly or indirectly expressed their support for each Congress.

Meetings of FIAMC

- **Nov. 1966 Manila, 11th Congress**, on "The catholic Physicians and the problems of the population" - Mgr Silvio Luoni represents the Secretary of State - After having just received its new statutes approved by the Holy See, the "International Medical Secretariat" (of Pax Romana) officially becomes the FIAMC, an independent and democratic federation - Participants from 20 countries - Its first regularly elected president is Dr. Mariano M. Alimurung (Philippines). — The Executive Committee meets in Nov. 1968 in Miami (USA).

• **May 1974 Barcelona** (Spain), 13th Congress, on "The freedom of the children of God" - Letter from Cardinal Villot, Secretary of State - 400 participants from all continents - President: Dr. Gino Papola (USA). — The Executive Committee meets in April 1975 in Philadelphia (USA), and June 1977 in Rome.

• **Jan. 1978 Bombay** (India), 14th Congress, on "The quality of life in a society in evolution" - Archbishop G. Caprio represents the Holy See - Mother Teresa is present - Numerous participants from all continents (150 from Europe) - President Gino Papola is reelected. — The Executive Committee meets in May 1979 in Copenhagen, Sept. 1980 in Chicago (USA), and Sept. 1981 in Rome. — **Sept. 1981, Bombay:** Creation of the "FIAMC Biomedical Ethics Centre" (FBMEC) by Dr. Chicot J. Vas and Cardinal Simon Pimenta.


• **Sept. 1990 Bonn** (Germany), 17th Congress, on "Biological nature and dignity of the Human Person" - Papal message, sent by Cardinal Casaroli - 34 countries are represented - President Thomas-Patrick Linehan is reelected.


• **May 2006 Barcelona, 22th Congress**, on "Catholic Physicians, Globalization, and Poverty" - Cardinal Martino represents the holy See - more than 1 300 participants - President: Dr. José-

- May 2010 Lourdes, 23th Congress, on Our Faith as physicians - Mgr Zygmund Zimowski represents the Holy See - 400 participants from 36 countries of all continents - President José-Maria Simon-Castellvi is reelected. — The Executive Committee meets in Nov. 2010, Nov. 2012, and Nov. 2013 in Rome. — 2 Nov. 2013, Rome: A meeting on Trafficking in human beings is organized with the Pontifical Academy of Sciences - Short meeting and photo with Pope Francis outside Domus Santae Marthae.

- Oct. 2014 Manila, 24th Congress, on Our Faith as physicians - 275 participants from 36 countries of all continents - President: Dr. John Lee (Singapore).

The World Congresses

Europe 17, Asia 4, North America 2, Latin America 1, Africa & Oceania 0
In accordance with its statutes, FIAMC is divided in 6 regions

1. Africa

Several countries in Africa have had an Association member of FIAMC:
- Rwanda (1987-90),
- Zimbabwe (1988-91),
- Ghana (represented from 1991 to 2006 by Dr. John Wilson),
- Kenya (1994-96),
- Angola (1995-2002),
- Ivory Coast (1993-96),
- Tanzania (1995-99),
- Benin (1999-2000),
- Burkina-Faso (2006),
- Madagascar (2006-14),
- Nigeria (represented since 2012 by Dr. Henrietta Williams).

The sustainability of these associations may have been at least partly conditioned by problems of political stability.

2. Asia

- The first Catholic medical guilds in Asia were founded in Philippines 1936, Shanghai 1938, Taiwan 1939, Singapore 1952, Hong-Kong 1953, and Japan 1957...

- **1960 Manila: 1st Congress of AFCMA** (Asian Federation of Catholic Medical Associations).

- **1962 Saigon** (Vietnam): **2nd Congress**

- **26-30 Nov. 1964 Mumbai** (India): **3rd Congress** on "The physician and the Family".

- **1968 Tokyo: 4th Congress**

- **11 Dec. 1972 Bangkok: 5th Congress**

- **1976 Hong-Kong: 6th Congress**

- **1980 Seoul: 7th Congress**

- **1984 Manila: 8th Congress**

- **10-14 Sept. 1988 Nagasaki** (Japan): **9th Congress** on "Socio-medical and moral problems in Asian countries" - 239 delegates, among them 56 represented 9 countries (Japan, Korea, Thailand, Malaysia, Philippines, Nationalist China, Pakistan, India and Antigua) - President: Prof. Yong Whee Bahk (Korea).

- **8-11 Nov. 1992 Bangkok: 10th Congress** - President Yong Whee Bahk (Korea) is reelected.

- **5-9 Nov. 1996 Singapore, 11th Congress** on "Pastoral Medicine 2000" - more than 200 participants - President Yong Whee Bahk (Korea) is reelected.


- **25-27 Nov. 2004 Taipei: 13th Congress** on "Love, Faith, and Hope in family health care" - President: Dr. Kwang-Ho Meng (Korea).

- **27-30 Nov. 2008, Hong-Kong, 14th Congress** on "Human Dignity in modern medicine" - President: Dr. Freddie Loh (Malaysia).

- **8-21 Oct. 2012, Bali (Indonesia): 15th Congress** on "Challenges of Catholic Doctors in the changing World" - President: Dr. Ignatius Widjaja (Indonesia)

- **2016: Kyoto (Japan): 16th Congress**:

- 13 Associations are members of AFCMA: Hong-Kong, India, Indonesia, Japan, Korea, Malaysia, Pakistan, Philippines, Sri Lanka, Singapore, Taiwan, Thailand, and Oman.

- Viet-Nam, Australia, and New-Zealand sent observers.
3. Oceania

- There are or have been Catholic Medical Associations in Australia:
  - Catholic Doctor's Association of Western Australia (Perth) has existed since 1985, and was represented for several years by Dr. Michael Shanahan.
  - There have been Associations in New South Wales, Victoria, Queensland, and South Australia?
- An Association has existed in New Zealand since before 1991 to December 2002. An Association of Catholic Doctors is now affiliated with the New Zealand Medical Association.

4. Europe

- The first Associations were born in France and Barcelona in 1884, Milan 1897, Netherlands 1904, Britain 1910, Portugal 1915, Belgium 1922, Hungary and Ireland 1931, Austria 1932, Switzerland 1933...
- Sept. 1964, Malta (10 days before its independance): 1st European Congress, on "The catholic doctor and the family" - Message from Pope Paul VI - 400-500 participants from 20 countries - A European Working Group is created, president: Prof. Jean Lereboullet (France).
- May 1972 Nuremberg (Germany), 2nd Congress, on "Sex education, development and personal integration of sex life" - 120 participants from 10 countries - President Jean Lereboullet is reelected. — FEAMC Board meets in May 1973 in Paris, Sept. 1973 in London, Jan. 1974 in...
Paris, May 1974 in Barcelona (Spain), Jan. 1975 in Zurich (Switzerland), May 1975 in Augsbourg (Germany), and Feb. 1976 in Paris.


**March 1992 Venice (Italy), 7th Congress**, on "Medicine at the dawn of the third millenium" - Participants from around 20 european countries - President: Dr. Josef Bättig (Switzerland). He resigns for health reasons in 1994, and is replaced by Dr. Paul Deschepper (Belgium). — FEAMC Board meets in Oct. 1992 in Fribourg (Switzerland), May 1993 in Bratislava, Oct. 1993 in Lourdes (France), April 1994 in Heeswijk (Netherlands), Sept. 1994 in Porto (Portugal), May 1995 in Prague, and Oct. 1995 in Brugge (Belgium).


Nov. 2007 in Lisbon, and June 2008 in Prague.


- **Nov. 2012 Rome, 12th Congress**, on "Bioethics and Christian Europe" - More than 300 participants from 20 european countries - Audience and speech of the Holy Father Benedict XVI - President François Blin is reelected. — **FEAMC Board** meets in May 2013 in Zagreb, Oct. 2013 in Conversano (Italy, Ecumenical meeting), June 2014 in Bratislava, and April 2015 in Paris (Symposium on "End of Life in Europe").

**2016, Porto, 13th Congress**

- 21 Associations are members of FEAMC:
  - From western Europe: Belgium, Britain, France, Germany, Ireland, Italy, Netherlands, Portugal, Scandinavia, Spain and Catalonia, Switzerland.
  - And (since the fall of the Berlin wall in 1989) from Eastern Europe: Croatia, Czech Republic, Hungary, Lithuania, Poland, Romania, Slovenia, Slovakia, Ukraine.

5. **North America**

- 1910: The 2 first Guilds were founded in New York, and Boston.
- 1911: Philadelphia.
- 1931: A congress in New York gathered more than 400 catholic doctors.
- 1932: Dr. RA Rendrick creates the **National Federation of Catholic Physicians Guilds (NFCPG)**. It gathers 100 guilds in 1961 and has 10,000 physicians in 1967.
- 1997: The NFCPG becomes the **Catholic Medical Association (CMA)**, authorizing individual membership. It has now 89 Guilds in 36 states.


- A "**Jamaica Association of Catholic Doctors**" was founded by Dr. Matthew Beaubrun in 1989, and was a member of FIAMC until 2002.

6. **Latin America**

- Catholic medical societies were created in Rio de Janeiro 1904, Bogota 1926, Buenos-Aires 1929, Mexico 1934, and Santiago-de-Chile 1939...
- August 1986, Buenos-Aires: XVI Congress of FIAMC
- November 1987, Montevideo: meeting of delegates from Uruguay, Chile, Paraguay, and Argentina (Dr. Obiglio, Vice-president of FIAMC)


12 Associations are members of FAMCLAM: Argentina, Brazil, Chile, Colombia, Cuba, Honduras, Mexico, Panama, Paraguay, Peru, Dominican Republic, Uruguay, Venezuela, and Trinidad & Tobago were members until a few years ago.

**Conclusion**

50 to 60 national Associations are members of FIAMC.

FIAMC got in 1997 a "Special consultative status" at the *United Nations Economic and Social Council* (ECOSOC). A participative status near other international bodies such as UNESCO, WHO, and the Council of Europe, if claimed, could make FIAMC's voice better heard.

**Sources**

- Archives of the Diocese of Paris, 1883-1992
- Archives of the French Catholic Medical Association (CCMF), Paris, 1884-2014 (130 years!)
- Archives of *Pax Romana* (Cantonal University Library, Fribourg, Switzerland), 1930-1966
- Archives of the Jesuits of the Province of France, 1934-1961
- Archives of FEAMC, since 1964 (50 years!), given by Dr. Otto Jungo, and Dr. Hans Stevens
- Archives of FIAMC (Palazzo San Calisto, Rome), since 1966
- Personal archives, since 1985
- Documents given or lent by Prof. Walter Osswald, Dr. Alexandre Laureano Santos, and Dr. José-Maria Simón-Castelvi
- Websites of FIAMC, AFCMA, FAMCLAM, and of the Associations

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**Sexuality Teaching in the Context of Adult Responsibility** *(Teen Star)*

*Sr. Hanna Klaus, MD (USA), Natural Family Planning Center of Washington, D.C. Inc. and Teen Star Program, 4400 East West Highway # 911, Bethesda, MD 20814-*

**Abstract**

At puberty teens acquire procreative capacity. Messages in many cultures encourage teens to become sexually active while demanding postponement of pregnancy and avoidance of contracting sexually transmitted infections by chemical or mechanical means. Separation of sex from procreation is contrary to the developmental need to integrate the two tasks, hence is either rejected outright leading to teen pregnancy and STI’s, or, if accepted, delays psychosexual maturity, enhanced by the additional of steroidal contraceptives. Utilizing fertility awareness has been shown to support virginity and/or a return to premarital abstinence as borne out by behavioral outcome data from Teen STAR programs in Chile, USA, France, Uganda and Ethiopia.

**Slides**

1-3: Hanna Klaus, M.D. FACOG, NFP Center of Washington, DC, and Teen STAR Program, 4400 East West Highway, Bethesda, MD 20814 - teenstarprogram@earthlink.net - www.teenstarprogram.org - https://facebook.com/TeenSTARUS
4. Is a developmental curriculum which utilizes the experience of the body’s fertility patterns to help teens discover their inherent value and derive behavioral norms. Teaches responsible decision making and communication skills in the area of sexual behavior. Enhances teens’ self-understanding and self-esteem. Minors require parental permission.

5-7. Country Report (2012 - to Date) Overview: Monitors trained / Students receiving Teen Star:

- **Europe**: Austria 56 / 1468 — Croatia 135 / 414 — France 374 / 3373 — Germany 56 / 121 — Italy 726 / 1597 — Slovakia 5 / 24 — Spain 1006 / 7115 — Switzerland 70 / 385
- **Africa**: Ethiopia 355 / 9379 — Uganda 8 / 768 — Madagascar ? / 1060
- **America** (only last year info, except Chile): Canada 12 / ? — USA ? / 68 — Mexico 1 / 4 — Chile 1321 / 13650 — Brazil 90 / ? (only summer 2013)

8. Cumulative Number of Students Receiving Teen STAR (2012-2014)

9. Monitors and Students per Country (2012-2014)

10. Because Teen STAR had demonstrated support for primary and secondary Abstinence a PEPFAR grant was awarded to deliver Teen STAR in Ethiopia and Uganda.
11. Teen Star® Program 2006-2012

<table>
<thead>
<tr>
<th></th>
<th>Ethiopia</th>
<th>Uganda</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Volunteer teachers trained</td>
<td>355</td>
<td>774</td>
</tr>
<tr>
<td>N students graduated</td>
<td>29,733</td>
<td>27,238</td>
</tr>
<tr>
<td>N gen. reached</td>
<td>97,980</td>
<td>39,357</td>
</tr>
</tbody>
</table>

12. Two and three year post program: Follow-up of accessible students

13. Sexual activity prior to entry: 3.5%
   • Initiated during program: 4%
   • Discontinued > 1 year ago: 33.3%
   • Discontinued 7-12 months ago: 16.7%

14-15. Influence on sexual behavior: by country, and by gender

16. Reasons for abstaining in order of frequency:
   • Morally wrong
   • Don’t want to be used
   • Don’t want to disappoint my parents
   • Against my religious beliefs
   • Prevent unwanted pregnancy

17. Teen STAR 2 adds the theology of the body
   • Behavioral outcomes for both programs are comparable
   • Experiential learning allows teens to own their sexuality and fertility and behave appropriately.

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Curriculum vitae

Hanna Klaus, M.D. is a Medical Mission Sister and obstetrician/Gynecologist who began the Teen STAR program in the US after serving seven years in Holy Family Hospitals in Rawalpindi, Pakistan and Dhaka, Bangladesh. Prior to entering the Medical Mission Sisters she had obtained her M.D. from the
University of Louisville, in Louisville Kentucky, USA, had a rotating internship at Louisville General Hospital, then 2 years of residency in Pathology at Massachusetts General Hospital, three years of Ob/Gyn residency at Barnes and Allied Hospitals in St. Louis, Missouri and a one year National Cancer Society fellowship at Peter Bent Brigham Hospital and Harvard Medical School. In 1973 she learned the Billings Ovulation Method and, five years later was asked by Dr. John Billings to interest herself in working with the teenagers. Research with Teen STAR began in 1980, and when it was found that the program supported primary and secondary abstinence, teacher training began, a curriculum for young men followed. Today the International Teen STAR Association

Anthropology and the New Evangelization
Ermanno Pier Pavesi, MD, FIAMC Secretary General (Switzerland)

Abstract
Western societies, and other countries insofar as they have assimilated the western culture, are in an anthropological crisis. A dominant ideology is rapidly shaping all aspects, including religious, of human life. It proposes a new vision of man, grounded to some extent on scientific and naturalistic theories. According to this ideology, natural sciences are only able to describe and explain human thought and activity. They refuse the stable nature of human being, negate the existence of a spiritual soul and cast doubt on the role of the free will. Such a vision of man entails a sceptical attitude to religion and is an obstacle to the good news and the new evangelisation. Catholic doctors have to contribute to the new evangelisation, defending the personalistic vision of man, and Catholic academies have to deal with reductionist scientific theories.

Text
The crisis of the civilization
Western civilization is in a serious crisis due to several factors as secularization, globalization, mass migration, economic crisis, and the like. However, the primary cause of this crisis is cultural, and precisely an anthropological one. This crisis is affecting regions and cultures which have a long-standing Christian tradition in a particular way, but it does not only concern western countries. Insofar as the western culture has spread in other areas, the crisis became more or less global and represents not only a threat for traditional religions but also an obstacle to the evangelisation. This new situation needs a new strategy: the new evangelisation.

The new evangelisation
The strategy of the new evangelisation was formulated by John Paul II. Yet, several decades before him, in face to socio-cultural changes, the Church had felt the urgency of considering a new way to announce the Gospel. We can recall, for example, the Apostolic Exhortation of Pope Paul VI Evangelii nuntiandi promulgated on December 8, 1975 or the Pastoral constitution of the Second Vatican Council on the Church in the modern World, Gaudium et Spes, (December 7, 1965).

This crisis has typical features, but it also shows similarities to past situations when philosophical mainstreams disregarded or fought the Catholic faith and the Church had to defend and proclaim its view of reality and human being. “This would not be the first time that the Church has undertaken this task. Our history provides evidence of the role which she has been able to fulfil at times of cultural crisis and of momentous change”(56).

Dominant cultures have previously challenged the Church. For instance, in late Middle Age, Hellenistic and Islamic interpretations of the Aristotelian works on natural philosophy became predominant at the universities. Theories like the eternity of the universe, the mortality of the individual human soul, the negation of the creation, of human being’s personal nature and of the free will, and the like, only seemed to be scientific ones. Consequently the religious faith would have had to adapt itself to them. Then, theologians as Albert the Great (1193/1206 – November 15, 1280), Bonaventura (1221 – 15 July 1274) and Thomas Aquinas (1225 – 7 March 1274) sustained the compatibility of the Christian faith with correct interpretations of contemporary scientific knowledge. According to Benedict XVI the greatest merit is due to Thomas Aquinas: “When, in the 13th century through the Jewish and Arab philosophers, Aristotelian thought came into contact with Medieval Christianity formed in the Platonic tradition and faith and reason risked entering an irreconcilable contradiction, it was above all St Thomas Aquinas who mediated the new encounter between faith and Aristotelian philosophy, thereby setting faith in a positive relationship with the form of reason prevalent in his time.”(57).

Not only Church Fathers but also laymen like most the Italian humanists began to question the validity of such theories, to deny materialistic and naturalistic interpretations of scientific knowledge, and to defend the immortality of the soul and the human dignity rooted in creation in God’s image and likeness. We can recall, for instance, the main work of the humanist Marsilio Ficino (1433-1499) because of his defence of the immortality of the soul against naturalistic theories(58).

Can we still believe in God today?

Benedict XVI, in a sermon, focussed on an aspect of the current crisis of the faith, the fact that the dominant culture is increasingly influenced by scientistic theories that transmit a materialistic view of the world and of human beings, which claims to fully explain the reality and to exclude God.

“We believe in God. This is a fundamental decision on our part. But again the question has to be asked: is this still possible today? Is it reasonable? From the Enlightenment on, science, at least in part, has applied itself to seeking an explanation of the world in which God would be unnecessary. And if this were so, he would also become unnecessary in our lives”(59).

Pope Francis emphasizes the need to distinguish between scientific knowledge and laws from theories and hypothesis: “Whenever the sciences – rigorously focused on their specific field of inquiry – arrive at a conclusion which reason cannot refute, faith does not contradict it. Neither can believers claim that a scientific opinion which is attractive but not sufficiently verified has the same weight as a dogma of faith. At times some scientists have exceeded the limits of their scientific competence by making certain statements or claims. But here the problem is not with reason itself, but with the promotion of a particular ideology which blocks the path to authentic, serene and productive dialogue”(60).

Science and reason can benefit from faith. Faith is capable of opening the mind to recognize and admire the intrinsic order and the harmony of the nature, whose complexity cannot be explained by reason or scientific theories. As Benedict stated: “it is not the laws of matter and of evolution that have the final say, but reason, will, love—a Person”(61)

. This insight forewarns scientists about the risk of overrating the capacity of their theories to understand and explain the nature, living beings and man.

Pope Francis too emphasizes the need to distinguish between certain scientific knowledge and assumptions or hypothesis: faith “also illumines the material world, trusts its inherent order and knows that it calls us to an ever widening path of harmony and understanding. The gaze of science thus benefits from faith: faith encourages the scientist to remain constantly open to reality in all its inexhaustible richness. Faith awakens the critical sense by preventing research from being satisfied with its own formulae and helps it to realize that nature is always greater. By stimulating wonder before the profound mystery of creation, faith broadens the horizons of reason

88. Marsilio Ficino, Platonic theology on the immortality of the soul.
60. Francis, Apostolic Exhortation Evangelii Gaudium, N. 243.
to shed greater light on the world which discloses itself to scientific investigation”\(^{62}\).

Naturalistic theories

Theories like materialistic neuroscience and philosophy of mind represent a challenge for the catholic anthropology. Naturalistic theories reject the idea of a stable and inviolable human nature, with a special dignity, but define it as "speciesism" as a form of racism that assumes human superiority over all other living beings. The proponents of naturalistic theories do not realize that just the concept of human dignity based on its status as an image of God certainly grants a special role among all living beings, but at the same time forces everyone to recognize that all living beings and all nature were created by God and to respect the intrinsic order of creation. “In this vocation to exercise dominion over the earth by putting it at his service through work, one can see an aspect of the image of God. But human intervention is not "creative"; it encounters a material nature which like itself has its origin in God the Creator and of which man has been constituted the "noble and wise guardian"\(^{24}\) \(^{63}\). Naturalistic thinkers accuse Christianity of justifying all forms of exploitation of nature, but in denying the real roots of human dignity, they legitimate abuses of science and manipulations of nature.

Some neuroscientists and philosophers of the mind claim to explain all mental states as physiological processes and states. According to this theory, it is not necessary to suppose the existence of a spiritual soul, in contrast attempts to explain human thought and activity by an immaterial soul would fail to recognize the true origins of mental activity and behaviour. Spiritualistic interpretations of the mental activity are viewed merely as superstition and as relic of old non-scientific and no longer justifiable meanings. For example, the human being is not considered a person but a machine developed during centuries, adapted to certain circumstances.

Consequences for the bioethics

Theories like neuroscience and philosophy of mind offer the theoretical background for biotechnological experiments. If the man is like a machine it would be possible to change some part of the body, for example transferring genes taken from other species into human genome, i.e. transgenesis, in order to enhance human abilities. “For example, humans could have the hearing of dogs, the visual acuity of hawks, the night vision of owls, or even be able to navigate by sonar employed from bats"\(^{64}\). Would such a transgenic being be more human? The stated purpose of various scientists and bioethicists is not to prevent diseases and restore health, but to remake and transform man’s nature, passing through the intermediate stage of trans-human to achieve a post-human being, different from today's man. The so called humanism of the modern culture reveals itself as an antihuman doctrine aiming to change the man into a different being corresponding to an utopian or science fiction ideal of a perfect being.

Do all the scientific discoveries and biotechnological interventions accord with man's moral and spiritual progress? As St. Paul has stated “If I speak in human and angelic tongues but do not have love, I am a resounding gong or a clashing cymbal. And if I have the gift of prophecy and comprehend all mysteries and all knowledge […] but do not have love, I am nothing” (1 Cor, 13, 1-2).

What to do?

We have to act on many levels.

Benedict XVI warned: “A particularly crucial battleground in today's cultural struggle between the supremacy of technology and human moral responsibility is the field of bioethics, where the very possibility of integral human development is radically called into question”\(^{65}\). Especially in universities, in the field of research and in catholic academies we must be aware of this cultural struggle.

"We need powerful and coherent categories and analysis that challenge cultural projects denying finitude, promising a technocratic agenda that ushers in almost total human control over all of the natural world, including those natures we call human”\(^{66}\).

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\(^{62}\) Francis, Encyclical Letter Lumen fidei, N. 34.


\(^{65}\) Benedict XVI, Encyclical Letter Caritas in veritate, n. 74.

We must be aware that our everyday practice is a form of Christian witness through our respect for the dignity of every patient, according to the natural law based on the order of creation.

Curriculum vitae
Ermanno Pavesi, 1947, M.D. and Psychiatrist, has practised the profession in psychiatric clinics in the German part of Switzerland, at the Universities of Basel and Zurich, amongst others. After his retirement, he has been working part-time in the psychiatric clinic in Wil in the Canton St. Gallen. He is also a psychology lecturer at various institutions.
He has held the post of Secretary of the Association of Swiss Catholic Doctors for 20 years. From 1992 to 1996, he was the Secretary of the European Federation of the Catholic Medical Association FEAMC. He also holds the post of Secretary General of the World Federation FIAMC, which he was appointed to in 2010.
He has authored a few books and approximately 200 articles, especially in psychology and anthropology.

Evidence Based Medicine and Care
Bertrand Galichon, MD
President of the Catholic Center of French Physicians CCMF (France)
(Read by Hans Stevens, MD, Netherlands)

Text
Raising this issue comes down to asking the question: does « evidence-based medicine » meet the patient’s primary needs? Indeed a patient’s demand reaches beyond the « cure », it isn’t restricted to the treatment itself. A sufferer seeks for the deep meaning of any health problem. Why did it happen and what is its purpose? A sick person hopes to become a patient, that is, a person who understands his illness and is able to integrate it in his own biography, to give it a meaning. Such is the value of true recovery. In trying to comprehend the whys and wherefores of illness, we are led to ask ourselves: what is the purpose of a Christian doctor? Indeed “care” cannot disregard the spiritual dimension of a man.

1. Cure and “evidence-based medicine”
Knowledge exists independently of man. For each one of us “one and one makes two” is obvious independently of our will.
A treatment or « cure » must be seen as an answer limited to the exact pathology for which a sufferer is consulting. It is not intended to take charge of the whole sufferer, responsibility allocated to the “care. Therefore such pathology holding such symptoms requires such therapeutic response. This therapeutic response is supported by scientific knowledge. One just needs to master that knowledge and apply it in the framework of a codified protocol closely adjusted to the sufferer’s biology. This medicine established by science has undeniably allowed certain and
significant progress. This progress stems from scientific doubt devoid of any conviction. This attitude, fulfilling professional standards, brings the most technically and scientifically approved response and justifies the medical progress that each one of us applies in our daily practice. This scientific and technical intelligence and its implementation bring us new opportunities like telemedicine. With telemedicine, the expert can offer advice without ever meeting the sufferer, without knowing the sufferer but only knowing which pathology is involved. The human dimension of the illness is not considered. The expert’s advice is strictly factual, incomplete and meaningless. The standardization of methods based on scientific knowledge allows the transfer of tasks towards a well-trained paramedical staff. One can easily see the advantages of this in the context of a limited budget or geographic remoteness, whilst being aware of the limitations of such practices. Another positive aspect of evidence-based medicine is that in case of a complaint filed against him, a doctor can produce evidence that he executed all acts scientifically approved by healthcare and thus met the patient’s expectations. But has he done so thoroughly? Also this modern, scientific medicine increases the number of chronic diseases and consequently the number of people suffering from them. What liberty is the one bestowed upon these “sufferer-healed” by this medicine that generated them? The coming development of transhumanism is going to complicate this question of the patient’s liberty. So what is the meaning of care? That is the question. I shall conclude this first part quoting Belgian economist Philippe de Woost in his «Letter to Christian decision-makers in times of crisis»: “Science is not the only mode of knowledge held by man. It only reveals the part of reality exposed by method of observation, measurement and experimentation. It gives away nothing on a person’s uniqueness, nothing about the meaning and the purposes, nothing tangible about the suffering, the pain and the destiny. These essential questions are beyond science’s reach. And yet, they are central to our choices…” 2. Care, the «taking care» and consciousness It is an illusion to think that illness does not affect the entire person. The sufferer is struck as a whole. There is a before and an after, time is interrupted. The sick person only longs to find his place again in the community of men, where he can exert his liberty, that is, his responsibilities. The point is for him to find a new meaning in life. The sufferer becomes a patient by integrating his illness in his biography. Experienced as a useless, negative point, it becomes a critical moment in a patient’s life. It becomes meaningful. We have seen that «care» goes beyond the simple treatment. It implies to take charge of the patient in his whole dimension. To accomplish this objective, a relation well adjusted to the person is necessary. Care cannot be undertaken without knowing a sufferer, his background. Care only makes sense adapted to a unique situation. The doctor and the patient must figure out this adapted relationship. The possibility of getting to know the other is drawn by a will open to the unexpected, to the possible “other”. It is source to creativity. Therefore, care given to two given patients presenting the same illness will be different in order to respond with appropriate adjustment to each. In other words, the scientifically-normed cure can actually be limited in its adjustment to the patient and his treatment. Telemedicine and expert scientific advice are no longer valid. Care is a man-to-man encounter, heart to heart. Medicine is an art that goes beyond science. Science is limited by knowledge no matter how great, and by technical acts. 3. A doctor’s mission. Humanity respected. Suffering is a loss of liberty, a difficulty to manage one’s responsibilities. Liberty and responsibility are synonymous. To take care is to help the rising of this liberty, to give the patient the means to restore his place in community. In order to do that, care is first of all a presence. This unique encounter doctor/sufferer is undoubtedly a meeting between science and conscience. Indeed, the doctor holds a science, a comprehension of the illness presented. But he is meant to meet his patient, to get to know him. And the sufferer has acquired an embodied knowledge of his illness, a consciousness. This peculiar meeting is most of all a meeting of two liberties meant to adjust. One cannot exist fully without the other. The humanist doctor respects fully his patient in a concern for reciprocity. Do to the other what you
want them to do to you. It’s a win-win situation, lex talionis. The humanity of the patient is fully respected. But is that good enough?

4. The Christian doctor. Dignity
To be respected is the least a patient asks for. But for the care to be fully accomplished, his dignity must be recognized as inalienable, as the most intimate part of himself and source of life. As a Christian, I consider that our dignity is not self-proclaimed. Our dignity has been granted to us along with our status of sons and daughters of our Father the Creator. We don’t belong to ourselves. Our dignity is a gift, justified by his creating Love.

The deepest, strongest desire of a patient is to have his dignity be recognized in order to live as a spiritual human being, gifted with good-judgment and liberty. For the Christian doctors that we are, the care takes charge of our dignity in the entirety of our humanity as sons of God. It is not the face of Christ that I am taking care of but the face of a person loved as much as I am by the Father. This man, ruined by illness, by (a difficult?) life is as important as I am in the eyes of the Father. Through this Agape, I owe myself to him.

It is at this point that the “care” finds its accomplishment and adjustment. This is how care becomes the archetypal situation for the Revelation. Our spiritual reality is tangible at this most incarnate level of our soul.

Christian spirituality encourages us to find an « other », to reveal ourselves in an area that goes beyond the domain of science and technique to fully accomplish the “care”.

“Go, your faith has saved you” is an invitation to true liberty, ultimate goal of care: a capacity for freedom. Christian spirituality is not a matter of intelligence of the law and its strict enforcement but a matter of getting to know the word of God, getting to know God. Therefore the first common point between care and Christian spirituality is this confident otherness that finds root in a Trinitarian movement. Science is not a biblical or theological term, it is a human creation. Consciousness is eminently spiritual and runs throughout the Bible.

5. Conclusion:
Humility is to be a doctor first quality, especially for a Christian doctor. With experience, he becomes convinced that medicine does not do it all. This humbleness allows us to keep a distance with a scientific knowledge that claims to be complete or totalitarian and to give place to a creative act, liberating and open to a possible otherness, an unexpected. This humbleness allows us to consider the sufferer as loveable as we are by the Father. We find ourselves as care-takers, caught in a movement of adjustment to the other. This humbleness leads us on a path of fidelity. Are the stakes not to create a space of liberty where care can be accomplished?

The development of chronic diseases, the growing technical complexity of curing and the rise of transhumanism will also in their term enlarge the field of our thoughts. The “Faith and Reason” debate also plays its role in care, in this complementarity between “care” and “cure”. Quoting Philippe de Woodt again: “Science and technique are moving faster than our political, legal, ethical reasoning. They lay new questions that leave us clueless” (Ph. de Woodt, op cit). Our Faith will be more stimulated. We have as Christians the huge responsibility to focus on the essential in order to witness our Hope. We must question our practices to stay adjusted.

I am not here to take care the face of Christ but the dignity of my brother in Christ in the eyes of the same Father.
End of Life Issues and Advanced Medical Directives
Freddie Loh, MD, Past-President of AFCMA (Malaysia)

Slides

1. End of life issues & advanced medical directives
   - Dr Freddie Loh, Family Physician, Malaysia
   - Immediate Past President AFCMA, Asian representative to FIAMC
   - Past President Catholic Doctors Assoc.of Malaysia

2. Introduction… “Thou shall not kill”

3. 1) End of life issues: Brain death, Euthanasia, Ordinary vs. extraordinary care

4. Death… how to diagnose & certify medically
   - Cardiopulmonary (conventional): Heart stops & spontaneous breathing stops
   - Brain death: Brain, including brainstem stops functioning
     - No universal acceptance or criteria… but can be seen in EEG (flat)

5-9. 1a) Brain death
   - Which part of brain is affected?
     - Cerebrum – higher centres
     - Cerebellum – small brain
     - Brainstem – vital centres controlling breathing, blood pressure, pulse rate
     - Note: EEG activity – there will be some in coma patients; none in brain death
   - Harvard criteria for brain death proposed by Harvard Medical School ad hoc Committee for irreversible coma:
     - Unreceptivity & unresponsiveness
     - No movement or breathing
     - No reflexes
     - Flat EEG (confirmatory)
     - Body temperature > 32 degree Celsius
     - Absence of CNS depressants
   - Whole Brain Death: The Uniform Determination of Death Act in the U.S. provided the legal definition of whole brain criteria of death as ‘irreversible cessation of all functions of the brain including the brain stem’.
   - Christopher Pallis’ criteria for brainstem death (BMJ 1982) include:
     - Absence of brain stem reflexes
     - Deeply comatose
     - Ventilator-dependent patient
   - Legal definitions vary (eg, Pallis’criteria is accepted in UK, India, Malaysia; but not accepted in America)
   - Catholic definition of brain death:
     - no clear cut directive from Magisterium
     - Pope John Paul II: “the complete and irreversible cessation of all brain activity, if rigorously applied, does not seem to conflict with the essential elements of a sound anthropology. Therefore a health-worker professionally responsible for ascertaining death can use these criteria in each individual case as the basis for arriving at that degree of assurance in ethical judgement which moral teaching describes as "moral certainty". 
- Address of the Holy Father John Paul II to the 18th International Congress of the Transplantation Society, 29 August 2000.

• Importance of establishing brain death
  - "Organ viability decreases the longer a patient is brain dead. This is believed to be secondary to hormonal, hemodynamic, and inflammatory changes, and may particularly pertain to the viability of transplantable kidneys and livers" Gene Sung (MD) & David Greer (MD), Neurology 2011.

- Problem – defining the precise moment of death became important mainly because of organ transplantation and the need to keep the organs perfused. Otherwise the only organs for successful transplantation will only be available from living donors.

10. Terminal illness
• an advanced stage of a disease with an unfavorable prognosis and no known cure (Mosby's Medical Dictionary, 2009). It can also be caused by injury.
• Life-sustaining treatment would only serve to postpone the moment of death of the patient.

11-17. 1b) Euthanasia
• An act or omission which of itself and by intention causes death with the intention of eliminating all suffering – Pope John Paul II (Evangelicum Vitae, The Gospel of Life)
• Human life is sacred (Humanae Vitae) and healthcare personnel should remain faithful to the service of life and assisting it to the end.
• Declaration on Euthanasia by Sacred Congregation for the Doctrine of Faith:
  “It is necessary to state firmly once more that nothing and no one can in any way permit the killing of an innocent human being, whether a fetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person who is dying. Furthermore, no one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly.”

• But the world thinks differently… It thinks that one can justify euthanasia to give relief to those who are terminally ill, have incurable diseases, elderly, mentally ill, abnormal babies, etc.
• Emily and Caitlin Copeland – 18 year old joint twins from America. The doctors gave their parents the option to terminate / abort the pregnancy at 17 weeks. After praying, their parents decided to go through with the pregnancy.
• Terri Schiavo – vegetative state since 1990… feeding tube was removed ~15 years later upon request of husband and legal advisers vs. her parents (staunch Catholics). Death due to starvation and dehydration. Her husband ordered the removal of the tube, saying there was no written Directive from Terri. Florida law allows removal of feeding tubes in persistent vegetative states (PVS) &/or end stage condition.
• Assisted suicide:
  - Some countries and certain states in USA have legalised Physician Assisted Suicide - lethal drug is injected.
  - In Oregon (USA)
• What euthanasia is NOT
  - There is no euthanasia unless the death is intentionally caused by what was done or not done.
  - Some forms of “passive euthanasia” are not euthanasia since the intention to take life is lacking.
  Eg. Not commencing treatment that will not benefit the patient
  Eg. Withdrawing treatment that has shown to be ineffective, too burdensome or is unwanted
  Eg. Giving high doses of painkillers that may endanger life when they have shown to be necessary
  These are all part of good medical practice endorsed by law when they are properly carried out. The Church does not oblige the Catholic to forego medical treatment for pain even when such treatment may deprive the patient of full consciousness or indirectly shorten life. This is the application of the principle of double effect.

18-21. 1c) Ordinary vs. Extraordinary care
• Extraordinary treatment = treatment or care that does not offer a reasonable hope or benefit to the patient, or which cannot be accomplished without excessive pain, expense, or other great burden; ET is an ethical determination about rendering care depending upon the patient’s condition and prognosis.
Catechism of the Catholic Church 2278 states: Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of "over-zealous" treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.

Declaration on Euthanasia by Sacred Congregation for the Doctrine of Faith
“is it necessary in all circumstances to have recourse to all possible remedies? … One cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community.”

21-25. 2) What is an Advanced Directive?
- Document written with instructions made by a person before he/she reaches terminal phase of a terminal illness or a persistent vegetative state and is incapable of asking decisions about medical treatment.
- Preferably executed by person of legal age & sound mind, in consultation with physician and family members.
- To make sound moral decisions, patients must receive all relevant information including the proposed treatment and its - Benefits
- Possible risks
- Sick effects
- Costs

Categories of Advance Directives:
- Living will – specifies what type of medical treatment are desired should the individual become incapacitated. Eg. “Do not resuscitate”; “Do not intubate” {mechanical ventilation}
- Healthcare Proxy – delegate another person to make healthcare decisions on behalf if the person is incapable of making his/her wishes known.
- Power of attorney – authorises a person to make bank transactions, pay utility bills, etc on behalf of the incapacitated individual.

Advance directives in Asia
- Some effort to promote in Japan, Hong Kong, Philippines… but not yet legalised.
- Singapore has passed its Advance Medical Directive Act (Chapter 4A) on July 1997 to provide for and give legal effect to Advance Directives to medical practitioners against artificial prolongation of the dying process… The Act permits only natural death and not euthanasia or abetment of suicide.

Physician Orders for Life-sustaining Treatment (POLST)
- Form signed by doctor & patient

26. 3) Conclusion
- Advance Directives and End-of-Life issues like Euthanasia, Brain Death and Ordinary and Extraordinary Care have been described. Whilst Advance Directives are commonly used in the U.S. and are legalised, in Asia only Singapore has legalised it. Advance Directives may not be popular in Asian countries as the Family Bond is very strong amongst Asian Families.
- Advance Directives like LIVING WILLS attack the sacred value of human life by allowing individuals to control their end-of-life issues independent of Catholic Health Care Ethical values. However Durable Power of Attorney is acceptable and helpful towards the medically incapacitated individual like paying the utility bill, etc..
**From embryonic stem cells to induced pluripotent stem cells:**

**An ethical perspective**

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**Text**

**Introduction**

1) Definitions

Stem cells are undifferentiated, primitive cells, present in the embryo and in all organs and tissues of the organism, that can renew themselves and give rise through differentiation and maturation to different specialized types of cells with specific functions in the body.

The survival of multicellular organisms depends on the biological activity of these cells. An adult human person lose something on the order of 1 million cells every second, 50-70 billion cells/day, a process by which in each year an individual will produce and dispose of a mass of cells equal to its own body weight. This loss is compensated by the activity of stem cells, giving a mean cellular turnover of 39 days for the epidermal cells, 20 days for the hematopoietic system (1 trillion cells a day), 5-7 days for the intestinal epithelial cell lining (two days for the small intestine, one day for the colon and the gastric antrum).

In man, the sources of stem cells that have been identified hitherto are:

- the embryo in the first stages of its development (the internal cell mass of the blastocysts) (embryonic stem cells or ES cells),
- the fetus (in particular the germ cells or EGCs),
- the blood and the Wharton’s jelly of the umbilical cord (UCB),
- and various tissues in adults (bone marrow, muscle, fat, brain, skin, teeth, myocardium, pancreatic tissue, and others)("adult stem cells").

The capacity of stem cells to generate different types of differentiated cells is called ‘potency’.

- It is said that a stem cell is ‘totipotent’ when it is able to create all the cell types of the human organism, including those of the trophoblast, from which come the embryonic annexes (placenta). The cells that make the early embryo up to the stage of morula (4-5 days after fertilization) are "totipotent".
- It is said that a stem cell is ‘pluripotent’ when it has the capacity to give rise to every cell type in the body, but not those of the embryonic annexes. Pluripotent stem cells are derived from germ cells or from cells that can make germ cells, that is the cells of the early embryo.
- Stem cells are said to be "multipotent" when they are able to give rise to different types of differentiated cells, but not to every cell in the body. The so called "adult stem cells" or "somatic" stem cells are multipotent stem cells.

2) Adult stem cells

Adult stem cells were the first stem cells to have been discovered. This happened as a consequence of the observations made in the years 50's on the effect of radiations on tissues and blood cells.
Which led to the individualization of hematopoietic stem cells in bone marrow. Stem cells were afterward identified in adult tissues that undergo extensive cell replacement due to physiological turnover or injury such as the hematopoietic, intestinal or epidermal systems. In 1974 Knudson showed the presence of hematopoietic stem cells in umbilical cord blood. Adult stem cells and umbilical cord blood stem cells are obtained without ethical problems, and they are currently used in patients, especially the hematopoietic stem cells which help to reconstitute blood cells after chemotherapy. They serve also for treating patients with degenerative diseases, vascular diseases or myocardial infarction. The mesenchymal stem cells also help patients, in particular in the field of auto-immune diseases.

But these adult stem cells are rare, hard to find and to individuate, and they are unstable in culture. Moreover they are only multipotent stem cells, with a capacity to differentiate limited to one or two types of cells. The cells from the umbilical cord are younger, and they grow well in culture. They have good hematopoietic properties and represent a useful alternative to bone marrow stem cells. But they are in a limited number in each cord used.

3) Embryonic stem cells

For that reason, the technical possibility given by J.A.Thomson in 1998 to obtain embryonic stem cells from discarded human embryos came as a true revolution in that field. Embryonic stem cells (ES) offer indeed a unique whole of exceptional properties, coming from their nature of pluripotent, undifferentiated stem cells:
- unlimited self-renewal in culture
- capacity to give all cell types of the organism when they are induced to differentiate.
- stable karyotype
- high level of telomerase which is correlated with immortality in human cell lines. As long as they are kept undifferentiated, they remain very young, and proliferate abundantly.
- When undifferentiated ES cells are introduced into a blastocyst by microinjection, they associate with the inner cell mass cells of the embryo and chimerize the resulting animal. In the resulting chimeric embryo, ES cell descendants are represented among all cells types, including functional gametes
- When ES cells are aggregated with developmentally compromised tetraploid embryos (ES tetraploid complementation), they can produce all the cells of the developing fetus, and the resulting newborn would be the product of this development.

All these properties confer to ESCs a unique capacity to secure the repair of damaged tissues and organs, superior to that of any other type of stem cell. For the scientists working in the field of stem cells, the hESCs represent therefore the "gold standard" of stem cells, their must-have point of reference, regarding pluripotency and differentiation.

4) Problems with embryonic stem cells

However, hESCs are problematic:
- They are tumorigenic, growing into teratomas or teratocarcinomas when injected in the adult organism. This property is linked to pluripotency. This is why ES cells cannot be used in vivo when they are still in the undifferentiated state.
- They are rejected by the immune defenses of the organism of the recipient when they are transplanted. To apply hESCs or their derivatives to patients for regenerative medicine purpose, it will therefore be necessary to associate an immunodepressive treatment, which will complicate the regenerative treatment.
- They are obtained from the inner cell mass of a blastocyst, which is lost in the process. For getting human ESCs scientists use human embryos that are “left over” from IVF and abandoned, or given to science by their biological parents.

4) Proposed solutions

- To overcome the biological obstacle, the proposed solution has been to develop stem cells with the same qualities as hESCs but avoiding immunological rejection.
- To overcome the ethical obstacle, scientists have look after alternative ways of research allowing obtaining stem cells with the same qualities as hESCs but obtained without destroying human embryos.

So, between human embryonic stem cell research, attracting but non ethical and research into adult
or umbilical stem cells, ethical but more limited in its possibilities, a third avenue of stem cell research was opened: that of the so called “alternative proposals” which seek to obtain stem cells of the quality of ES but without the biological or ethical problems of the ES.s

These various proposals include:
- proposals that still involve the destruction of human embryos.
- proposals to use defective or “altered” human embryos;
- proposals that do not involve the destruction of human embryos.

I - Alternative proposals involving embryo destruction

A - "Therapeutic cloning" to produce immuno-compatible human es cells

"Therapeutic cloning", better called "research cloning" (Lanza et al., 1999), would create a human embryo by nuclear transfer of one of the patient’s somatic cells into an enucleated human oocyte. hESCs extracted from that embryo when arrived at the blastocyst stage, would therefore be immunologically compatible with the organism of the patient. Administered to the patient for regenerative purpose, they would not be rejected. However, this proposal immediately came up against serious biological and ethical difficulties.

From the biological standpoint, the nuclear transfer technique, even limited simply to the production of blastocysts from which to obtain stem cells, has produced positive, consistent results in only some species (mouse, bovine, rabbit). In primates, the Oregon National Primate Research Center team, after years of not very fruitful work in this field, managed to obtain two ES cell lines from 35 macacus rhesus blastocysts created by SCNT (out of 213 prepared embryos) (Byrne JA et al. 2007) then, more recently, two other ES cell lines from six blastocysts created by SCNT (out of 71 prepared embryos)(Sparman et al., 2009). In humans, therapeutic cloning, despite repeated efforts and some false announcements (Wang et al. 2005), has still not produced any consistent results. Finally, in 2013, Shoukrat Mitalipov and colleagues from the University of Oregon announced that they had succeeded in creating four lines of human embryonic stem cells through the nuclear transfer technique (nuclear transfer ES cells) (NT ES cells) . They recently reported that these NSCT hES cells are of a quality comparable to that of IVF ES cells (2014). But "Therapeutic cloning" in humans remains a costly undertaking, severely limited by the number of human oocytes it requires.

This procedure raises two types of ethical objection The first, which applies to all the technologies that use embryonic stem cells, is related to the way in which they depend on the destruction of incipient human life. The second type of objection is more specific to "therapeutic cloning": in contrast to the usual research on embryonic stem cells, which can use frozen embryos left over from artificial fertilization procedures, "therapeutic cloning" requires the deliberate creation of an early-stage human embryo, followed by its disaggregation.

Even if "therapeutic cloning" were to become more efficient and produce consistent results in the human species, it will always bring an ethical problem. Such action would be indeed contrary to the ethical principle expressed by Emanuel Kant, according to which an individual human being should not be thought of solely as a means, but always as an end.

B - Human cytoplasmic hybrid embryo ("cybrid") proposal

Because of the difficulty of collecting a sufficient number of human oocytes in order to be able to create human embryos by cloning and extract the stem cells from them, some have suggested using the interspecies somatic cell nuclear transfer (iSNCT) technique that seeks to create cloned embryos by the nuclear transfer of a human somatic cell into an enucleated animal oocyte (Tecirlioglu, 2006). These would be "cytoplasmic hybrid" embryos – therefore "cybrids" - with a human nuclear DNA and an animal cytoplasm containing the animal mitochondrial DNA.

Human-animal cytoplasmic hybrid embryos would thus be created (99.9% human due to the nuclear DNA, 0.1% animal due to the mitochondrial DNA), from which human-like embryonic stem cells could be extracted once these embryos have developed to the blastocyst stage. These ES cells would be genetically human, and could therefore be used therapeutically.

The Advanced Cell Technologies (Massachusetts) team, led by Robert P.Lanza, Jose B.Cibelli and Michael D.West, was the first to study this possibility. In 1999, these authors reported that they had created embryos by nuclear transfer of human somatic cells into enucleated cow oocytes (Lanza et al., 1999). 26% of these embryos (n=6) was said to have been able to develop to the 4-16 cell stage and only one of them to have reached the 400-cell stage.

In April 2006, Karl Illmensee, Panayiotis Zavos and co-workers (Illmensee et al., 2006) reported the
creation of 37 human/cow hybrid embryos, seven of which were said to have reached the blastocyst stage, but no ES cells could be extracted from these blastocysts. These authors, admitting the paucity of their results, put them down to aberrant reprogramming of the embryos created in that way.

Despite this repeated lack of success, the British HFEA (Human Fertilization and Embryology Authority), declared on 5 September 2007 that it was in favor of the creation of such "cybrids", declaring them “necessary and desirable in both scientific and ethical terms "

Questionable from a biological point of view, the creation of "cybrids" is however a serious matter from an ethical point of view. Even if the individual resulting from this transfer into a bovine oocyte is genetically 99% human, the process itself does not respect the humankind of which the cybrid is a part, as a "member of the human family" (Universal Declaration of Human Rights, Preamble).

II – Alternative proposals to obtain hes-like cells
from embryos with no development potential

The second line of response to problems connected with obtaining hES cells is different from the first in that what is primarily sought here is not the solution to the biological problems posed by hES, but the development of ethically acceptable methods to enable hES cells to be collected without viable embryos having to be destroyed.

Four proposals for acceptable alternative methods of obtaining hES cells have thus been put forward:

- H.A.Zucker and D.W.Landry proposal to use poor-quality embryos rejected by the IVF centers,
- proposal to use parthenogenetically created embryos ;
- proposal to use created embryos that are defective and unable to implant: W.Hurlbut’s ANT, M.Grompe’s OAR

A - Use of poor-quality embryos

The first proposal, which was presented by D.Landry and Howard Zucker (2004) (Landry & Zucker, 2004), is to use as a source of hES cells the human embryos created in the IVF centers and discarded because of their poor morphology suggesting embryonic "death". Such embryos still contain live cells that are a potential source of hES cells.

In 2003, M.Mitalipova, S.Tice and co-workers of the University of Georgia (Mitalipova et al., 2003) reported that they had been able to derive hES cells from surplus human embryos from IVF clinics and that they had been able to obtain four hES cell lines from such embryos.

In October 2003, S.J.Pickering, S.Minger and co-workers at King’s College, London reported obtaining three hES cell lines from 58 human embryos created by IVF, subjected to preimplantation diagnosis.

P.H.Lerou, G.Q.Daley, and co-workers (Harvard Medical School, Boston) (Lerou et al., 2008) showed that there was a possibility, albeit very low (0.6%), of deriving hES cells from three-day embryos considered to be of poor quality. hES cell derivation efficiency was clearly better (4.1%) when these poor-quality embryos had reached five days of development, and it was 8.5% when these embryos had become blastocysts.

From the biological standpoint, this proposal does not offer a real solution to the problem of the limited number of human embryos available for the obtaining of hES cells, because to be effective it requires blastocysts. Most arrested embryos or those presenting morphological changes do not reach this stage of development. Nor does it solve the problem of the immunological rejection of hES cells, if these cells were to be used clinically.

The idea of using embryos facing certain death as a source of hES cells might be defended from an ethical standpoint based on the analogy of taking organs from brain-dead patients. However, to be able to justify taking the inner cell mass of these embryos, there would have to be certainty about their state of "embryonic death". At present there are no reliable, early criteria for declaring an embryo "dead".

B – Parthenogenesis

Parthenogenesis is the process by which a new individual develops from a non-fertilized oocyte. It can be induced in mammals by artificial, chemical or electrical stimulation of an oocyte, which then becomes a zygote, and develops to form an embryo that only has the genetic programme of the mother and is called a "parthenote". In primates, embryos created in this way cannot develop correctly and are generally lost before they can implant probably due to a lack of expression of the
paternal imprinted genes.

Recourse to parthenogenesis was proposed by J.B.Cibelli and co-workers (Cibelli et al., 2002) as a way of obtaining immunocompatible hES cells from a female donor. This approach would moreover be ethically acceptable, because it does not lead to destroying normal human embryos. These authors had derived embryonic-like parthenogenetic stem cells from four monkey (Macaca fascicularis) embryos at the blastocyst stage. These parthenogenetic embryonic stem cells (PESCs) were capable of multiplying in vitro for more than ten months. The possibility of getting good quality human embryonic stem cells from parthenogenetic embryos that are homozygous for human leukocyte antigens is still today presented by some groups as an attracting alternative to human IVF ES.

From the biological standpoint, studies show that the stem cells harvested in the "parthenote" embryo have characteristics similar to those of hES cells collected from viable embryos created by fertilization. Moreover, these cells are histocompatible with the oocyte donor, which to a certain extent solves the.

The derivation of these embryonic-like pluripotent cells from non-fertilized human oocytes activated to parthenotes would be ethically acceptable, because the product of this activation, i.e. the parthenogenetically created embryo should not be regarded and treated as a real embryo. This "parthenote", incapable of developing beyond the blastocyst stage, with no future potential, should be considered as potentially dead, an apparent organism breaking down, and treated as such.

But this opinion seems questionable, because these activated human oocytes behave exactly like normal embryos until their epigenetic imbalance curbs their development and stops them implanting in utero.

**C – Altered nuclear transfer: W. Hurlbut**

The proposal presented by William Hurlbut (Stanford University) (2005) entitled "Altered Nuclear Transfer "(ANT) aimed to create by cloning (SCNT), an "altered" human embryo, that is to say, an embryo incapable of implanting in the maternal uterus or of developing after implantation, which could become a morally licit source of hES cells. To achieve this goal, this embryo would have been created with a genetic defect preventing it from implanting, but not interfering in its pre-implantation development, in such a way that good quality embryonic stem cells could be obtained from it.

Hurlbut’s plan was to create embryos deficient in the cdx2 gene needed for trophoblast individuation by RNA interference. cdx2-deficient blastocysts are indeed unable to implant but they develop an inner cell mass from which embryonic stem cells can be derived. Once these cells had been obtained, they would have their cdx2 gene re-expressed , turning that way into normal pluripotent hES cells.

According to Hurlbut, the biological result of this "altered nuclear transfer" with cdx2 deficiency would not be an embryo, since it would not have the ability to develop, but a "group of cloned cells", comparable to a teratoma, the tumor that forms from embryos arrested in their development, a disorganized mass with no future.

The comparison between a defective embryo that does not manage to implant and a teratoma is not correct. The teratoma is a cell formation that has no organization, no internal drive to develop, and is therefore not an "organism" or a biological "individual". The cdx2–deficient embryo behaved like an organism with a development plan, through to the blastocyst stage. The fact that it was unable to implant takes nothing away from its quality as a biological individual. A defective embryo, unable to develop, remains an embryo until the dissolution of its organic unity.

The proposal to manipulate the genome of human embryos created by cloning to make them incapable of implantation is perplexing. The fact that many embryos produced through sexual relations have chromosomal or genetic anomalies that prevent them from developing properly or implanting does not justify the deliberate creation of such anomalies.

**D - Markus grompe’s Oocyte-Assisted Reprogramming (OAR)**

M.Grompe and R.George took up W.Hurlbut’s idea of ANT and modified it (2005). Their idea was to make the nanog gene overexpress in an early embryo created by nuclear transfer. That would be achieved by artificially inducing Nanog to overproduce in the somatic cell nucleus that is to be transferred in the enucleated oocyte. Nanog is required for the acquisition of pluripotency by pre-implantation embryo cells, but an excess of Nanog too early in the development of the pre-implantation embryo would induce too soon the instauration of pluripotency in the blastomeres.
of this embryo and this would make the embryo incapable to implant. Grompe considered that such an embryo would not be a real one but a but a group of pluripotent cells, from which hES cells could be derived without troubling the conscience. Even if such an operation would be technically feasible and would allow to get Es cells from the embryo in which Nanog is overexpressed, which is not proven, it would fall under the same ethical objection than the ANT’s project of Hurlbut: impeding voluntarily the implantation of a human embryo in order to declare this embryo unfit and then to destroy it without problems of conscience is analogous to the criminal action of crippling a child in order to use him as a beggar.

III – Alternative proposals that do not involve the destruction of embryos

Alongside these alternative proposals on obtaining hES cells from viable blastocysts, which all involve the use of cloned or defective human embryos and which do not therefore really solve the ethical problem associated with obtaining hES cells, other proposals have been made to obtain hES cells without having to destroy human embryos. They are:

- using blastomeres harvested by embryo biopsy.
- reprogramming somatic cells to an embryonic-like state.

A - ES cells derived from a single blastomere collected by embryo biopsy

Another proposal to obtain hES-like cells without embryo destruction is to remove by biopsy one blastomere from an embryo in the segmentation phase. This would be cultured and would multiply to produce hES cells. ES cell lines have been indeed repeatedly derived from blastomeres of early pre-implantation embryos, in the mouse. (Takumi Takeuchi and Ameeta Bahia, 2005). The idea was taken up by Robert Lanza, Y.Chung, I.Klimanskaya and co-workers at Advanced Cell Technology (Worcester, Massachusetts), who proposed to derive hES from human blastomeres removed from human embryos. They reported (2006) to have created that way two hES cell lines obtained by biopsying human embryos (Klimanskaya et al., 2006) The procedure proved however to be very inefficient, since only 2% of the blastomeres collected in this way had given rise to an hES cell line.

From an ethical standpoint, Robert Lanza, Y.Chung, I.Klimanskaya have stressed the moral aspect of their enterprise when they presented the blastomere biopsy technique as an ethical way for getting hES cells. But their presentation was misleading because in fact they used for their demonstration all the blastomeres of the human embryos that they have received, and did not spare the life of these embryos.

The reality is that very few human blastomeres, after being removed by biopsy, prove to be capable of multiplication in vitro in order to produce hES. Even if they did it well, it would be unacceptable from an ethical standpoint to take advantage of a procedure of preimplantation genetic diagnosis to remove blastomeres from human embryos that may be implanted afterward.

B - Somatic cell reprogramming

The other proposal for obtaining embryonic-like, pluripotent stem cells without having to destroy human embryos is "nuclear reprogramming". Nuclear reprogramming is the name given to the change that occurs in the nucleus of a somatic cell when it is induced to revert from its differentiated state and assume a pluripotent state. Up to recent years, the scientific community believed that differentiated state was fixed, irreversible. To explain the stability of the differentiated state of the cells in the body, August Weissmann had indeed proposed in 1892 a theory following which all development and cell differentiation depended on a loss of hereditary material.

Recent studies have shown that going backward in the differentiation slope was in fact possible, not by a change in the genetic material of the cell, that is of its DNA, but by a processus of an epigenetic nature, which happened through provoked changes in the selective expression of some specific genes, that have been “silenced” during the differentiation process.

Using reprogramming it would be therefore theoretically possible to turn an ordinary, differentiated cell of the adult organism into a cell more or less identical to an embryonic stem cell. If nuclear reprogramming were possible and effective, I would be a valid and very attractive way for obtaining pluripotent, ES like cells, without having to destroy human embryos.

The systematic study of nuclear reprogramming has followed four ways:

• the transdifferentiation by cell fusion of one cell with a particular function in a cell with a different function, in the "heterokaryons" studied by Helen Blau
• the "rejuvenation" of the nucleus of an adult, differentiated cell to the state of the nucleus of a
zygote by the cytoplasmic factors of the ovocyte, in the nuclear transfer experiments, carried out by John Gurdon;

- the reprogramming by hybridization through the fusion of a somatic differentiated cell with an ES cell.
- the epigenetic reprogramming of somatic differentiated cells into pluripotent stem cells, using transcription factors, developed by Yamanaka

1) The “heterokaryons” of Helen Blau

The possibility of the reactivation of some silenced genes in somatic cells under the influence of specific “reprogramming factors” present in the cytoplasm of other cells has been demonstrated in the «hétérokaryons» existing naturally or created experimentally. The Heterokaryons are cells that contain several nucleus genetically different between themselves. This phenomenon can happen naturally (mycelium of the mushrooms). It can be through the fusion of two cells genetically different.

Helen Blau in the years 80 has conducted experiments of fusion of specialized cells belonging to the three different cell types representative of the three embryonic germ layers, with skeletal muscle cells of mice. She has shown that in the multinuclear heterokaryons thus created, some genes could be activated in the absence of any replication of the DNA, through a processus entirely epigenetic. Helen Blau has reported that way the apparition of the expression of nuclear genes muscle specific in amniocytes, keratinocytes, fibroblasts and human hepatocytes, fused with mice skeletal muscle cells, while there was no DNA activity in these cells. (Blau, Cell 1983, 1984, 1985, Science 1985)

These results indicated that cell differentiation was a reversible process and that through the activation of some specific genes, responsible of the maintenance of the pluripotent, undifferentiated state in the cells of the early embryo, somatic, differentiated cells could return to a primitive, immature, undifferentiated, and pluripotent state.

2) The demonstration that nuclear reprogramming is possible through nuclear transfer in enucleated ovocytes: John Gurdon and the beginning of SCNT.

One another approach to reprogramming has been the study the reprogramming of somatic cell nuclei through nuclear transfer in enucleated ovocytes. (SCNT)

This technique has been pioneered by Robert Briggs and Thomas King in the years 50s in Rana pipiens. Then John Gurdon applying it to Xenopus. has shown that the nucleus of a differentiated cells was able to recover the capacities of the nucleus of a zygote when it was transferred into an enucleated ovocyte. The truthfulness of this new concept found its most convincing illustration and proof with the birth if the sheep "Dolly" by the care of Ian Wilmut and the subsequent successes of nuclear transfer cloning in various species.

Such a reprogramming had to come from “factors of reprogramming” that were present in the cytoplasm of the enucleated ovocyte, and these factors most probably corresponded to the factors that maintain pluripotency and undifferentiated state in the ES cells.

3) Reprogramming through hybridization

This epigenetic reprogramming by hybridization (Surani, 2001) approach uses therefore the ability of human ES cells to "reprogram" somatic stem cells to pluripotencies The result of this "reprogramming" are tetraploid cells with capabilities comparable to those of ES (Strelchenko et al., 2006).

The promoter of this approach, K.Eggan., says that this somatic stem cell reprogramming should not raise ethical difficulties because the new stem cell lines obtained in this way would not require the use of embryos or oocytes for their creation. But such tetraploid cells cannot be used in patients not only because they carry an oncogenic risk but also because they are rejected immunologically once transplanted because of the diversity of origin of their chromosomes.

The success of reprogramming through fusion with ES cells gave the proof that ES cells, as the other pluripotent cells, contain factors that induce pluripotency in somatic cells.

4) Reprogramming using defined transcription factors

The “factors of reprogramming” present in the enucleated ovocyte in SCNT and in the ES cell which are able to trigger the expression of the corresponding silent genes in the nucleus of a somatic cell through SCNT or fusion with an ES cell correspond to the transcription factors that are responsible for the maintenance of pluripotency in ES cells. Theoretically it should be possible
to obtain the reprogramming to a pluripotent state of the nucleus of a somatic cell in a direct way, by introducing in this nucleus, with a vector, some of the genes coding for these transcription factors that can best activate the genes involved in pluripotency. If this strategy were efficient it would provide a direct reprogramming of the nucleus, that is a reprogramming independent of the intervention of an enucleated ovocyte or of a fused ES cell. But this enterprise looked difficult if not hopeless because of the number of factors having a role in pluripotency. The Japanese scientist Shinya Yamanaka (Kyoto University) faced that difficulty using a protocol of screening for finding out which combination of which factors would give the best results of direct reprogramming. Using a technique of transfer by retroviral vector of some of the genes coding for the transcription factors responsible for pluripotency in ES cells, and doing a genetic selection of the reprogrammed cells for the expression of Fbx15, Yamanaka et al individualized different associations of ectopic genes that were more successful in inducing pluripotency in somatic, differentiated cells.

In July 2006 Shinya Yamanaka and colleagues reported their results at the Congress of the International Society for Stem Cell Research (ISSCR) in Toronto. Their report showed that the retroviral expression of the transcription factors Oct4, Sox2, c-Myc and Klf4 in the nucleus of tip tail mice fibroblasts, combined with a selection of these transfected cells through resistance to Neomycin for the expression of Fbx15, generated directly the transformation of these fibroblasts in pluripotent cells. They called the cells reprogrammed that way “induced pluripotent stem cells” (iPSCs).

- These cells has apparently all the properties of embryonic stem cells, comprising the phenotype of ES cells, their unlimited proliferation in vitro, and their capacity to give, when differentiating, all cellular types of the organism.
- K.Takahashi and S.Yamanaka published their results on 25 August 2006, in the journal "Cell". However, this first generation of mice iPSCs lacked of some of the characteristics of embryonic stem cells regarding the methylation profile of DNA, and the capacity to produce chimeras when introduced into a developing embryo, and this left some doubts about the quality of their pluripotency.

- The scientific world realized the importance of this work, and its value, when the results of Yamanaka and colleagues were confirmed by three different teams of researchers, - one in Japan (Okita et al. 2007), - and two in the United States, the one of K.Hochedlinger (Harvard Stem Cell Institute, Boston) cooperating with Kathrin Plath (UCLA, California) (N.Maherali et al., 2007) and the one of the Whitehead Institute for Biomedical Research (Cambridge, MA) led by Rudolf Jaenisch (Wernig M. et al., 2007).

- Meanwhile S.Yamanaka and colleagues had presented a new generation of iPSCs, selected that time in function of Nanog expression, which answered to all test of pluripotency, comprising the methylation profile of DNA and the capacity to produce chimera in an embryo. (K.Okita et al.

- There was no more room now for doubts on the validity of the reprogramming method reported by S.Yamanaka.

In November 2007, Takahashi and colleagues published identical cell reprogramming

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67. Yamanaka S, Identification of factors that generate ES-like pluripotent cells from fibroblast culture, Plenary session IV, Reprogramming and cloning, June 30 (Friday) 9.45 a.m.-10.10 a.m., International Society for Stem Cell Research, 4th Annual Meeting, 29 June-1 July, Toronto, Canada.
results, but this time for human fibroblasts.
- At the end of 2007 J.Yu, J.A.Thomson and colleagues (University of Wisconsin-Madison) published their own results of cell reprogramming using transcription factors (Yu et al., 2007) which were in agreement with the results of S.Yamanaka and colleagues.
- In December 2007, the group of the Children’s hospital (Boston) led by G.Q.Daley joined these authors in the publication of the reprogramming of human somatic cells in iPSCs, including the reprogramming of fibroblasts from a human skin biopsy.
- Then, in 2008, the group of UCLA led by Kathrin Plath, publishing their production of human iPSCs from human skin fibroblasts showed that these iPSCs could differentiate in cell lines representative of the three to the three different cell types representative of the three embryonic germ layers.
- Also in December 2007, the team of the Whitehead Institute led by R.Jaenisch produced the first experimental evidence of the therapeutic interest of the iPSCs. They reported that mice made model of human sickle cell disease had been cured by transplantation of hematopoietic progenitors obtained in vitro from iPSC cells derived from tip tail fibroblasts of these same mice and that had been corrected of the genetic sickle cell defect by homologous recombination.

The demonstration by these various authors that somatic cells can be reprogrammed directly in pluripotent stem cells, ES like, was greeted as the most important scientific breakthrough of 2008 (Vogel, 2008).

Thus it happened in these years that the hope of finding a way to get cells having all the characteristics and properties of hES cells without the need for destroying human embryos had become reality.

IV - IPS cell new deal

A – IPS cells are identical to es cells in morphology and function

Human iPSCs (hiPS), as produced by Yamanaka, Takahashi and colleagues from human skin fibroblasts, through the ectopic expression of the four transcription factors Oct4, Sox2, Klf4 et Myc, present all the characteristics of embryonic stem cells as regards morphology, self-renewal, feeder dependence and abundant, stable and unlimited in vitro proliferation capability. At the molecular level the iPSCs well reprogrammed show transcriptional characteristics identical to those of hESCs. The profile of the expression of the genes in these cells is very close, if not identical to that of hESCs.

The iPSCs share with hESCs a same level of expression of these genes involved in keeping pluripotency, undifferentiated state, an self-renewal such as Oct3/4, Sox2, de Nanog, Lin 28, Zic 3, GDF3 (growth and differentiation factor 3), Rex1(reduced expression 1), Fgf4 (fibroblast growth factor 4), Esgr1 (embryonic cell-specific gene 1), Dppa2 (developmental pluripotency-associated 2), Dpp4, et hTert (telomerase reverse transcriptase). These genes are the “hallmark” of ES cells, their “specific epigenetic markers”, and their expression is the genomic signature of the pluripotent state.

The epigenetic status of fully reprogrammed iPSCs, selected by Nanog, is identical to that of hESCs. The epigenetics specificities proper to hESCs are also found in iPSCs. Thus, in mice, the iPSCs derived from feminine fibroblasts show a reactivation of the X chromosome, which is silenced in the somatic cells, in such a way that miPSCs as mESCs have two X active chromosomes. This X chromosome reactivated by reprogramming is silenced when iPSCs start to differentiate.

ES-specific surface antigens are found on the iPS. iPSCs are positives for alkaline phosphatase and for the surfaced marker SSEA-1 specific of ES cells.

By restoring pluripotency in the fibroblasts, the reprogramming resets the biological age of the cell to its starting point, suppressing the biological signs of senescence in the cell. This shows up especially in an activation of the telomerase, which brings a lengthening of the telomeres. The reprogramming not only reset the « biologic clock » of the cell to a younger age through the rejuvenation of the telomeres, but could also rejuvenate the mitochondria themselves, The iPSCS show mitochondrial properties identical to those of the ESCs, which suggests that reprogramming

through ectopic transcription factors could modulate the mitochondrial oxidative stress way, inducing that way a rejuvenated state which would escape from senescence. This “rejuvenation” is spectacular when cells from old persons – even centenarians - are reprogrammed.

iPS are capable of producing in vitro derived cells representing the three embryonic germ layers, and can subsequently produce all the cell types of the organism, including germ cells (Okita et al., 2007).

Like ES cells, iPS cells form embryoid bodies in vitro and develop into teratomas when they are injected subcutaneously into laboratory mice.

When iPS cells are introduced into embryos at the blastocyst stage, they take part, as do ES cells, in the development of the three primitive embryonic germ layers, producing a "chimerical" embryo in which the descendants of the injected iPS cells, which originated in these three germ layers, are of all cell types, including gametes (Prelle et al., 2002).

The property of ES cells of being able to generate a whole animal when they are aggregated into tetraploid embryos (embryos incapable of developing by themselves), had not been found initially with the first and second generation of iPSCs. It has been demonstrated later on by Chinese scientists (Zhao et al., 2009) which, through tetraploid complementation, were able to get a mouse to develop from iPS cells (Xiao Xiao). This result was confirmed afterward by a team of scientists from the Scripps Research Institute (La Jolla, California).

Nuclear reprogramming through the ectopic expression of the four transcription factors selected by Yamanaka and colleagues allows therefore the generation of human pluripotent stem cells almost identical to human embryonic stem cells, without any harm done to human embryos. Furthermore, iPSCs compared to ESCs offer the great advantage of an unlimited supply, and of the possibility to get autologous iPSCs for transplantation because the somatic cells that are reprogrammed in iPSCs can be obtained from same the patient who will receive afterward the reprogrammed cells.

iPSCs represent therefore a very attractive cellular material, either for the needs of research, or in the perspective of regenerative medicine.

B – There are limits in the reprogramming for iPS

However, there are three obstacles that limit this reprogramming:
- the inefficiency of the processus;
- the use of retroviral vectors for getting a good transfection of the reprogramming factors in the nucleus of the somatic cell;
- the use of the transgenes c-myc and Klf4 which are proto-oncogenes and are found overexpressed in some human cancers.

The first weak point of reprogramming through ectopic transcription factors is its inefficiency. Indeed, less than 0.1% of the skin fibroblasts that Yamanaka had treated in this way demonstrated effective reprogramming. The efficiency of the processus has been even lower, around 0.01% in the various studies on iPSCS carried out afterward. It has been raised to 0.5% by the team of Whitehead Institute who used a selection of the reprogrammed cells by the Neomycin resistance gene inserted in the loci of Oct4 and Nanog. Various strategies have been proposed to increase the efficiency of the reprogramming. Most of these strategies are based on the overexpression of silencing of additional transcription factors that intervene in the reprogramming.

A second weak point of Yamanaka’s reprogramming method is the use of the c-myc transgene, given that this oncogene causes cancers in the host animals.
- R.Blelloch et al.(2007) showed that it was possible, in the Yamanaka protocol, to substitute the n-myc gene for the c-myc oncogene, without adversely affecting reprogramming efficiency.
- James Thomson and co-workers successfully used other reprogramming factors than those chosen by S.Yamanaka and colleagues, especially Nanog and Lin28.

A third criticism of the work of Yamanaka and colleagues concern the use of multiple retroviral vectors - one for every gene transferred - to reprogramme skin fibroblasts by pluripotency gene transfer. Indeed, since 1999 and the death of Jesse Gelsinger (Lehrman, 1999), these vectors have had a bad press, and the more recent finding of insertional mutagenesis leukaemias due to the retroviral vectors used in the Necker Hospital (Paris) to treat children suffering from severe immunodeficiency (SCID-X) with gene therapy, did nothing to improve this verdict (Hacein-Bey-Abina et al. 2003). It was therefore said that Yamanaka’s use of these multiple viral vectors would cause patients receiving iPS to run a disproportionate risk of insertional mutagenesis. Again, more

recent work has shown that this risk can be reduced, and moreover the efficiency of the gene transfer improved at the same time. Efficient reprogramming has been obtained for example by using other vectors than retrovirus, for example:
- adenoviral vectors (Stadtfeld, 2008),
- a single lentiviral, polycistronic vector (carrying four reprogramming genes) (Carey et al., 2009; Sommer et al., 2009),
- a non-viral polycistronic vector (plasmid)(Okita, 2008: Gonsalez 2009),
- a transposon (Woltjen et al., 2009),
- a vector carrying transgenes that was excised once the reprogramming had been done,
- a non-integrating episomal vector (plasmid whose presence depends on an antibiotic) (Yu, 2009).

However the efficiency of iPS cell generation when an adenoviral vector or a plasmid is used is very low.

Another way to avoid the viral vector being integrated into the genome with its risk of mutagenesis is to generate iPS by using small molecules that promote or facilitate cell reprogramming. Various groups have already identified such molecules which can replace one or two reprogramming factors during iPS cell generation (Huangfu et al., 2008 (Huangfu et al., 2008; Shi et al., 2008; Li et al., 2009; Lyssiotis et al., 2009).

C – Problems proper to iPS cells

Beyond these difficulties of reprogramming, the iPSCs technology suffers also of some specific problems:
- risk of generating tumors;
- heterogeneity in the iPSCs lines generated.
- epigenetic memory of the cell of origin;
- genetic and epigenetic abnormalities:
- chromosome abnormalities.

1) Risk of generating tumors

Because they are pluripotent cells, the iPSCs give tumors when injected into recipient animals. This happens the same with ES cells. The onset of differentiation in the iPSCs eliminate this risk. But all remaining pluripotent stem cell in the batch of differentiated iPSCs has to be eliminated. This can be realized through various technique of sorting. C.Tang et M.Drukker(2011) have developed a monoclonal antibody directed against residual pluripotential stem cells (anti-stage-specific-embryonic antigen)(SSEA)-5. J.F.Loring and colleagues (La Jolla, CA) have developed specific\ biomarkers of pluripotent stem cells, which allow to eliminate them from the batch of differentiated iPSCs.

However the elimination of remaining pluripotent stem cells from the batch of differentiated iPSCs prepared for clinical use may be not enough to avoid the formation of tumors by progenitor cells derived from iPSCs.

Lee MO et al. (2013) link the tendency of iPSCs and ESCs to form teratomas, to their sensibility to apoptotic stimuli . They proposed to target the antiapoptopic factors present in pluripotent stem cells by small molecules (like the inhibitors of Survivin), in order to eliminate the risk of the formation of teratomas in therapies based on the use of these pluripotent stem cells. They have indeed found that one unique treatment by the inhibitors of survivine – such as quercetin or YM15- of a mixed population of differentiated and undifferentiated cells derived from hESCs results in the complete elimination of the pluripotent undifferentiated cells from this population.

2) Heterogeneity in the reprogramming of iPSCs

A second limitation in the field of iPSCs is that the quality of reprogramming is not equal in all the somatic cells that are submitted in the same batch to the reprogramming factors. This results in an heterogeneity in the degree of reprogramming of the cells called iPSCs. Only some of these cells have properties comparable to those of ES cells and this explains the variability of the results published by the various authors in their evaluation of the properties of iPSCs. It is therefore necessary to purify the preparations of iPSCs before use or study, and to keep only the truly pluripotent stem cells. But such step of purification takes a long time, necessitating up to five hours depending on the detection system that is used.

Chen HF et al (Taiwan) have shown (2011)⁷⁶ that the surface markers EpCAM (epithelial cells

⁷⁶ Chen HF, Chuang CY, Lee WC, Huang HP, Wu HC, Ho HN, Chen YJ, Kuo HC, Surface marker epithelial cell adhesion
adhesion molecule) and E-cadherin (epithelaia cadherin), whose expression is activated only after the activation of endogene Nanog and Oct4, and which remain inactivated in the iPSCs incompletely reprogrammed allow to find out the only iPSCS that are fully reprogrammed. It would be possible therefore by that mean to select only the iPSCs that are fully reprogrammed, in function of the expression EpCAM in these cells.

3) The epigenetic memory of the somatic cell of origin
Doubts on the similitude of iPSCs and ESCs at the molecular level have raised when some differences in the global genetic expression profile of these cells were detected. The first doubt came when some authors found that iPSCs conserved an epigenetic « memory » of the type of cell from which they had come (Marchetto MC et al., 2009; Polo JM, 2010; K.Kim and G.Q Daley, 2010). The transcriptional and epigenetic profiles of these cells were found indeed different whether the iPSCs came from fibroblasts, hematopoietic cells, and myogenic cells. These differences diminished with the passing of time of these cells in culture, indicating that there was a possibility of self-correction of this particularity. This ‘transcriptional memory’ of the somatic cell of origin could be explained by an incomplete methylation of DNA in their genome. (Ohi Y et al., 2011) The genes that are not completely silenced would tend to be isolated from the other genes that are repressed during reprogramming.
It does not seem that this epigenetic memory has consequences on the functional and differentiation capacities of the iPSCs.
This epigenetic memory can be erased by repeating the reprogramming processus on the considered iPSCs, and by multiplying the cell culture passaging.

4) Genetic and epigenetic abnormalities in the iPSCs
Three studies published in 2011 in the same issue of « Nature » have reported the presence of genetic and epigenetic abnormalities in the cells during reprogramming and in the following cell culture.
Hussein SM et al (Toronto) have found variations in the number of copies in the ADN more important in iPSCS than in their cells of origin and than in the ESCs. These CNVs (copy number variations) coming from a de novo variation generated a genetic mosaicism in the first passing of iPS cells , but the expansion of human iPSCs operate a selection against these mutated cells, bringing back the cells in the group of normal iPSCs, which became always more identical to ES cells..
Lister R et al. (La Jolla, CA), studying the methylation profile of DNA in the iPSCS, have found that the iPSCs that they studied presented significant variations in the epigenetic reprogramming. A.Gore et al. (San Diego) have reported the presence of point mutations in the DNA of 22 iPS cells lines that they have studied. Half of them were already present in the fibroblasts from which came the iPSCs. This showed that iPSCs acquired genetic modifications during reprogramming. These results were considered with prudence by the scientific community, and were not supported by further publications.
In fact, MJ Guenther, R.Jaenisch et RA Young have reported (2010) that they had not find differences in the chromatin structure between iPSCS and ESCs (epigenetic ), and that they had not find either a consistent difference in the transcription programs between iPSCs and ESCs (genetic).
Kotton DN et al. (Boston University) (2011) have not found functional differences between iPSCs and ESCs. According to them, iPSCs have properties of differentiation identical to those of ESCs.

6) Chromosomal abnormalities
Mayshar Y and colleagues (Jerusalem) (2010) have studied the chromosomal integrity of various pluripotent cell lines, iPSCs and ESCs. They found chromosomal aberrations in 12 out of the 38 ES cells lines they studied, with six of these aberrations having consequences on genetic expression, and in 13 of the iPSCs lines out of the 66 studied (20%).
The chromosomal abnormalities observed in the iPSCs are also found in the ESCs. They cannot therefore be linked only with the reprogramming process. They are probably associated with the pluripotency.

D – First results

Human iPS cells not only present the same characteristics and the same biological and therapeutic potentialities as hES cells, but also offer advantages over the latter in that they are free of any ethical problem and solve some of the biological difficulties that militate against the clinical use of hES.

Less than one year after their initial report, the iPS cells were already used with success for different applications in which their substituted themselves to the ESCs because of their pluripotency, their availability, and the absence of ethical problems in their obtaining.

1) The constitution of cellular models of diseases

The first application today of iPSCs is in the constitution of cellular models of disease (“disease in a dish”). This is because they can prepared very easily and in large number from somatic cells of human donors, which is not the case for human ES, or for adult multipotent stem cells.

The main application of iPS up to now has therefore been in the creation of cellular « models » of various pathologies for in vitro studies. This development is precious for the pharmaceutical industry which needs such models for assessing new medicaments and, individualizing molecules that could have a specific therapeutic effect. It is also precious for the study of the etiologic and pathogenic factors that enter in the onset and development of diseases. Soon after the discovery of the iPSCs, four team had already produced iPSCs from patients with neurodegenerative diseases – amyotrophic lateral sclerosis (Dimos et al., 2008) spinal muscular atrophy (SMA)(Ebert et al., 2009) , and Parkinson’s disease (Soldner et al., 2009) Then iPSCs from patients with mendelian genetic diseases or complex genetic diseases were created (Park et al., 2008)...

iPSCS derived from somatic cells of patients have thus been used to constitute cellular models of many different pathologies:
- genetic pathologies: Prader-Willy syndrome (Stelzer Y et al., 2014), Fanconi anemia (Liu Gh et al., 2014), Hemophilia A, ? Thalassemia, mitochondrial myocardiopathy of the Barth syndrome (Wang G et al., 2014), Gaucher disease (Panicker LM et al., 2014), Fragile X syndrome (Sheridan SD et al., 2011),
- chromosomal pathologies: trisomy 21 (Pipino C et al., 2014)

The cardiomyocytes obtained by differentiation of human iPSCs have been used to constitute cellular models of cardiac diseases, genetic and non genetic: long QT syndrome. (Itzhaki I et al., 2011), LEOPARD syndrome (hypertrophic cardiomyopathy)(Carvajal-Vergara X et al.,2010), cellular model for arrhythmias , cellular models for cardiac sodium channel diseases.

2) Obtaining differentiated cells

The second main application of iPSCs today comes from their pluripotency and their abundant capacity of proliferating in vitro.

Human iPSCs being pluripotent stem cells of the « primed » model, like human ESCs, and having the capacity of differentiating in all types of cells of the organism, except the cells of trophoblastic origin, that is the amniotic and placental cells, they are used as an unlimited and abundant source of progenitors of differentiated cells.

One of the main goal of reprogramming somatic cells in pluripotent stem cells is indeed to get the capacity of generating in vitro from these pluripotent stem cells, in an abundant, easy and consistent way, these progenitor cells or differentiated cells that would be otherwise difficult to obtain, and which are needed in reconstructive or substitutive medicine, for the repair of specific tissues and organs, or for the need of bioengineering.

The types of cells which are more requested from differentiating iPSCs are neurons, cardiomyocytes, hematopoietic cells, insulin producing cells, hepatic cells.

Thus, it has been shown in the immediate following of the discovery of iPSCs that mice and human iPSCs can provide, with efficiency comparable to that of human ESCs, functional human neurons, electrically active (S.Karumbayaram et al., Los Angeles, 2009), that can be:
- glutamatergic neurons (Zeng H et al., 2010),
- mesencephalic motoneurons that produce dopamine, (Soldner F et al., 2009
- spinal motoneurons (Chambers S.M. et al., 2009)
- cerebellar neurons (Erceg S et al, 2012)
- spiny neurons of the striatum (Carri AD et al., 2013,
- astrocytes (Juopperi TA, 2012),
- oligodendrocytes (Ogawas S et al., 2011)
- astroglial cells (Krencik R et al., 2011).
- Schwann cells (Ziegler L et al., 2011).

Aside from these neurons, iPSCs have been differentiated in cardiomyocytes (Zhang J. et al., 2009), hematopoietic cells and endothelial cells (K-D.Choi et al., 2009), hepatocytes (Song Z et al., 2009), dendritic cells and macrophages (Senju S. et al., 2009), adipose cells (Taura D. et al., 2009), vascular cells (Taura D. et al., 2009).

3) Use in bioengineering, for the creation of replacement tissues or organs

4) Regenerative medicine
The iPSCs have not been used in patients up to now because of the in certitudes on their possible oncogenic property. But the studies done in animals show that they would have efficiency similar at that of hESCs in regenerative medicine, because of their capacity of unlimited proliferation, and their pluripotency which allow to differentiate from them all the types of cells present in the organism. Great expectances are associated with a future therapeutic utilization of iPSCs in regenerative medicine.

Cardiomyocytes obtained from the differentiation of human iPSCs are able to repair the infarcted heart. Nelson T.J. et al., (Mayo Clinic, Rochester, 2009) have shown that iPSCs derived from mice fibroblasts and injected into the myocardium of a mice, can repair this myocardium when infarcted, through their graft in the myocardium and their multiplication there, and this without the induction of teratomas in the animal. The transplanted iPSCs restore the contractile performances of the heart, the thickness of the ventricular wall, and the electrical stability of the heart. They bring the in situ regeneration of the cardiac muscle and of the associated endothelial tissue.

Neural stem cells obtained from the differentiation of human iPSCs can integrate the brain and correct the alterations brought by neuro degenerative diseases.

- Wernig M and colleagues were the first to demonstrate these possibilities. In 2008 they showed that neural cells obtained from the differentiation of iPSCs when transplanted into the brain of a rat made hemiparkinsonian by treatment with 6-hydroxy dopamine (6-OH-DA), integrated well in the striatum of the animal and improved its movements.
- Hargus G et al. (2010) have reported in 2010 the correction by dopaminergic neurons obtained from iPSCs of Parkinson’s disease abnormal locomotion in rats made parkinsonian with 6 hydroxydopamine.

One of the great opportunity offered by iPSCs is that they can be combined with genetic engineering or gene therapy to correct efficiently genetic diseases.

- Zou J et al. (John Hopkins School of Medicine) (2009) have corrected by gene targeting in iPSCs patient specific the pathology of paroxysmal nocturnal hemoglobinuria.
- J.Hanna and collaborators (2007) have shown that iPS cells obtained from an animal model of sickle cell disease can be corrected in vitro of the genetic disease, then transplanted into the animal and there reconstitute its hematopoietic system...
- A.Raya et al. (Barcelona, 2009) have generated iPSCs from somatic cells, taken from patients with Fanconi anemia, and they have corrected in these iPSCs the genetic defect responsible for the disease, using a lentiviral vector coding for FANCA or FANCD2. Such iPSCs, obtained from somatic cells of the patient, and corrected genetically, would be very useful for an efficient treatment of the disease.
- Li LB et al. (University of Seattle) have generated iPSCs from trisomy 21 patients and have been able to correct in these cells the functional abnormalities linked with trisomy 21 through the targeted removal of the entire supplementary chromosome.

A similar correction of trisomy 21 at the cellular level in iPSCs derived from fibroblasts of trisomic patients has been done by Hibaoouy Y et al. (Geneva University, 2014) through the targeting of dual-specificity tyrosine-(Y)-phosphorylation regulated kinase 1A (DYRK1A) on chromosome 21.

5) The constitution of iPSCs banks
The hiPSCs have been welcomed with great interest by medical doctors because they resolved the problems of immunological rejection which limits the use of ESCs. They could indeed be developed from somatic cells belonging to a patient, and, once multiplicated and eventually
genetically corrected; they would be administered as autologous cells, to the same patient. But this perspective of patient-specific stem cells would be limited. Such a « personalized » form of would very expensive, because of the cost of a the preparation of these « patient–specific stem cells » and because of the many controls for security that it would imply. Moreover, the time requested for the production of autologous iPSCs would make impossible the use of such autologous cells for treating acute affections such as myocardial infarction, or spinal cord injuries. It will be therefore probable that, for a usual clinical use of iPSCs , it will be necessary to use donor iPSCs, HLA compatible, coming from a bank. It is in that perspective that different projects for the constitution of iPSCs bank are studied (CIRM, California) or are already initiated (Yamanaka, Japan) (Kim Dong Uk, Korea.

E – Ethical perspective on iPS
From the ethical standpoint, the development of iPSC offers a valuable alternative method to the collection of hES through the harvest of the inner cell mass of human blastocysts. In effect, it enables stem cells to be obtained that are of comparable quality to hES in terms of stability, in vitro proliferation in the undifferentiated condition, differentiation into all types of tissue, without the ethical barrier of embryonic destruction that paralyses research on ES cells and their clinical use. iPSC cells thus solve the ethical dilemma that began in 1998 with the demonstration by James Thomson that it was possible to culture hES cells. The way they are obtained does not pose any ethical problem, they do not involve the destruction of any embryo, and their production fully respects the dignity of the person who supplied the initial somatic cells. Although the iPS technology eliminates certain ethical questions proper to hES cell research, it raises new questions, and possibly new challenges.

These questions are no more related to the way the cells are obtained, but to their possible future use in patients.

1) The question of the moral status of iPSC cells
Some authors (Sagan A, Singer P, 2007) (Magill G, Neaves WB, 2009) who deny a particular moral status to human embryos have taken advantage of the properties of iPSCs to give an embryo through tetraploid complementation for arguing that iPSCs should be given the same moral status as human embryos. As it seems absurd to grant a dignity to pluripotent undifferentiated cells derived from ordinary somatic cells, these authors inferred that it is also absurds to grant a dignity to human embryos when these human embryos can be obtained from these pluripotent stem cells. The argument is perfectly specious, but has been taken seriously by some moralists (Denker, 2009) who have started to condemn the development of iPSCs because of the potential that have these cells of giving a human embryo. But this proposal is absurd because neither the iPSCs nor the ESCs can generate spontaneously, through their own development, a human embryo. This could be only achieved by a blastomere extracted from a human embryo, and even there, the embryo that may be obtained is not able to implant. There is therefore no reason to speak about iPSCs of their “potential” to develop into a living human being.

2) The possibility offered by iPSCs to realize reproductive human cloning
Because mice iPSCS can develop into an embryo when combined with a tetraploid embryo (embryo obtained by fusion of two blastomeres, in which each chromosome is repeated four fold) and because the mice obtained that way from mouse iPSCs are genetically identical to the iPSC cells that have been injected in the tetraploid embryo for inducing its development, iPSCs could be theoretically used for reproductive cloning. This raise the question whether or not this new technique of iPSCs could not constitute a new way for reaching the goal of reproductive human cloning. (Denker HW, 2009). In theory indeed, the injection of hiPSCs in a human blastocyst made tetraploid could lead to the development of this embryo and the birth of a child who would be a clone of the somatic cell from which was derived the iPSCs used in tetraploid complementation. Up to now however, tetraploid complementation with iPSCs cells has only been performed in mice.

3) Production of gametes from iPSCs
This possibility of getting gametes of both sex from iPSC cells is real because iPSC can differentiate in vitro in all the types of cells present in the organism, comprising the germ cells. These gametes in turn could enter into a fertilization process, leading to the birth of a child. This child would be considered as the biological son (or the daughter) of the person who gave the somatic cell from
which was derived the iPS, source of the gamete. It could be that way possible to give a son/daughter to an infertile person or to a person of the same sex than the one who gave the other, natural gamete for fertilization. Theoretically the iPSCs technology could therefore be used to provide gametes for a fertilization with only one parent (giver of male and female gamete through the iPSCs obtained from his/her cells) or a fertilization in an homosexual couple.

As soon as the possibility of deriving hES cell lines from human blastocysts was demonstrated by J.A.Thomson in 1998, researchers began to try to differentiate hES cells into gametes. The advent of iPSCs has brought a new opportunity in that field of getting gametes from pluripotent stem cells. Indeed, the iPSCs offer the advantage over the ESCs that they can be obtained from somatic cells obtained from a specific person. If it became possible to get normal, functional gametes from the differentiation of iPSCs, then it would be possible to obtain gametes of opposite sex from the same person (opening a way to cloning) or to obtain male gametes from a woman and female gamete from a man.

The possibility of obtaining post meiotic haploid cells of both genetic sex from hiPSCs of various origins (keratinocytes, blood) has been clearly shown by C.Eguizabal et al. (Barcelona, 2011). And then Mitinori Saitou et al. (Kyoto university) (2011) have obtained from hESCs as well as from hiPSCS the generation of cells of the type of primordial germ cells (PGCLCs), with a robust capacity for spermatogenesis. Thus it appears that the obtaining through differentiation of hiPSCs of functional gametes of both sexes ready for fertilization has become possible in a very near future.

This possibility of using iPSCs to produce functional gametes of both sexes raises serious ethical questions. It represents, with the possibility of reproductive cloning, the more questionable potential use of the iPSCs technology. It could give the most artificial of all the techniques that have been developed for helping procreation. It will not be even a question of substitution but of fertilization with artificial gametes without any link to the sexuality of the “biological parents”. This technique would deny entirely the right of the child to be born from his parents or to know his parents (in case of an heterologous fertilization). Moreover, as the somatic cells designated to be reprogrammed in iPSCs could be obtained surreptitiously from a person, without her knowledge, it would be that way possible to a single person to get a child from somebody without that person knowing it.

Conclusion

The development of induced pluripotent cells, or iPS, obtained by somatic cell dedifferentiation, constitutes a considerable progress, not only in stem cell studies, but for cell biology in general. iPSCs offer a clear, simple and effective alternative to embryonic stem cells. Today they are as promising as embryonic stem cells in terms of in vitro self-reproduction-expansion capability and their clinical and ethical advantages cannot be ignored.

The arrival of iPSCs has clearly changed the normative and ethical perspective on stem cells research dominated until recently by the question of whether or not preimplantation embryos are respected. Stem cells ethics must now confront an increasingly active field of research, at a time of great interest in perfecting iPS technology, but also at a time of renewed interest in hES cell research, to the extent that these cells serve as a sort of benchmark, mirror, and counterpart to iPSCs.

The ethical reflex ion on pluripotent stem cells has to go now beyond the question of the source of stem cells to define more precisely the conditions of a clinical use of these cells. Clinical trial of iPSCs has already started in Japan. Masayo Takahashi M.D., Ph.D., of the Laboratory for Retinal Regeneration, RIKEN Center for Developmental Biology, is conducting a trial of retinal cells derived from iPSCs for Age-related macular degeneration (AMD), the most common cause of visual impairment in the elderly. Trial of neuronal stem cells derived from iPSCs for spinal cord injuries will probably follow. These pluripotent stem cells and the differentiated cells obtained from iPSCs carry with them without any doubt great hopes for the development of an effective regenerative medicine. It should be immoral to deprive patients of this therapeutic mean by an undue excess of precaution and red tape. But there is a need for regulations in the use of iPSCs, regarding in particular the possible obtaining of gametes from iPSCs.

The advent of iPSC technology has changed the field of stem cell research for the better. Great hopes lay on these cells. But we should not fall in an over optimistic expectation from these cells. There is still a need to improve them. But what should be clear for us is that the advent of iPSCs has
removed its last justifications to human embryonic stem cell research. The technical, biological and ethical progress represented by the development of the cell reprogramming method does not eliminate the use of somatic (adult) stem cells and umbilical cord blood cells. In therapeutics, the individuation of stem cells capable of prolonged self-renewal and pluripotency that are derived from already individuated stem cells in umbilical cord blood and in various tissues of the adult organism is now well established, and has produced positive results in the clinical field. Moreover adult and umbilical stem cells are safer and less problematic than the iPSCs. They are still needed.

Ethical Issues in Stem Cell and Gene Therapy
Fr. Stephen Fernandes (Mumbai, India)

Slides

2. Introduction
- In this paper a comprehensive meaning of the terms cloning, stem cell research and gene therapy will first be presented.
- The ethical consequences and the Church’s response to these technologies are then analyzed.
- A short conclusion follows by way of a moral and pastoral reflection.

3. Introduction to Cloning
- Cloning is a broad term that refers to the production of a precise genetic copy of any molecule (including the DNA molecule), cell, tissue, plant or animal.

4. Cloning
- In popular terminology, cloning refers to the production of an identical human being through a process technically called "somatic cell nuclear transfer".

5-7. Somatic Cell Nuclear Transfer:
- Step one: Take a donated unfertilized egg (or sex cell) of a female of the species from any fertility clinic and removing its nucleus (i.e., the enucleation of the DNA or genetic material). (DNA is taken from an unfertilized egg).
- Step two: In a petri dish, put the dormant DNA nucleus of a somatic cell (a body cell and not a sex cell) from the same species or from another of the species (male or female).
- Step three: Then, by electric shock, the dormant DNA is (parthenogenetically) reactivated, and so begins to multiply like a fertilized egg, and then divide to form early embryos.

8. Cloning
- No male participation is necessary, and the reproduction process is or can be parthenogenic.
- The result will be an exact genetic and biological replica of the one who gave the DNA.
- Thus, cloning is a form of artificial reproduction which is achieved without the contribution of the two gametes. There are 3 types of cloning. They are:

9. How cloning might be used therapeutically
- Anucleate unfertilized egg from donor + Adult cell from patient —> Nucleus transfer

10. Reproductive Human Cloning
- It is an asexual method of reproduction meant to produce individuals that are biologically (somatically) identical to the adult which provided the nuclear genetic inheritance. This type of cloning can be either
Embryo Cloning or adult DNA cloning.

11. **Human Embryo Cloning**:
- It involves the removing of one or more cells from an embryo and encouraging the cell to develop into a separate embryo with the same DNA as the original.

12. **Human embryo cloning starts with a standard in vitro fertilization procedure**
- Sperm and an egg cell are mixed together on a glass dish.
- After conception, the zygote (fertilized egg) is allowed to develop into a blastula (a hollow mass of cells).
- The zygote divides first into two cells, then four, then eight... A chemical is added to the dish to remove the "zona pellucida" covering.

13. **Cell Division**
- This material provides nutrients to the cells to promote cell division.
- With the covering removed, the blastula is divided into individual cells which are deposited on individual dishes.
- They are then coated with an artificial zona pellucida and allowed to divide and develop.

14. **In Vitro Fertilization**
- In conventional in vitro fertilization, doctors attempt to start with many ova, fertilize each with sperm and implant some of them in the woman's womb in the hope that one will result in pregnancy.
- But some women can only supply a single egg; her chances of becoming pregnant are slim.

15. **Nature itself is the greatest cloning agent**
- In about one of every 75 human conceptions, the fertilized ovum splits for some unknown reason and produces monozygotic (identical) twins.
- Each has a genetic makeup identical to the other. In cloning, this same operation is done intentionally in a laboratory.

16. **Adult DNA Cloning**

17. **Adult DNA Cloning (cell nuclear replacement)**:
- With the exception of the sperm and egg, every cell in the body contains all of the genetic material in its DNA to theoretically create an exact clone of the original body.
- But cells have been "biochemically programmed to perform limited functions." The other functions are
turned off.

• In the past, scientists had believed that such differentiated cells could not be reprogrammed to be capable of behaving as a fertilized egg.

18. In the case of the sheep "Dolly" (described below)
• A cell was taken from the mammary tissue of a mature 6 year old sheep while its DNA was in a dormant state.
• It was fused with a sheep ovum which had had its nucleus removed.
• It is noteworthy that no semen from a ram was involved.
• The "fertilized" cell was then stimulated with an electric pulse.

19. Dolly
• Out of 277 attempts at cell fusion, only 29 began to divide.
• These were all implanted in ewes. Eight became pregnant but only one lamb, Dolly, was born.

20-21. Cloning of Dolly
22. A Heterosexual Couple
- A heterosexual couple in which the husband was completely sterile can use adult DNA cloning to produce a child.
- An ovum from the woman would be coupled with a cell from the man's body.
- Both would contribute to the child: the woman would provide the "home" for creating cells; the man would provide the "genetic information". Cloning using the DNA from the cell of an adult with the desired traits or talents might produce an infant with similar potential.

23. Two Lesbians
- Two lesbians could choose to have a child by adult DNA cloning rather than by artificial insemination by a man's sperm.
- Each would then contribute part of her body to the fertilized ovum: one woman would donate the ovum, which contains some genetic material in its mitochondria; the other woman the nuclear genetic material.
- Both would have parts of their bodies involved in the conception.

24-25. Therapeutic Cloning:
- Therapeutic cloning would involve making an embryo that is a clone of a person, extracting its stem cells, and then using them to create tissue or a complete organ.
- The latter would then be transplanted into the patient. Since the tissue or organ contains the person's DNA, there would be no possibility of rejection.
- This starts with the same procedure as is used in adult DNA cloning. The resultant embryo would be allowed to grow for about 14 days in a woman’s uterus.
- Its stem cells would then be extracted and encouraged to grow into a human organ for transplant. Stem cells would be removed from the embryo. (This is a destructive step; the embryo would be killed in the process).

26. Stem Cells
- The stem cells would be encouraged to grow into whatever tissue or organ is needed to treat the patient.
- Stem cells are a unique form of human cell that can theoretically develop into many organs or body parts.
- The tissue or organ would be transplanted into the patient.
- Thus, the end result would not be a human being; it would be a replacement organ, or piece of nerve tissue, quantity of skin.

27. Therapeutic Human Cloning
28. Adult Therapeutic Cloning: How it takes place:

29. Therapeutic Vs. Reproductive Cloning

30. What are stem cells
   • Stem Cell Research bears some points of similarity with cloning.
   • They both start with an ovum and initially use some of the same techniques.
   • The eventual goal of human cloning is to create a twin human.
   • The eventual goal of stem cell research is to create a replacement organ or part of an organ

31. Stem cells: Understanding stem cells (Illustration by Cell Imagine Core of the Center for Reproductive Sciences)

32. Embryonic Stem Cells harvested
33. What are stem cells
• However, in both cases, scientists use living human beings as mere research materials.
• The political and moral implications of destroying embryonic human life are not considered by a section of the scientific community who see only the promise of medical and scientific progress.
• Human morality thus becomes subjected to technology.

34. Promise to develop cures
• Stem cell research shows promise to develop cures and new treatments for people who are suffering from a wide variety of diseases and disorders.
• Due to a shortage of organ and tissue donor in most countries, human embryonic stem (hES) cells are sought after by researchers for both scientific and therapeutic purposes.

35. A Stem Cell is Uncommitted
• Most cells of the body such as brain cells or heart cells are committed to conduct a specific function.
• A stem cell is uncommitted and remains so till it receives a signal to develop into a specialized cell.
• Stem cells are nature’s blank cells that have the potential of developing into any of the more than 260 cell types that make up the human body.

36. Harvesting + Coaxing the Cells
• Scientists are trying to harvest the cells before they have differentiated, and then coax them into becoming certain types of cells such as nerve cells, heart cells, or kidney cells.

37. Harvesting Embryonic Stem Cells
• When a sperm fertilizes with an egg, a single cell is created which has the potential to form an entire human being.
• This fertilized egg is totipotent and implies that its potential is total.
• Twenty-four hours after fertilization, the fertilized egg cell divides into identical totipotent cells.
• This means that if any one of these cells is placed in the uterus of a woman, it has the potential to develop into a fetus).

38. Human Embryonic Stem Cells
• They are called hES cells because they are derived from the inner cell mass (ICM) of a six to seven day human blastocyst, that is, the early stage of the developing embryo.
• In the process of extracting the hES cells, the human blastocyst is destroyed.
• The result is that no further embryonic development is possible.

39. Totipotency
• Totipotency is the capacity of a zygote or other cell to develop as a complete, integrated, living being.
• A naturally conceived zygote - a single-celled embryo brought into being by fertilization - is totipotent. Embryonic stem cells are pluripotent, that is, they cannot form a zygote and much less a fetus.

40. 4 to 7 days after fertilization
• 4 to 7 days after fertilization, the embryo develops into a tiny multi-colored ball called a blastocyst.
• The cells of this developing embryo begin to specialize and carry out different functions.
• In this process of specialization, some cells move to form an outer layer of cells called the trophoblast layer (which mediates implantation); some cells move to form a cluster of cells, called the inner cell mass (ICM) or embryoblast

41. Outer Layer of Cells
• This outer layer of cells go on to form the placenta and other tissues needed for fetal development

42. The ICM cells are pluripotent
• Pluripotency is the capacity of a cell to give rise to many if not all the different cell types of the human body.
• They are pluripotent because they can give rise to many types of cells of the body.
• However, the ICM cells cannot form the fetus because they are unable to generate the placenta and supporting tissues which are necessary for development in the uterus.

43. Because the potential of the ICM cells are not total, they are not embryos
• The ICM which are removed from the blastocyst are placed in a culture dish in a laboratory where scientists can obtain the hES cells.
• Researchers would like to induce these pluripotent hES cells to form blood, muscle, neural, cardiac and other body tissues cells in regenerative medicine. For example, neural stem cells are found in nerve tissues.
• These pluripotent cells could become many of the 260 types of cells in the human body.
44. Stem cells are a type of primitive cell
• They are the units of embryogenesis and persist throughout the life of an individual.
• They are found in embryos, in babies, in children and in adults.
• For example, the blood or hematopoietic stem cells reside in the bone marrow of every child and adult and can even be found in small numbers in the rest of the body.
• A human person cannot live without the hematopoietic stem cells.

45. Altered Nuclear Transfer (ANT)
• The whole idea of Altered Nuclear Transfer (ANT) is to produce pluripotent stem cells without creating an embryo.
• In ANT, the adult somatic cell nucleus or the egg cytoplasm (or both) are altered before the nucleus is transferred into the enucleated egg.
• This would allow the construction of cellular structures that could produce pluripotent stem cells, but not embryos.

46. Growth without Life:
In altered nuclear transfer, targeted alterations to the somatic cell nucleus (or to the egg cytoplasm) preclude the integrated organization and potential for development of an embryo.

47. Embryonic stem cell research
• Embryonic stem cell research has caused much ethical controversy, and it has provoked a variety of legislative responses in many countries.
• Many hold that there is something unethical about embryonic stem cell research, but seem to be tempted with the bouquet of benefits it brings.

48. Concrete benefits for children resulting from pluripotent stem cell research with human embryos.
• For example, treatments for spinal cord and bone injuries, diabetes, primary or acquired immunodeficiencies, cancer, metabolic and genetic disorders, and a variety of birth defects.
• The stem cells of the embryos are extracted for use in research.
• Tissue from the brain of an aborted human embryo of about 9 to 12 weeks has used in the treatment of Parkinson.

49-50. Embryonic Stem Cells
• Many illnesses result from cellular disruption or destruction of the body’s tissues.
• The ability of embryonic stem cells to become any cell in the body, gives it great potential for therapies that could help the eradication of humanity’s most devastating diseases.
• Embryonic stem cells have the ability to proliferate in vitro without differentiation.
• This lack of differentiation means that in the course of the embryonic stem cell development, the cells can be integrated into specific types of diseased tissues.
• Thus, embryonic stem cells could become heart cells and join themselves to strengthen weakened hearts or become brain cells that alleviate Alzheimer’s disease.

51. Benefits of embryonic stem cells
• Help to diabetic patients
• Help to heart patients
• Cancer research
• Prevention of blindness

52. Help to diabetic patients
• In people who suffer from Type I diabetics, the production of insulin by specialized pancreatic cells, called islet cells is disrupted.
• Transplantation of either the entire pancreas or isolated islet cells could reduce or do away with the need for insulin injections.
• Islet cell lines derived from human pluripotent stem cells could be used for transplantation.

53. Help to heart patients
• Transplant of healthy heart muscle cells could provide new hope for patients with chronic heart disease whose hearts cannot pump adequately.
• The hope is to develop heart muscle cells from human pluripotent stem cells and transplant them into the failing heart muscle in order to augment the function of the failing heart.

54. Cancer Research
• Cancer research is possibly the most important reason for embryo cloning.
• Oncologists believe that embryonic study will advance understanding of the rapid cell growth of cancer.
• Cancer cells develop at approximately the same phenomenal speed as embryonic cells do.
• By studying the embryonic cell growth, scientists may be able to determine how to stop it, and also stop cancer growth in turn

55. Prevention of blindness
• When a part of the human eye called limbus, which generates the ocular surface of the cornea, is damaged, it causes blindness.
• The normal treatment of this is to transplant the limbal tissue. But at the Hyderabad eye institute, doctors take 1-2 mm of limbal tissue from the healthy eye of the patient, culture them on an appropriate surface and graft it on the diseased eye.
• Such limbal cell treatment is available in India, the US, and Taiwan.

56. A rare inherited disorder of the mitochondria
• In the treatment of sufferers from a rare inherited disorder of the mitochondria - the "power-plant" of the cell - which surround the nuclei of cells.
• This problem can cause blindness and epilepsy.
• By removing the nucleus - minus the defective mitochondria - from an embryo created by in-vitro fertilisation in the normal way and placing it in a donated egg stripped of its own nucleus, a cloned baby could be created that would be the genetic offspring of its parents, but without the disorder.

57. Bouquet of benefits

58-60. Adult Stem Cell research:
• The enormous promise of stem cells is not exclusively confined to embryonic stem cells, but is present as well in adult stem cells that do not suffer the problem of immune rejection.
• Adult stem cells (ASC) have far greater therapeutic potential than previously thought.
• They are able to cross over from one fundamental cell layer type (Endoderm, mesoderm, ectoderm) to another.
• Adult stem cells now appear to have the capacity to become cells of other types.
• Given the moral problem associated with the destruction of human embryos in the case of embryonic stem cell research, the more utility there is to be gleaned from adult stem cells, the less these concerns about embryonic stem cells will matter.
• Great progress has been made in the experimental field in analyzing the genetic programme at work in stem cells which, when implanted are also able to restore specific functions to damaged tissue.
• Adult stem cells also offer effective treatment of many pathologies.

61-63. Ethical issues connected with the scientific and therapeutic use of human embryonic stem cells

1) Use of ANT and ANT-OAR
• Can research establish beyond a reasonable doubt that oocyte assisted reprogramming can reliably be used to produce pluripotent stem cells without creating embryos?
• The ethical objections raised in many quarters to therapeutic cloning and to the use of human embryos formed in vitro have led some researchers to propose new techniques which are presented as capable of producing stem cells of an embryonic type without implying the destruction of true human embryos.
• These proposals have been met with questions of both a scientific and an ethical nature regarding above all the ontological status of the embryo obtained in this way.
• These doubts have to be clarified The statement of the Encyclical Evangelium Vitae needs to be kept in mind:

64. Evangelium Vitae
• “what is at stake is so important that, from the standpoint of moral obligation, the mere probability that a human person is involved would suffice to justify an absolutely clear prohibition of any intervention aimed at killing a human embryo”

65-67. Stem Cells and Embryo Destruction
• Embryonic stem cells are obtained from the inner cell mass (the embryoblast), and thus are the actual cells of the developing human being.
• One can only obtain these cells by destroying a human embryo at the blastocyst stage and taking them out.
• Inner cell mass cells continue to proliferate indefinitely in culture
  Dissociate  —> Subculture  —> Freeze (liquid nitrogen)  —> Thaw  —> Pluripotent stem cells
• Unfortunately, for many researchers, it is possible to destroy human embryos in an ethical manner because the benefits obtained by that destruction outweigh any inherent value that belongs to the human embryo.
• The reasoning is utilitarian in character and makes no reference to the inherent dignity of human life.
• They fail to realize that the destruction of a human embryo for research constitutes one of the most serious abuses of science.
68. Using Therapeutic Cloning for Producing Embryo Stem Cells
• Question: Is it morally justifiable to engage in therapeutic cloning by producing cloned human embryos and then destroying them in order to produce embryo stem cells?
• Answer: It is illicit because human embryos are destroyed.

69-71. The production and/or use of human embryos for preparing embryo stem cells
• First, a living human embryo from the moment of the union of the gametes is a human subject with a well-defined identity having continuous and gradual development. Hence at no stage can it be considered a simple mass of cells.
• Second, as a human individual, the embryo has the right to its own life.
• Third, the removal of the inner cell mass of the blastocyst, which irretrievably damages the human embryo is a gravely immoral act.
• Fourth, no end believed to be good such as the use of stem cells for therapeutic procedures can justify an intervention of this kind. —> A good end does not make right an act which is wrong in itself.
• Finally, the position of the Church is clearly expounded in both Evangelium Vitae, Donum Vitae and Instruction Dignitatis Personae.

72-75. Can a mother’s right over her offspring be forfeited?
• Parenthood is a sacred trust which depends for its legitimacy on the maxim that all "parental decisions are governed by an overriding concern for the health and well-being of the child".
• According to Bopp and Burtchaell, when a pregnant woman resolves to destroy her offspring, she has abdicated her office and duty as the guardian of her offspring, and thereby forfeits her tutelary powers.
• A woman who aborts her child severs her relationship with the child, as mother or even guardian. She has made her decision not to be a ‘mother’, by not allowing the child to be born, sustained, nurtured or protected.
• She does not also allow others from providing that care to the child.

76. The Question of complicity: e.g. The Nuremberg War Crimes Trial of 1946

77. The Question of Complicity: Re: Use of fetal tissues
• Complicity of doctors in death of the camp prisoners were established.
• The Nuremberg trial makes the point that one need not cause a wrongful act to be a party to it; it is enough to have in some way it cooperated with it.

78-79. The Question of Complicity
• The researcher (doctor) involved in this type of complicity is not actually joining in the work itself but somehow enters into a supportive alliance.
• The researcher becomes an associate by resorting to the abortionist as a ready supplier of tissue from unborn humans who have been intentionally destroyed 78
• By befitting in the abortionists injurious behaviour, the researcher places himself/herself in silent but unmistakable alliance with what the abortionist is doing.
• In the first fetal transplant Dr. Freed reassembled fetal remains to be sure that abortions were complete. Such actions represent a clear participation in and agreement with the abortion procedure

80-81. Is the use of fetal tissue for transplantation in humans morally justified?
• Fetal tissue research which uses tissue from live fetuses is ruled out by Donum Vitae because of the risk it imposes on the fetus.
• Donum Vitae does allow for experimental research or medical use of human embryo and fetal remains.
• They are to be treated with the same respect as other human remains, and so can be used only under certain conditions

82-83. Conditions for use of fetal remains. These conditions are:
• 1) death must be verified;
• 2) parental consent must be obtained;
• 3) there must be no complicity in deliberate abortion;
• 4) the risk of scandal must be avoided; and
• 5) there must be no commercial trafficking in dead fetuses
• Thus, Donum Vitae permits fetal tissue transplantation if the tissue is acquired from the remains of spontaneous abortions and ectopic pregnancies under the above mentioned conditions, and if the conditions found in the encyclical for the use of the remains of human embryos and fetuses are fulfilled
Currently available methods to generate pluripotent stem cells from adult somatic or germ cells

**Use of Adult Stem Cells:**
- The Pontifical Academy for Life has affirmed the use of adult stem cells to attain the same goals which would be sought with embryonic stem cells.
- Adult stem cells represent a more reasonable and human method for making correct and sound progress in the field of therapeutic research which gives great hope for a significant number of suffering people.

**Adult Stem Cells**
- In the methods of obtaining stem cells, the origin of the stem cells must be taken into consideration.
- Methods which do not cause serious harm to the subject from whom the stem cells are taken are to be considered licit.

**Adult Vs. Embryo Stem Cells**
- When tissues are taken from: a) an adult organism; b) the blood of the umbilical cord at the time of birth; c) fetuses who have died of natural causes.
- The obtaining of stem cells from a living human embryo, on the other hand, invariably causes the death of the embryo and is consequently gravely illicit: “research, in such cases, irrespective of efficacious therapeutic results, is not truly at the service of humanity”.

**Gene therapy**
- Gene therapy is the intentional alteration of genes in cells or tissues in such a way as to treat or prevent an inherited disorder, or to make another pathological condition more amenable to treatment.

**Somatic cell gene therapy**
- It is called somatic cell gene therapy if the alteration affects only individual cells of an individual on whom it is carried out.
- Somatic cell gene therapy seeks to eliminate or reduce the genetic defects on the level of the somatic cells that make up the tissue and organs of the body.

**Germ line gene therapy**
- It is called germ line gene therapy if the intervention takes place on the germ line cells – that is, sperm, ova or their precursors, and will affect not only the particular individual but also his or her descendants.
- The goal of the gene therapy is to treat human disease by correcting the genetic defects present in the germ line cells or by adding new genes to the patient in order to provide or enhance a therapeutic option.

**Genetic enhancement**
- In addition to these forms of gene therapy, there exists also the possibility of genetic enhancement, i.e. efforts to improve or enhance, by genetic engineering, characteristics such as size, skin, colour, intelligence, etc.
The Morality of Germ-Line Therapy:
• The moral evaluation of germ line cell therapy is different. Whatever genetic modifications are effected on the germ cells of a person will be transmitted to any potential offspring.
• Because the risks connected to any genetic manipulation are considerable and as yet not fully controllable, in the present state of research, it is not morally permissible to act in a way that may cause possible harm to the resulting progeny.
• In the hypothesis of gene therapy on the embryo, it needs to be added that this only takes place in the context of in vitro fertilization and thus runs up against all the ethical objections to such procedures.
• For these reasons, therefore, it must be stated that, in its current state, germ line cell therapy in all its forms is morally illicit.

The Morality of Genetic Enhancement:
• Some have imagined the possibility of using techniques of genetic engineering to introduce alterations with the presumed aim of improving and strengthening the gene pool.
• Some of these proposals exhibit a certain dissatisfaction or even rejection of the value of the human being as a finite creature and person.
• Apart from technical difficulties and the real and potential risks involved, such manipulation would promote a eugenic mentality and would lead to indirect social stigma with regard to people who lack certain qualities, while privileging qualities that happen to be appreciated by a certain culture or society; such qualities do not constitute what is specifically human.
• This would be in contrast with the fundamental truth of the equality of all human beings which is expressed in the principle of justice, the violation of which, in the long run, would harm peaceful coexistence among individuals.

Church teaching on cloning and stem cell research:
• Research on cloning and embryonic stem cells poses serious challenges to those who defend human life right from the moment of fertilization.

World eager to use embryos
• The scientific and medical communities all over the world are eager to harness the powers of the stem cells of very young human embryos without considering the ethical consequences of these acts.

Child: human achievement or God's gift?
• Technological reproduction, and specially cloning would tempt many to view a child as a human achievement rather than as a gift of God.

Dialogue with the researchers
• We need to educate ourselves on the new technology in order to dialogue intelligently and confidently with these researchers.

Church is not opposed to technological progress
• The Church seeks to guide what the technological development has to serve, viz. the human person.

Vatican Council II
• Technological progress is not to be seen as the conquest of the human person, but as the sign of the greatness of God and the fulfillment of his project and plans.

Saint John Paul II affirmed:
• "The Church for her part invites us to look confidently at the most holy mission of science and encourage every form of research which is respectful to man’s dignity, for she sees in it what we could term the inexhaustible capacities of intelligence, the reflection and imprint of the intelligence of God".
• At a time when human life is experiencing such serious dramatic aggressions, the Church, by virtue of her pastoral mission, feels the duty to support scientific research in the awareness that faith and science interface in that wisdom wherein God’s design fully upholds.

Conclusion
• Those who threw Christians to the lions did not do so merely for the pleasure of seeing their enemies brutally torn to pieces, but also in the cruel hope that the defenders of Christ would abandon their commitment to the truth of their faith.
• Those who reject high moral principles abandon their deeply held convictions in the face of destruction.
• Those who propagate a culture of death fully expect the same to occur over new therapies and technological advances that are invented as a result of the destruction of human embryos.
• However, those strong in the faith are ready to suffer debilitating diseases and untimely deaths by their refusal in conscience to profit from the destruction of others.
• Human cloning is both “in method the most despotic and in its aim the most slavish form of genetic manipulation, its objective is not an arbitrary modification of the hereditary material but precisely its...
equally arbitrary fixation in contrast to the dominant strategy of nature”.
• Eradicating the human cloning project and embryonic stem cell research is a moral duty which we must work together to achieve.
• The obtaining of stem cells from a living human embryo, on the other hand, invariably causes the death of the embryo and is consequently gravely illicit: “research, in such cases, irrespective of efficacious therapeutic results, is not truly at the service of humanity.

109. Conclusion: Pope Benedict XVI
• Embryonic stem cell research advances through the suppression of human lives that are equal in dignity to the lives of other human individuals and to the lives of the researchers themselves.
• History itself has condemned such a science in the past and will condemn it in the future, not only because it lacks the light of God but also because it lacks humanity.

110. Conclusion: Dignitatis Personae
• The use of embryonic stem cells or differentiated cells derived from them – even when these are provided by other researchers through the destruction of embryos or when such cells are commercially available – presents serious problems from the standpoint of cooperation in evil and scandal.

111. Conclusion:
• There are no moral objections to the clinical use of stem cells that have been obtained licitly; however, the common criteria of medical ethics need to be respected. Hence:
• Research initiatives involving the use of adult stem cells, since they do not present ethical problems, should be encouraged and supported

Ethical Issues in Stem Cell Therapy
Jose-Maria Simon-Castellvi, MD (Spain)

XII. Session 9
Building for the Future Technology:
Analyzing Strengths / Weaknesses, Opportunities, and Threats

Utilizing our Profession in Spreading our Faith
John Lee, MD (Singapore)

Text
MAGANDANG UMAGA PO. Good morning my dear brothers and sisters in Christ. This is my second time in your beautiful country and my only regret is that I have leave so soon. I first came here in 2006 to deliver the Dr Jose Ma Delgrado memorial lecture. I must confess that I felt rather inadequate than as I feel now when I think of the achievements of this great physician and humanitarian. However I am comforted by the fact that Jesus chose simple folks, fishermen like Peter rather than eloquent and educated people like the rabbi to be his first disciples. So if what you hear sounds like the rambling of a simplistic fisherman you can blame Edna for that.
For those who are unaware the 1st FIAMC Congress was held here in Philippines in 1966 and the
theme was “The Catholic Physician and the problems of the population”. So when the organizers asked me to talk about utilizing our profession in spreading our faith, I felt that it would be appropriate if I begin by talking about our “vocation” rather than profession as a Catholic doctor.

Who is the Catholic doctor?
There are many Catholics who are doctors but there are very few Catholic doctors. What do I mean by this statement? For many of us, our faith is something which we confine to Sunday worship and church activities and maybe even to the family. It is not easy to see how Christian principles can be applied to our professional life especially when we work in organisations that are secular. Very few of us are Catholic doctors. All too often we tend to dissociate our religion from our professional life especially if we live in a multi-religious society.

In a predominantly Catholic society like Philippines, it might be easier to practice your faith in your daily lives but in a pluralistic society like Singapore where Catholics are a distinct minority, because of a multitude of reasons like the oft quoted issue of religious sensitivity we tend to put Christ aside in dealing with our patients. If we adopt this attitude then our work which constitute a large part of our lives would soon become meaningless. If we allow God into our daily lives regardless of how mundane it is, then like St Teresa of Liseux we can become sanctified in doing whatever God has called us to do. In this aspect we can learn from the lives of true Catholic physicians like Dr Jose Delgrado and Dr M Mariano Alimurung.

I was truly humbled when I read a summary of the life of Dr Jose Delgrado. From him we learn that the Catholic doctor is not only a physician who is accomplished but also someone who is deeply involved in the community he lives in and strives to improve the community in every aspect.

I cannot talk about the Catholic doctor without mentioning Dr M Mariano Alimurung. I am sure most of you present know who he is but for those who do not, Dr Alimurung who was a founding member of the famous Makati Medical Centre, was a prominent cardiologist. In addition to his brilliant career and achievements in the fields of medicine and cardiology, he was also a man of vision and a pioneer. In 1960 he was one of those who initiated the formation of the Asian Federation of Catholic Medical Associations (AFCMA). In 1966 Dr Alimurung was elected the 1st president of the newly constituted World Federation of Catholic Medical Associations (known by its French acronym FIAMC) which succeeded the International Federation of Catholic Physicians. Tragically he was murdered while attending a cardiology convention in Florida in 1980.

Can work make us holy?
Can you recall your primary motivation for becoming a doctor? For some of us, the draw may have been the prestige of becoming a doctor or because the “money is good”. Some of you may have chosen to become doctors for truly altruistic reasons and felt the calling to serve others. What was your primary reason for becoming a doctor? Had your decision anything to do with God? Do you believe that work can make you holy?

Many of us who started off with the belief that God wanted us to be in a particular profession have found it difficult to see how God’s intervention is needed in our work. The prevailing philosophy of the world tells us that there is nothing that cannot be handled, figured out or developed by man; that the world can make us happy. (crossing the threshold of hope by Pope John Paul II)

This apparent confusion about how God plays a part in our work makes it difficult for us to approach the issues which arise in our work with clarity. What are these issues? These are not necessarily confined to big issues such as abortion but include those which arise in everyday situations in our work place. Do we place the dignity of the persons before productivity? Do we allow pride and self love to come before the needs of others? Do we allow worries to override the trust we should place in God? Productivity, technology, work including its fruits become our little gods and we the slaves. This will eventually give rise to a nagging restlessness within ourselves and end up in despair and hopelessness. In John 15:6 we are told “Cut off from me, you are like a dried up branch, thrown away to be burnt”.

As Christians we are told that there is no dichotomy between human knowledge and Christian revelation. They are both facets of a single truth. In Summa Theologiae, St Thomas Aquinas tells us that “all human knowledge has its source in God.”

The Catholic Church teaches us that the answer lies in our giving to God a central role in our work. In giving Him dominion over our lives, we realise our human dignity. Only then can we recognize the dignity of others. Far from the slavery we have subjected ourselves to, the Church teaches us that God the Creator of all things has called us to be masters over our professions and to “subdue
the earth”. The truth is that work can make us holy; it brings us into a close partnership with God and allows us to integrate into His plans to overcome the world by permeating the medical profession with Christian faith and principles.

**Working in the kingdom**

In John 21:15-17 Jesus asked Simon Peter, “Simon, son of John, do you love Me more than these?” The fact that you are present here today tells me that all of you will give the same reply that Peter gave, “Yes Lord, you know that I love you.” I am sure all of you aspire to develop a deeper love relationship with God not only as a Catholic doctor but in every aspect of your life.

The basis of spirituality of work is the recognition that work is the means to the realization in history of the Divine plan. In other words, we are called through work to building up the world that God created. Pope John Paul views work as being linked with the Cross and the Resurrection. By enduring the toil of work, the human person is united with Christ in His sufferings.

**A call to Holiness**

Some are born holy, other achieve holiness and others yet have holiness thrust on them. Very few of us are born holy and fortunately not many of us are thrust into perilous situations where we have no choice. So how do we achieve holiness? A good place to start would be to examine the lives of the saints who were ordinary people like us and in many instances led less than exemplary lives until they found Christ. Since most of us are Catholic doctors, I would like to focus on the Physician Saints. Amongst the most well known are St Luke, Saints Cosmas and Damien who were your ancient day general practitioner.

**St Luke: Physician and Evangelist**

The figure of St. Luke looms large out of both the New Testament and the pages of documented human history so that nearly two thousand years after his death his awesome image is undiminished. His fellow apostle St. Paul called him the "glorious physician," but that was only one of the talents which this magnificent man applied in service to God.

Hailing from the ancient city of Antioch, Syria, Luke was a well-educated Greek-speaking Roman citizen whose early conversion to Christianity took place after meeting Paul. He became the Church's most articulate historian and wrote with such sensitivity and clarity that his Gospel in the New Testament has been rightfully called the most beautiful book ever written. Luke's gospel is particularly known for its inclusion of the parable of the Good Samaritan, which is the guiding parable for Christian medical care. In it, he gave great insights into the methods of caring for those in need.

Luke's contributions to the cause of Jesus Christ are beyond all measure, and his influence enabled the Christian Church to rise to its ever increasing role in human experience, including its leadership in providing medical care. Although his skill as a physician and his talent as an artist may have by themselves given St. Luke a small place in history, it was his consummate gift as a writer, displayed in the Gospel of St. Luke and the Acts of the Apostles, which made him one of the greatest figures in all Christendom.

Here is a well-known prayer to St. Luke:

"Most charming and saintly Physician, you were animated by the heavenly Spirit of love. In faithfully detailing the humanity of Christ, you also showed his divinity and his genuine compassion for all human beings. Inspire our physicians with your professionalism and with the divine compassion for their patients. Enable them to cure the ills of both body and spirit that afflict so many in our day. Amen”.

**Saints Cosmas and Damien**

How many of you are familiar with these two saints to whom many Catholic medical associations have been dedicated and in whose honour many churches, a basilica in Rome and even a city have been build?

Saints Cosmas and Damien were twin brothers born in Syria in 270AD. When their father died, their mother Theodata was left to raise the five brothers. Cosmas and Damien were educated in science and medicine and became physicians who were skilled and enthusiastic about their work. Cosmas and Damien saw in every patient a brother or sister in Christ. For this reason, they showed great charity to all and treated their patients to the best of their ability. Yet no matter how much care a patient required, neither Cosmas nor Damien ever accepted any money for their services. For this reason, they were called anargyroi in Greek which means “the penniless ones”.

Every chance they had, the two saints told their patients about Jesus Christ, the Son of God. Because all the people loved these twin doctors, they listened to them willingly. Cosmas and Damien often brought health back to both the bodies and the souls of those who came to them for help.

When the Diocletian’s persecution of Christians began in their city, both the brothers were arrested. They had never tried to hide their great love for their Christian faith. They were tortured, but nothing could make them give up their belief in Christ and refused to worship the Roman idols. They were finally beheaded in 303 AD at the age of 33.

Cosmas and Damien followed the instruction Jesus gave to his 12 apostles, which was relayed in the gospels of Luke and Matthew. "He sent them out to proclaim the kingdom of God and to heal (Luke 9:2), and instructed them "Cure the sick, raise the dead, cleanse those suffering from leprosy, drive out devils. You received without charge, give without charge." (Matthew 10:8). These two appear to have been especially revered for adhering to this latter teaching, which was rarely followed by others. The lives of these two great saints offer us many lessons.

The Catholic doctor sees Christ in his patients

The account of how Cosmas and Damien treated their patients reminds me of a story of another modern day “saint”. An American journalist who was filming Mother Teresa turned away in disgust at the nauseating smell when Mother was cleaning the wound of a leper exclaiming, “I would not do this for a million dollars!” Mother turned to her and smiled saying, “Neither would I.” She then went on to explain that she was doing it because she saw Christ in every person regardless of how abject they appear. If you knew that the dirty, filthy and smelly beggar in front of you was Jesus Christ, you would have no hesitation in hugging him. The simple truth is that Jesus tells us “that whatever you do for the least of your brethren you are doing it for Me.” Not many of us can make this leap of faith and honestly say we see Jesus in every patient. However if we can keep this in our mind, it will be the first step towards sanctification!

Sadly in many places in the world like Orista, India and Pakistan, Christians are being persecuted and even killed for their faith. In 2002, we were standing at the bank of the Han River in Seoul Korea after visiting a chapel dedicated to the Christian martyrs. At that very spot, some 10,000 Christians - including entire families - were beheaded and their bodies thrown into the river because they refused to renounce their faith. I wondered what my answer would be if they lined up my family. Saint Cosmas and Damien showed us by their example how we can bring the word of God to people not only in the way they lived their lives as Christian physicians but also in how they died for Him.

I would like to ask all of you to join me in offering up this prayer to Sts Cosmas and Damien for all those people who are being persecuted for Christ especially the Christians in India and Pakistan and especially for Catholic physicians who are persecuted for our faith like Dr Chazan that he will strengthen our resolute:-

O My Jesus, Saints Cosmas and Damien were twins who became excellent doctors. They refused payment for their medical care because they believed that when they treated patients, they were also caring for You. By conveying great love, they won the hearts of their patients as they taught them about the Faith. I ask them to pray for my special skills, that I use them for Your glory. I also ask them to pray for all those in the medical field, that they grow in generosity of spirit. Bring conversion to the unsaved and teach Christians to serve You through their professional lives. Saints Cosmas and Damien, pray for us. Amen

Catholic Doctor – A Vocation and Calling to Sanctification

For myself, I realised that medicine was a vocation and not a career and the fact is that I became a doctor was more by God’s design than my own efforts. Many much more brilliant and hardworking students who aspired to become doctors never made the grade. It is this sobering thought that led me on a Quixotic quest to find out why God chose me to become a doctor and the elusive reason for my existence. The reason which was staring me in the face, was so simple and obvious that it eluded me for a long time.

The Way

The blessed Josemaria Escriva, founder of Opus Dei wrote in the book called “The Way” that the calling to follow Christ does not involve an invitation to leave one’s place, to choose another way of life: in fact, for the great majority of Christians it is an invitation to face the ordinary circumstances of one’s existence and find there the divine way which must be made holy. In fact
he rejects the temptation to “get out of place” (832) because this amounts to avoiding the will of God. Each Christian must find a holiness in keeping with his own mission and his own state-in-life; and so the ordinary Christian who lives in the middle of the world, should sanctify himself and others by means of the world itself, sanctifying his professional work and his whole life.

We might never know why He chose us to become doctors but that is not important. What is important as Josemaria tells us is that we are all called to sainthood in our vocation and we must share the call to holiness with people whom we touch in our lives by being an apostle of apostles. “Go preach the gospel… I will be with you.” Jesus has said this and he said it to you.

A strong prayer life

An integral aspect of the road to sanctification is a strong prayer life. An article which appeared in Dec 2008 in the magazine, Christian Post suggests that fewer doctors believe in the importance of everyday prayer as compared to 4 years ago. Two national surveys conducted amongst physicians of many faiths in America, found that 30% as opposed to 46% in 2004 agree that prayer is important in everyday life. Though fewer physicians may see prayer as important in everyday life, more than half (55 per cent) still find themselves occasionally praying for individual patients and some 70% say they believe that miracles are possible. Still the majority of physicians (71%) say they believe that very little or none of the outcome of medical and surgical treatment of their patients is related to forces totally outside of their control, such as the “supernatural” or an “Act of God”. The researchers commented that in a profession that depends on skill and knowledge, healthcare professionals must turn inward and rely on skills and scientific knowledge. While I agree that it is important for all doctors to continually to aspire to attain new knowledge and refine their skill, the good Catholic doctor understands that he is merely an instrument in the hands of God. In his humility he understands that there is very little that he can do to cure the patient and that the healing process begins and ends with God.

In my short 32 years career as a doctor, I have witness many inexplicable cures and miracles which are definitely not due to human skills especially my rather limited competence. Regardless of their religion, one of my most frequent prescription is to ask my patients to pray. If they have no specific religion, I will invite them to visit the sanctuary at the Novena Church or to say the Jesus Prayer, “Lord Jesus Christ, Son of God have mercy on me a sinner”. Prayer is probably the single most powerful medicine.

I remember once a Muslim patient, Norhayati in desperation asked me to pray over her. It is an extraordinary request because a Muslim will never ask a Christian to pray over her. She was in severe pain and had gone for seven back operations and was relying on Pethidine injections. After her last operation her regular surgeon told her not to see him again because she was possessed. Apparently when he was operating on her his head started expanding and pounding with intolerable pain. In disbelief about his lack of professionalism, I telephoned him and he verified the story. Her husband and son also collaborated her accounts of being pulled under the car and thrown to the top of a cupboard by some unseen force. Therefore it was a bit of trepidation that I prayed over her. I do not know what subsequently happened to her but at least for the moment, prayer was much more effective than the Pethidine jab.

Be proud to be identified as a Catholic

When I was a first year medical student, there were very few active Catholics on the campus. I used to be summon up to some seniors room to be prayed over as “Catholics were doomed to be sent to hell” To this day, I have always professed my religion with pride. Some friends have commented that it is remarkable that I have succeeded as a doctor in spite of being a rabid Catholic. However I fervently believe that I have become successful because I am a Catholic.

Here are some photos of my consultation room. It is clear to anyone walking in that I am a Catholic. However I enjoy a very good relationship with my patients who are predominantly non Catholics. In fact one regular Muslim patient gently chided me for putting the photo of the late John Paul II at the foot of the consultation couch as that might be misconstrued as a sign of disrespect. Following the exemplary examples of the Pope John Paul II and Mother Teresa, the Catholic doctor should always strive to spread the Gospel message in his everyday actions.
Lessons from the Parable of the Good Samaritan
The command of the Lord at the Last Supper: “Do this in memory of me”, besides referring to the breaking of bread, also alludes to the body given and the blood poured out by Christ for us (cf. Lk 22:19-20), in other words, to the gift of self for others. A particularly significant expression of this gift of self lies in service to the sick and suffering. In his encyclical Salvifici Doloris, Pope John Paul II touched on the meaning of suffering and exhorts healthcare workers to emulate the gospel example of the Good Samaritan to selflessly minister to the sick, the suffering and the dying drawing their strength and inspiration from their faith in the Lord Jesus.

What has this parable to say to each one of us here today?
Notice how the Samaritan reaches out to the patient. He is moved with deep compassion on seeing the injured man lying there along the way. What a feeling of “compassion”. What a wonderful sense of “a reaching-out love” and an expression of love in action.
Solidly rooted in charity, the Catholic healthcare worker continues Jesus' own mission in caring for the weak and the sick. In our approach to the sick and the suffering, we as Catholic Healthcare givers should be guided by a precise and all-round view of the human person “created in the image of God and endowed with a God-given dignity and inalienable human rights” (Ecclesia in Asia, 33).

With due respect to the religious present tonight, the healing ministry of a Catholic doctor is closer to the work of Jesus than that of the priest for in many instances Christ was a healer of both the body and soul. The Catholic doctor follows the example of Christ, the divine physician by being the perfect mirror of God’s love. I am greatly inspired by doctors like Dr Jose Delgrado and Dr Mariano Alimurung who like St Teresa of Liseux performed little and ordinary tasks in an extraordinary way and in doing so left an indelible mark in the lives of countless people. The harvest is plentiful but the laborers are few. One of the main reason why I chose medicine as a career was because I saw the respect that was accorded to my father who was a doctor. A doctor can walk amidst kings and the wealthy and not feel inferior in any aspect. As physicians you will command the respect of your community. People will look up to you as role models and listen to what you have to say. However with great power comes great responsibility. If you are wondering where this profound saying comes from it came from the movie Spiderman.
In the parable of the gold coins (Like 19:11-27) Jesus warns us that we will be asked to give an account of what we did with the talents given to us. I urge you to use your God given talents to be the salt of the earth and spread His word wherever He sends you.

How we can utilize our profession to spread our faith
When I first started mission work on behalf of FIAMC, I was focusing on medical support for
disaster relief, providing clean water and building clinics and hospitals. Although these are important I soon realized that education was equally if not more important as a long term measure to eradicate and change society. During the Jubilee year, FIAMC received a small donation which was used to create a Pope John Paul II scholarship for some students in Taunggyi, Myanmar who have since graduated and are assisting Archbishop Mathias in his programs.

I would like to describe briefly a program called ACTS (A Call To Share). ACTS is an example of how we as doctors can utilize our profession to spread our faith because of society’s innate respect for the physician. Before proceeding further I must emphasize that we as Catholics are called to evangelize not to proselytize. What is the difference? Simply put we are asked to propose God and not to impose God.

In December 2006, I went to Cambodia with a small group of around 20 people to work with the Salesian nuns. That mission was the birth of a multi-parish mission group called ACTS following the biblical example of the early day Apostles. Mission participants are given pre-mission formation sessions where they are taught Church social teachings and there is also daily mass and reflection sessions during missions. “Share” implies that true giving is a two way process i.e. in sharing our God given talents, the giver receives a lot more in return.(Acts 20:35)

ACTS (although strictly Catholic in orientation includes a significant number of non-Catholic participants) is now a year round program which amongst many activities feed thousands of Cambodian kids throughout the year, providing scholarships, building schools etc culminating in annual advent missions throughout Cambodia which have benefitted thousands of Cambodian children. The girl in the picture is Srey Pau. This beautiful girl of Vietnamese origin would most certainly have ended up as a prostitute except she got a scholarship to study in Don Bosco and is now preparing to do architectural studies in a Cambodian university. Another sterling example is a young man named Savouen who received a partial scholarship and has since graduated as a doctor. He is now helping the Church in ministering to the infirmed in sick shelters and also coordinated a mass vaccination program that a Jewish gentleman is sponsoring.

ACTS is primarily responsible for building the first major Catholic secondary school in Cambodia which will provide education up to university level enabling hundreds of students to avoid a fate of working in slave-like conditions in factories or prostitution. Every year ACTS brings several hundred mission participants to places like Cambodia, Myanmar, Vietnam and Philippines and has had participants from countries as far away as Mauritius and Australia. This December we will be bringing 380 participants to Phnom Penh alone. ACTS also encourages the better off Cambodian kids to get involved in our activities and several of them are passionate about helping our work. Indeed, the main beneficiaries are the mission participants who realize how fortunate they are and believe they can change the world in their own little ways. The most common response when an individual is confronted with the issue of tackling global poverty is an air of resignation and defeatism as to what they could do to alleviate the situation. The Bible tells us that if we only have faith the size of a mustard seed we can move mountains.

The work of ACTS is appreciated by the bishops throughout Cambodia and recognized by the Cambodian government. ACTS has been invited to replicate its program in other countries like Philippines, Myanmar, Vietnam and Indonesia. There are some doubting Thomases who wonder whether what we are doing has any real lasting value. There is no doubt that for those who have participated in the missions have found it a life-changing experience after experiencing what I call the “Joy of Service”. There are hundreds of testimony from the mission participants whom we refer to as “Apostles” after the disciples in the ACTS of the Apostles sharing how their reaching out to share God’s love has changed their lives. However has our effort made any real change in the communities which we minister to?

I would like to share with you a story of an incident which happened recently. Sometime in January, Joseph one of our mission leaders, received a rather cryptic email from a Cambodian volunteer who worked with his group in Poipet. In it the youth asked Joseph, “Would you give your favourite T shirt which your best friend has given you to a stranger on the street?” Puzzled Joseph asked him why he asked that question. The youth said that while he was cycling home last December which was unusually cold he saw an old man huddled with his grandchildren shivering from the cold. The youth went back to his dorm and collected all his and his friends’ spare clothing including the T shirt which the mission group had given him and went out to distribute the clothing to the homeless.
When Joseph asked him why he did this the youth simply said that he was inspired by the love of the Singaporeans for his people.

Over the last few years there have been several similar examples of Cambodian especially the youths who have been touched and inspired by what we are doing and I believe that this changing of the mindset of the youths of a nation which has been traumatized by the Pol Pot regime is the real fruit of our outreach. What we are doing may only be a drop in the ocean but as Mother Teresa says the ocean will be less because of the missing drop.”

I would like to conclude by showing you a photo of some volunteers who went to Poipet recently to welcome and give humanitarian assistance to the thousands of Cambodians who were forcibly repatriated from Thailand. Although ACTS was not involved in this mission of love, Sr Maria wrote that it was a nice thing that the students wore the ACTS T shirts because everybody then knew that they were students of Don Bosco. We were very touched by this gesture because ACTS has come to symbolize something pure and beautiful and a sign of God’s unconditional love. As Mother Teresa put it so eloquently, “I am but a little pencil in God’s hand writing a love letter to the world”.

Let us unite our efforts and prayers so that we can continue to be courageous witnesses of the Kingdom of God.
Identifying Issues and Solutions to our Weakening Faith
Robert Walley, MD (Canada)

Declaration of faith

Of Catholic doctors and students of medicine, on the sexuality and fertility of human beings. We, doctors, entrusted to protect human life from its conception until its natural end;

1. BELIEVE in one God, the Lord of Heaven and earth, who created man and woman in His own image and likeness.

2. PROCLAIM that the human body and life, being gifts from God, are sacred and inviolable and that,
   a. The body is subject to the laws of nature but is formed by The Creator;
   b. The moments of human conception and dying offer us, by God's grace, the opportunity to participate in God's love, creation and passion. If a person acts by their own will to negatively alter conception and bring about death, then he or she not only violates the basic commandments of the Decalogue, committing acts such as abortion, euthanasia, contraception, artificial insemination, and/or in vitro fertilisation, but rejects The Creator as well.

3. ACCEPT the truth that human sexuality is a gift of God and provides the method by which human beings are ennobled with the privilege to become "co-creators with God in the work of creation" through parenthood. The call to parenthood is God's plan, and only those bound with Him by the holy sacrament of marriage have the ability to rightly use these gifts, which are sacred, in the human body.

4. ACKNOWLEDGE that the foundation for the dignity and freedom of the Catholic doctor is exclusively his or her conscience, enlightened by the Holy Spirit and informed by the teaching of the Church, and that he or she has the right to act according to said conscience and in keeping with medical ethics that have established the doctor's right to oppose all acts that are against one's conscience.

5. RECOGNISE the priority of God's law over the law of nations and,
   a. The current need for providing alternatives to the anti-human ideologies and dictates imposed by some contemporary societies.
   b. The need to constantly deepen not only professional knowledge but also the knowledge of Christian anthropology and theology of the body.

6. BELIEVE that, while not imposing their beliefs and opinions, Catholics, including doctors and students, have a right to perform their professional activities in accordance with their conscience. "To Doctors and Nurses Likewise we hold in the highest esteem those doctors and members of the nursing profession who, in the exercise of their calling, endeavor to fulfill 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." (Paul VI, Humanae Vitae, 27)
Founding a Supporting System for Retired Priests, Nuns and Old Believers in an Aging Society

Shigeki Hitomi, MD (Japan)

Slides

1. Founding a Supporting System for Retired Priests, Nuns and Old Believers in Aging Society

Hitomi Shigeki, President of Japan Catholic Medical Association, Emeritus Professor of Kyoto University, Japan

2. Object of our study:
   • We would like to make a system with which doctors and flocks can support elderly priests, nuns and believers medically, economically and spiritually.

3. We will investigate
   • The age distribution of priests, nuns and believers.
   • Interview priests to enquire about their hopes about how to spend the rest of their lives.
   • Study the retirement houses for them, catholic nursing homes and non-catholic public nursing homes.
   • How can we make a system with which doctors and flocks can support them medically, economically and spiritually?

4-5. Age distribution of all 1,515 priests in Japan in 2012, and the percentage of over 65 years old priests.

All: 1515 = 49%
Japanese: 907 = 47%
Non-Japanese: 608 = 51%
6. Distribution of Age of 6 Convents in 2012 / Osaka (Number of nuns =431)

7. We die Questionnaires to priests (fielded to 86 Priests & Monks, and got responses from 51%)
   • What is your purpose in life?
   • Where and how do you want to live, when you need to have nursing care or therapy?
   • Do you have any worries, about when you will need to have health care? Explain.
   • What do you know about the social security system?
   • Do you have adequate communication with Catholic physicians?

8. The answer to Q1: What is your purpose in life? (plural answer acceptable): Missionary 29% - Sacramental 28% - Prayer 23% - Public activities 11% - Others 8% - No answer 1%

9. The answer to Q2: Where and how do you want to live, when you need to have nursing care or therapy?: Catholic nursing home / hospital 50% - Haven’t considered 16% - Care house for retired priest 14% - Priest home / convent with public care 9% - Public nursing home / hospital 7% - Don’t care 4%

10. The answer to Q3: Do you have any worries, about when you will need to have health care?: Health difficulty 27% - Nothing 20% - Decrease of missionary activity 17% - Personal circumstances 17% - Social security 7% - Others 7% - Economy 4%

11. The answer to Q4: What do you know about the social security system?: • I don't know very much 66% - I know well 14% - I dont know anything at all 11% - I have no interest 9%

12. The answer to Q5: Do you have adequate communications with Catholic physicians?: Not at all 32% (2 meanings: e¥ priests choose not to see a physician - e/ There are not enough doctors) - I want much more 30% - I want a little more 27% - Yes, enough 11%

13. Costs
   • 1) Care house for retired priests, monks and nuns: £5,000 monthly (It can not be fully covered by public insurance)
   • 2) Catholic nursing home / hospital: Where he/she can't walk ($1,750 monthly). (It can be fully supported by public insurance)
   • 3) Public nursing home/hospital=Same as No.2
   • 4) Living in priest home /convent with public care: Lowest-priced, because there is no room charge.
   • Income: The salary of priests and nuns is about $1,300 and the pension of retired priests/nuns is $700 monthly.

14. Pros & Cons of Care house for retired priests/nuns
   [Pros] • Chapel, Sacramental, Mass, Prayer
   • Enjoy hobbies,
   • Converse, Friendship with other priests
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[Cons] • Expensive! Because the house is closed to the public and can't be fully given public insurance.
  • It needs economic support from diocese /convent. Shortage of those houses, only 5 in Japan!
  • Might have to leave home and lose touch with old friends.
  • Might lose the chance of missionary.

15. Pros & Cons of Catholic & Public Nursing homes opened to the public
[Pros] • Cost is low with public insurance.
  • Chapel, Mass.
  • Flocks can visit retired priests/nuns.
  • Old friendships can be maintained.
  • Missionary to non Catholic persons is possible.
[Cons] • Shortage of homes(125 nursing homes, 13 hospitals and 8 hospices)
  • We need money to build new homes.

16. Pros & Cons of Public Nursing home opened to the public
[Pros] • Cost is low with public insurance.
  • Flocks can visit retired priests/nuns.
  • Old friendships can be maintained.
  • Missionary to the non catholic persons is possible.
  • More homes than Catholic homes.
[Cons] • No affiliation to the Catholic church.
  • No chapel and mass.
  • Priests and nuns have to attempt to integrate.
  • Shortage of homes even more than Catholic nursing homes, so they must wait.

17. Pros & Cons of Living in priest home/convent with public care
[Pros] • It's convenient to live the same place
  • Cost is low (no room charge)
  • Old communities can be continued.
[Cons] • The mutual support of priests/nuns who live together and by flocks is essential.
  • Nuns of retirement age, currently staying in their convents, are cared for by their colleagues, which is in fact "an old caring for the very old" situation.

18. Elderly believers have increased and continue to increase
• The Population of over 65 years old people is over 30 million, in 2014 in Japan .(about 1/4)
• One person household of over 65 years old has increased to 17% and continues to increase.
• Household of couples only has increased to 37 % and continue to increase.
• Elderly believers would like to help each other in their parish.

19. Progress of the Population over 65 years old
21. [The things which the flocks can do.]
- Support food & nutrition of priests who live alone.
- Raise money to hire cooks in priest home.
- Make a system in which Catholic doctors can work for priests/nuns.
- Make system in which flocks can support priests/nuns in priest's home/convents.
- Donate money to build homes for retired priests/nuns.
- Build Catholic nursing homes and public nursing homes.
- Build a supporting system in which believers support each other in their own parish.
- Donate the money for the fee of Catholic hospices.

22. Conclusion
In order to help the elderly priests/nuns and believers keep healthy and active as long as possible, we have to start as follows.
- Build up donations.
- Build up the supporting system for the elderly priests/nuns.
- Building the supporting system to help believers each other in their parish.
XIII. Paper Presentation / Case Discussion / Open Forum

Putting Modern Medical Science in the big picture of medical practice and in the bigger picture of human life: the role of humanistic formation for physicians in the technological age

Kathryn-Daphne M. Ong, MD (Philippines)

Introduction:
The bioethical challenges of today, in this age of secularization and technology, can be traced to a loss of the "sense of man", the loss of the sense of what is truly human in medical practice. This trend leads to the tragic dehumanization of medicine. The objective of this paper is to study a particular means that can help in the humanization of medicine, through the person of the physician.

In saying physician here, I refer to all physicians; everyone who has the capacity of upholding what is human in medical practice, on account of their capacity of distinguishing what is truly human through the natural light of reason. But this sweet task is of a greater responsibility for the catholic doctor, given the fact that aside from the natural light of reason, they also have a reason enlightened by faith, and a will strengthened by grace.

Method:
For this study, I looked into the works of authors from the fields of medicine, ethics, philosophy, and theology: Edmund Pellegrino, Leon Kass, Paul Ramsey, and Hans-Georg Gadamer. The study focused on the three strong points that they unanimously affirmed (1) their concern for the ongoing trend in medical practice: its dehumanization, as reflected in the present bioethical challenges, (2) their negative prediction of the future if action is not urgently taken to control these challenges, and (3) most importantly, their hope for a solution and for a better future: hope that is founded on the medical professional and his formation, especially the humanistic formation. To further illuminate this reflection, the thoughts of Robert Spaemann and Alasdair Macintyre are consulted for philosophical discussions and those of Elio Sgreccia for the bioethical discussions.

Problem: Putting Modern Medical Science in the big picture of medical practice and in the bigger picture of human life

The problem is how to put modern medical science in the big picture of medical practice and in the bigger picture of modern life. The verb utilized: "putting" tells us that this good has the possibility of being in-place or out-of-place. In-place when it is used, in proper orientation to the good of the patient: First, to the patient’s good which is the good of any medical action, that which is further ordained to the second good: health (the proper good of medicine), and finally, the good of health being ordained to the ultimate good of human life. Modern medical science becomes out of place when it is, as what we have now, in a relationship of domination and not of submission to medical practice. Looking at the current trends in medical practice, we see this disordered relationship quite clearly: As Kass comments:

"A new moral sensibility has developed: anything is permitted if it saves life, cures disease, and prevents death... The assumption that we have been operating: that everything should be done to preserve health and prolong life as much as possible and that all other values must bow down before the biomedical gods of better
This domination evidently results to a medical practice that is not in accordance with the nature of the medical profession, the art of healing. First, in so far as the therapeutic interventions done for the supposed purpose of reestablishing the equilibrium of health are applied without the indispensable reference to the patient’s totality and nature. And second, in so far as the therapeutic interventions done are, properly speaking, no longer therapeutic: since they now go beyond what is truly therapy.

Today, people claim as "therapy" the elimination of a congenital disease in a fetus through the elimination of the patient (by abortion). Nowadays, in cases of infertility where the disease that needs cure is an obstructed oviduct, the proposed treatment—under the pretense of "healing"—is the creation of a baby in the laboratory. Also, the trend of erroneously equating human therapy with human enhancement is widely diffused and progressing.

The art of healing is originally aimed at the good of the patient, in giving him the possibility of attaining a flourishing and fulfilling human life, through the good of health. Performing medical interventions that ultimately do not promote human flourishing, or worse, oppose it, we know, is contrary to the good of the patient. Medical practice of this type, devoid of the properly human and human-promoting qualities of medical profession, where the patient or the doctor is not considered in his human totality and end as person, is a dehumanized medical practice.

Dehumanized medical practice is one which denies and excludes what is properly human of human life. It denies that beginning of life is a miraculous fact, an incalculable play of chance, wherein the natural reality and circumstances have a significant impact on the person and in his relations, and instead affirms that it is simply a scientific process, perfectly reproducible in the laboratory. It is practice which denies that children are gifts that the family and society are duty-bound to humanize through speech and example in the light of the good; and instead affirms that they are designer products whose qualities are determined by manipulating their physical and intellectual constitutions through their genes, consulting only the parents’ subjective desires.

It is practice which denies the human experience of dying as a momentous event in a patient’s life where significant familial, spiritual, and personal issues are at play; and instead affirms that it is simply one more event in the modern hospital, where only technical (intubation, ventilation, pulling the plug), procedural (existence of living will or not) and economic (insurance coverage) factors are involved.

It is practice which denies that mortality has a significantly existential impact in man’s life, especially in terms of interest, engagement, seriousness, aspiration, beauty, love, virtue, excellence, and meaning; and instead affirms that the measures discovered to suppress it are signs of achievement, of how far scientific process has gone and can go.

As for the circumstances that contribute to the dehumanization of medical practice on account of the domination of modern medical science, the authors have named five factors:

1. **Technological Imperative and Technological Automatism:** Technological imperative is the belief that all type of innovation is progress. Hence, stopping or slowing its course is considered a negative regressive move for society and mankind. Technological automatism is the fatalistic way of thinking that what can be done shall be done; that there is no stopping it. As a result, even those who are not totally convinced that all innovation is progress, simply end up going with the flow, indifferent, thinking "what is the use of objecting when it will surely be done anyway?"

2. **Liberal Democracy:** In a society of liberal democracy, freedom is taken in the absolute sense, without any reference to nature and its laws, and to the true good of man. Here, freedom is implored in such ways as: "freedom" of science to progress (at all cost), "freedom" of couples to have offspring (even of non-capable couples, like same-sexed ones), "freedom" of pharmacologic industries to profit in the market (even at the risk of the subjects of clinical trials).

3. **Compassionate Humanitarianism:** This refers to the good intention, claimed "humanitarian" of relieving man’s condition, providing health, and reducing suffering. All for these motives and
everything at all cost, for these motives. Compassion, in the true sense, is good. In fact it is a virtue that a good doctor needs. The compassion that is referred here, on the other hand, is the false, purely sentimental type, which the author Stanley Hauerwas calls "killing compassion". With the humanitarian, compassionate motive of liberating the world from genetic diseases, eugenic genetic technologies is used in the production of designer babies. With the humanitarian, compassionate motives of liberating terminally ill patients from the agony of dying, doctors are becoming technical dispensers of death.

4. Cultural ideologies: Other factors in society that are pro-dehumanization of medicine include the widespread cultural ideology: gender theory, the separation of sexual identity from biological / natural sexuality. This ideology expressed by the tendency of totally separating human culture (what is of human construction) from nature (what is a given). What is unfortunate is that such attitude of culture-nature separation causes a vicious effect / cycle to the likewise separation of modern medicine from its indispensable reference to nature.

5. Economic motives: Today, there are increasingly powerful economic interests that serve as motor to biotechnology. As Gadamer points out, "there is today an inexorable transformation of all scientific know-how into technology as soon as something promises a profit." The domination of medical practice by modern medical science is not only tragic and alarming on account of its being dehumanized, but also on the fact that it leads to further dehumanization. Left to advance as it does now; it poses a threat to the progressive loss of the "sense of what is human."

Kass affirms that if society continues the uncontrolled, indiscriminate use of biotechnology up to the point of changing removing what is human in man: "Homogenization, mediocrity, pacification, drug-induced contentment, debasement of taste, souls without loves and longings—[would be] the inevitable results of making the essence of human nature the last project for technical mastery." He believes that it would lead to the "erosion, of the idea of man as noble, dignified, precious or godlike and its replacement with a view of man, no less than of nature, as mere raw material for manipulation and homogenization." What makes this threat more complicated is the fact that for many, the threat is not immediately and evidently recognized as such:

1. It is not so evident because of the involvement of complex, technical realities that are not easily captured by basic sense and experience. In artificial fertilization for example, If the human zygote and blastocyst were more like the 12 week old fetus (which already has a humanoid appearance, differentiated organs, and electrical activity of the brain), then there will be a much-diminished ethical dilemma regarding their deliberate creation and experimental use.

2. Apart from that, the threat is not evident since a lot of "non-scientific" concepts that do not have one univocal technical definition are at play. "We are quick to notice dangers to life, threats to freedom, risks of discrimination or exploitation of the poor, and interference with anyone’s pursuit of pleasure. But we are slow to recognize threats to human dignity, to the ways of doing and feeling, and being in the world that make human life rich, deep, and fulfilling."

3. Also, the danger of the threat is apparently subtle since the evils that are present, are very much linked to particular goods that are naturally pursued in medical practice and in human life. For example: the good of health (in the case of the pursuit for ageless body, stem cell research, and genetic diagnosis), the good of family life and reproduction (in the case of IVF). The evils are intertwined with the goods that are sought, and hence determining what is good and what is bad may not always come easily for everyone.

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82 S. Hauerwas, Dispatches from the front: Theological engagements with the secular, Duke University Press, 1994
86 Ibid, 87.
87 Ibid, 12.
4. Another factor is that the threat comes under the attractive mask of "humanization". In the sense that promoting the primacy of modern medical science is claimed to be actually promoting what is human, since reason / rationality is very much proper of human nature.

Not everything of human origin is humanizing in effect. Man does not live on rationality alone. Indeed, the foundations of our humanity—our sentiments, loves, attitudes, mores and characters, as well as the familial, social, religious and political institutions that nourish and are nourished by them—are not laid by scientific reason or rational technique, and may, in truth, be undermined by them, especially if our much-vaulted scientific rationality is philosophically unsound and finally unreasonable.

5. One other possible reason why the threat is not easily detected is that, now, man, has already been so accustomed to the infinitely upgrading realities brought by modern medical science. For the 21st century man, the new unmerited technology of yesterday becomes the ordinary necessity of today. As the rate of users of artificial fertilization practices increases, as the phenomenon of assisted suicide becomes legalized in more and more places, as digital information that man receives daily is increasingly filled with the technologically-driven albeit humanly-degrading novelties, man comes to regard these practices as natural, ordinary part of daily life, and simply unproblematic.

As to the danger of progressive dehumanization, Gadamer writes that: "Both [modern medical] science and the technical application of scientific knowledge, in dominating medical practice, have led to a domination of the natural world to an unparalleled extent. We have now reached a limit situation in which this knowledge ultimately has turned destructively against nature itself." All this discussion about the danger of dehumanized and dehumanizing medicine serves as an invitation not only to reflection but to action.

Medical Practice, the art of healing, is in need of modern medical science. Let it be clear here that we are not condemning medical science. In itself, science is an important good for medical practice. However, to be truly a good for the patient and even for the doctor, the place of medical science in medical practice needs to be well-ordered, well-oriented towards the direction of man’s ultimate good.

The challenge is to put science in the proper relationship of submission to medical practice. In seeking how to orient science, one can begin by looking once again at its nature. Science in itself, does not know, it is the person who knows. Science in itself is not morally good or bad. It is the person who uses it in a morally good or morally bad action. Science’s method: trial and error, does not care for the person, but the medical professional who applies the scientific procedure, yes.

The relationship between medical science and medical practice has a very important ethical dimension, insofar as such relationship exists in persons, lived by persons, and significantly affects persons. How the relationship goes ultimately depends on the only subject who is capable of controlling it: the person, in this case, the doctor. Orienting science would include putting boundaries to its limitless natures: that orientation which is largely in the hands of the doctor. Unfortunately, it seems that in current medical practice, the doctors are lacking in their powers to do so. One sign of this, as the philosopher Spaemann points out, is the exponential increase of bioethicists and ethical committees. Without undervaluing the importance of these agents, he writes that their sudden increase is a sign that the medical doctor of today is in crisis. That in his practice of the medical profession, he is having a difficulty in juggling goods and making medical decisions; difficulty particularly in coping with the burden of reflection needed in the art of healing. And the philosopher attributes this to a possible lack of preparation for reflection based on principles, on the part of the doctors. Hence, they are suspending judgments and are leaving the ethical committees to make it for them. Spaemann here does not negate the role of the agents in bioethics, what he emphasizes is that yes, the doctor should take into account the point of view of the competent advisers, but in the end, he must be capable of making a judgment, the best possible judgment for the patient. A judgment done through the correct orientation and ordering of the goods involved: the goods of medical science, of the patient’s good and of the doctor’s as well.

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89Ibid, 281.
Proposed Solution: Practical Wisdom through Humanistic Formation

This brings us to the second part of the paper, to the proposed solution on how to equip and empower to the physician to face the challenge of putting modern medical science in its proper place. And that solution is the acquisition of practical wisdom through humanistic formation.

Practical Wisdom
To be wise, in the practical sense, is to have the true and reasoned state of capacity to act with regard to human goods, to the things that are good or bad for man. Practical wisdom! This is the answer to how to order one particular good of medical practice, medical science, in the big picture of the medical profession, and more importantly in the even bigger picture of human life: of both the patient, doctor, and even of humanity in general. But before being able to know how to put the goods of the medical profession in the big picture, the doctor has to know what the big picture is in its totality: Life.

On the importance of this knowledge of life for the doctor, the philosopher Gadamer emphasizes that knowing what is truly appropriate for the patient is done under the standard of two types of measure, one belonging to the domain of science and the other belonging to the totality of one’s being-in-the world. Doctors are called on not merely to act upon the patients but to react to them, by treating them in a proper manner. To a manner which is proper for a human being insofar as he is a human being. This explains why doctors need not only be experts in medical science but to be experts of humanity as well.

Practical wisdom can be reached, according to the authors, through the promotion among the medical professionals of the following three elements: moral sentiments, habitual practice, and religious insights.

Moral Sentiments
In educating affectivity, the goal is that the doctor develops the adequate sentiment in front of the reality in front of him. The adequate sentiment, for example, of true compassion in front of a suffering patient; that which would motivate the doctor to want to do something to alleviate it. Or the sentiment of respect and esteem in front of the sacredness of another human being/human life, no matter in what developmental form it takes: in the five-week old embryo or in an old man in persistent vegetative state.

Educating the desires of the doctor is very important. As several times, he fails to act wisely in the therapeutic action simply on account of false sentiments. Subjecting the dying patient for example to overaggressive treatment, may be due to failure of seeing what is truly good for the patient, on account of the doctor’s strong sentiments of fear of losing "his good name" in the medical institution, or in the patient’s family, or even to himself, as the patient’s death could be thought of as a failure in his expertise.

Another manifestation of false sentiments is that which is especially prevalent in this age of hyper-rational, modern science mentality. Now, many medical professionals have developed a cold insensibility over human life. This is seen in how they handle embryos in the laboratory, how they perform abortion with such ease and spontaneity, and how the medical form for assisted suicide is treated as just one more clinical document, and the procedure itself as one more routine procedure.

In the formation of medical professionals, students are usually taught the theories that are necessary in performing the ethically correct action. The principles of beneficence, non-maleficence and justice for example are explained in good rational arguments. However, "application of theory requires bringing the theory into direct contact with the moral agent, not just into his reason, but into his desires, motives, and will, into that which is the mainspring of his actions. Thought, to be effective, must be inseparable from appetite". And this is ultimately the aim in forming the affectivity. Apart from educating the sentiments as to what is good to want, the endpoint is to help the doctor want to be, to do, to have, that which is good for him to be, to do, and to have. Such that what he wants (in the therapeutic action) is truly what is reasonably good for the patient.

Here is where the virtues enter, especially the moral ones. The moral virtues cultivate the capacity of anticipation proper to morally ordered affectivity. It is then that help put the harmony of liking what is truly and reasonably good.

94 L. Kass, Life, Liberty and the Defense of Dignity, cit., 68.
Habitual Practice

This refers to the habitual practice of the good therapeutic action by the good doctor. The pursuit of the good therapeutic action does not come out effortlessly. Apart from the fact that many factors need to be considered, the determination and realization of the good therapeutic action for this particular patient, in this particular circumstance require the proper order and integration of the goods that are involved, orienting them correctly and effectively into the patient’s best interest. The capacity to realize this challenging task, which is largely in the hands of the doctor, does not come out automatically as he finishes six years of anatomy, physiology, and pathology, and all the other specializations and skill-training in medical school.

Here, again, is where the virtues enter. They are excellent dispositions that are absolutely necessary for the doctor to realize the good and effective therapeutic action for the patient in a constant and habitual way. In so far as they serve as a unifying principle that helps integrate the faculties and powers of the doctor: his intellect (knowledge of medical science, beliefs, prejudices), his will (desire of helping the patient, of helping society, desire of becoming a good doctor, of becoming a good person), his passions and sentiments (lack of sympathy for a patient or its disordered, overpowering abundance) into the direction of achieving, through the concrete therapeutic action, the patient’s good of health, in view of his global good as a person. At the same time, these virtues serve as the unifying principle that integrates the same faculties and powers of the doctor into achieving good actions that lead to his own human flourishing, in his own good life. The virtues of the doctor then make him do his work well, make it good, but apart from that, given the self-determining dimension of human actions in doing the good work, the doctor becomes a good doctor, and a good person himself.

Different authors have proposed several lists of virtues that are necessary in the medical profession. In this paper, the list of the author Arduini was adopted, as the virtues that he included (the four moral or cardinal virtues), are ultimately the foundation and root of all the rest. The list includes Medical Prudence, the perfection of the practical reason of the doctor in knowing and ordaining, in the here and now, the good that the will desires, motivated by his integrated desire of achieving the convenient good for the patient; Medical Justice, the effective will of promoting that which is due the patient, that which is expected to be his (health) by virtue of his nature; Medical Fortitude, the firmness and strength of spirit that leads the doctor to pursue the good of the patient always, even when that pursuit is arduous. And Medical Temperance, the rectitude and right order of the affectivity in relation to the pleasures that come with the pursuit of the patient’s good.

Special mention is accorded to the virtue of prudence given its leading role in relation to the rest, as expressed by its classical image of being the charioteer of all the other cardinal virtues. It is that virtue which identifies the action (among all possible ones) in the particular circumstance (this patient with this particular disease, in this particular state of his life), and which leads to attaining the patient’s (even the doctor’s) good, in a way that such action is effectively realized.

Kass sympathizes with the medical professionals as he knows well that making medical decisions is not at all easy. With the medical professionals’ desire to help the patient, to answer his inquiries and questions, many times they are forced to come up with the rapid answer; which often unfortunately means quickness at the expense of lack of reflection. And usually, that which is rapid and fast is the quick, non-personalized application of what is provided by technology (the recently available intervention/method), or of what is provided by the institutionalized ethical committee (whose knowledge of the patient was no greater than from the one-paged medical report that was submitted to them for consultation), or of what is provided by the clinical practice guideline, that was issued by the medical society for general use.

Deliberation, in the process of really trying to find out what is best for this particular patient in this particular situation is time-consuming, arduous, and requires more than technical knowledge or general textbook guidelines from the part of the doctor. It requires virtues, knowledge of man and what is good for man in general, and knowledge of the particular man (this patient) and his particular good. It requires prudence. The rapid answer to the patient is yes an answer, but is not always the best (prudent) answer. Kass puts prudence as a necessary condition "... if the decision is indeed to be for the patient’s good."
Religious insight

This does not refer solely to an adhesion to a particular religious belief or group. What is proposed here is something that can be lived by all medical professionals, regardless of confessional state, since such insight refers to what is proper to man simply by virtue of being man; man who is a religious being by nature. For Kass, the core of the religious sentiment, which needs to be promoted, is reverence and the capacity for awe and wonder. This is expressed in the affective and effective recognition of the existence of the transcendent, of the existence of realities that surpass the rational-scientific understanding of man, of the existence of realities that in themselves merit reverence, awe, and as a consequence, respect. The promotion of religious insights is encouraged for the reason that it can give doctors a richer and a more total understanding of human life and of the human condition, which science cannot in any way give. He writes that, "religious thought has its own profound understanding of the human condition and teachings about the moral life, an understanding deep enough to help us address the large questions of our humanity at stake in life’s encounters with biotechnology."

Now going to more concrete and practical terms, the three elements for the acquisition of practical wisdom (moral sentiments, habitual practice, and religious insights) can be reached through the proposed intervention in this study: humanistic formation. This type of formation is realized, among others, in particular institutions and through a particular kind of education.

Humanistic Formation in the Institutions

In explaining the importance of promoting particular institutions, Kass states that we need to think about how to strengthen and defend those mediating institutions which cultivate the habits of moral affections and conduct—especially family, religious institutions. We should give special attention to institutions and customs that help shape medical practice and especially that shape the attitudes, sensibilities, and habits of medical practitioners as moral agents.

The argument that supports the promotion of the institutions is the fact that it is there where man gets in contact with the virtues, as seen, lived, experienced, and eventually (the goal) as imitated. Pellegrino, in explaining how virtues can be acquired in the medical profession, affirms that formation in virtue ethics happens primarily through role models. Seeing an example of how the virtues are concretely lived, seeing the natural attractiveness on account of the possessed virtues proper to virtuous doctors, virtuous persons; one is led to want to be, and to imitate a virtuous good doctor/person.

In a different perspective, Macintyre also refers to the importance of institutions when he discusses the role of the "others" in the formation of practical reasoning. He writes that "the acquisition of the necessary skills, virtues, and self-knowledge depends on the others.. for we continue to the end of our lives to need others to sustain us in our practical reasoning." One needs the others to prevent him from falling into intellectual and moral error. The "other" may be the doctors in one’s professional workplace, the others in one’s religious group, one’s family and friends. Through their comments, suggestions, corrections, or to simply hearing of their experience and point of view, they can help make the doctor aware of the particular mistakes, faults, omissions, in his actions. Especially faults with regard to knowledge, skills, and virtues.

Promotion of the institutions can take on various forms, here the possibilities are endless. In whatever way, promotion of one particular sector however should never be lacking: the family and the church. They are to be protected and promoted not only in as much as they are the first school of virtues, religious sentiments and basic education, but also in so far as it is there where private life, where humanity in its depth and richness, is primarily learned and lived and where it flourishes. As Kass writes, private life is where we come face to face with birth and love, death and sorrow, not merely as helpless victims but as connected, responsible, and thoughtful agents. Private life also provides liberty of worship, to acknowledge the dependence of human life—and of nature itself—on powers beyond us and not at our disposal.

As to other institutions, Pellegrino points out the importance of the role of the medical schools. He claims that if the medical profession is to be maintained as a moral enterprise and not a branch of high-tech industry, medical schools would need to pay attention and care to supplying not just...
pure technical knowledge and skills (which unfortunately is the current trend).

**Humanistic Formation: Humanistic Education**

The second concrete means that the authors promote is a particular type of education: that of a humanistic learning that truly humanizes. This education is not the technical scientific education that is already abundantly present in schools nowadays. It is, instead, the type of education that is not just for employment but one that is aimed at thoughtfulness, understanding, and in search of genuine wisdom: Liberal, Humanistic Education.

As a means to help orient the medical professionals in realizing the good therapeutic action, Spaemann also recommends the promotion of this type of education. According to him, in the pursuit of the patient’s good, the knowledge provided by modern medical science will never be sufficient. Comprehensive and total knowledge of the patient’s situation would require a certain type of knowledge that sees the same realities dealt with by science, but from a different perspective: perceived in the view "from the inside". That is to say, from understanding the meaning of human expressions, human actions. Spaemann refers to it as the "hermeneutic of nature", and this is what, he claims, is provided by humanistic science.

In explaining how formation in virtue is realized in the medical profession, together with the primary contribution of role models, Pellegrino also recognizes the role of humanistic studies. He states that:

Courses in medical ethics, the humanities, human values, etc., can sensitize, raise awareness and force critical reflection about the virtues of the good physician. Courses introduce students to a body of literature which gives evidence of the importance, depth and complexity of the moral issues commonplace in medical practice. They challenge the reflective student to at least examine, verify, assimilate or reject what he is being taught or what he sees.

**Building Blocks of Humanistic Formation**

As to which specific branches of knowledge should the ideal humanistic formation of medical professionals include, the study limited them to four particular fields. As these four fields were those most referred to, directly or indirectly, by the four main authors whose works were primarily studied in this paper. Such fields are Philosophy, Literature, History, and Religion.

1. **Philosophy:** Philosophy helps man recognize and unmask the defects of modern science. It helps in understanding human nature, and it affirms to the truth about human distinctiveness. That distinctiveness which modern science fails to see as it deals with humans as simply one more member of the animal kingdom like the rest of the non-human ones. Philosophy helps in truly knowing man in his totality, through the study of what he is and through the study of what he does. This is in contrast to modern science’s knowledge of man which is reached through simply the study of his material makeup and evolution. Philosophy also helps in understanding human existence: inwardness, freedom, purposiveness, wishing, loving. As to these concepts that make up the richness of human life, modern science, no matter how much it tries (expressing them in terms of electro-encephalic activity, chemical neurotransmitters, etc), will always fall short in defining them completely. Same goes with other concepts that are indispensable to good medical practice, such as truth (and error), human freedom, and human dignity. Science in itself can never recognize and explain them, but philosophy, yes.

Special emphasis is given to the specific philosophical fields that are more directly relevant to medical practice: Anthropology and Ethics. Anthropology, so as to obtain a total understanding of man, and Ethics so as to comprehensively situate oneself in man's end and conduct.

An important point needs to be included as regards the type of ethics that is even more directly involved in the medical profession: Bioethics. Both Kass and Ramsey warned against falling into the (heartless) bioethics that is hyper-rational and that simply functions on the basis of learning and applying principles. Not an ethics as theory with application, but instead, ethics as practice with reflection. A truly human bioethics that seeks to keep human life human; always keeping in view the defining and worthy features of human life.

2. **Literature:** Virtue, according to Macintyre, is not a disposition that makes for success only in some one particular situation. The habitual practice of the virtues that is desired for the medical profession, will truly be stable, habitual, and ingrained as character when the practice of the virtues is done in all aspects of the life of the doctor. The doctor can be qualified as genuinely

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103 R. Spaemann, "Ars Longa, Vita Brevis", cit., 6
104 E.D. Pellegrino, "Professionalism, Profession and the Virtues..." cit., 38
possessing the virtues when he manifests the virtues in very different types of situation. This refers to the unity of human life that Macintyre speaks of. Hence, it would be helpful also if the doctor learns through role models or through institutions and education, how the virtues are lived and how virtuous people live, not only within the sphere of the medical profession but in the unity of each lives, in human life in general.

According to him, the unity of a virtue in someone’s life is intelligible only as a characteristic of a unitary life, a life that can be conceived and evaluated as a whole. This type of evaluation which the person in question cannot perform by looking at his own life alone, since total view of it is impossible. A person can have access to this view only through narrative account seen in third person perspective.

Macintyre considers narrative history to be a basic and essential genre for the characterization of human actions. From narratives, one gets access to looking at human actions from a broader and richer point of view: in their motives, passions, intentions, proximate and final ends, virtues involved or lacking. All men live out narratives in their lives and they get to understand their own lives in terms of the narratives. The form of the narrative is appropriate for understanding human actions: one’s own and that of the others. The narrative helps one in understanding better his being human, personal, and relational.

As to the relational aspect, it helps one realize that the narrative of any one life is part of an interlocking set of narratives, where one action in one part affects the other. For the doctor, such perspective helps him to be more conscious of the reality that a big picture exists and needs to be considered. That indeed, there is a bigger picture beyond the twenty-minute consultation with the patient; that an indiscriminate medical decision, for example of doing a genetic screen, done in two minutes, barely with any reflection whatsoever, can have results that would impact not only the patient’s current physical and mental state, but his existence: the way he sees life, his relations with the others, his vast life story.

And since one’s narrative understanding of human life cannot be fully captured through looking at one’s life only, Macintyre recommends looking at human life through literature and even through accounts of human life in history.

3. History: The same promising formative role of exposure to the narrative genre holds true with history. Seeing the presence of virtues in those doctors in the past, who with all moral integrity and unity of life, have lived the medical profession in an edifying manner, can serve as sources of good role-models. Getting acquainted with historical events where the lack of faithfulness in the true nature of the medical professions, on account of the lack of virtues could serve as a lesson. The evils for example, of research among subjects who were not in the position to give their informed consent: the convicts in France in the 15th century, the prisoners in concentration camps during the war, the mentally retarded children in the case of Willowbrook in New York, and etc. These accounts give an impact, stronger perhaps than any ethics book can produce, on the importance of the informed consent, as an expression of the recognition and respect for the dignity and responsible freedom of the patient.

4. Religion: The other resource which Kass believes as available for man, in the quest of defending life against the dehumanizing threat of modern science, is Sacred Scriptures. This is, according to him, in so far as the bible offers a profound teaching on human nature, in relation to the deepest longings and concerns of man. The Bible perfectly addresses man in his humanity, in his nature as an existentially engaged human being whose day to day existence and actions are necessarily affected by the answers to his deepest longings and questions of his origin, end, the meaning of the world and his task in it. The Bible speaks of the order of the world and its intelligibility, the goodness and hierarchy of beings, the powers of God and man’s participation in them-- and hence his special status, his being gifted. Kass clarifies however, that the Bible does not claim competence over self-evident demonstration of these truths. Besides, philosophy is already there

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105 Cf. A. Macintyre, After Virtue, A Study in Moral Theory, University of Notre Dame Press, 1984, 204-205.
106 Ibid, 227.
107 Ibid, 208-214
108 Ibid.
110 Ibid.
111 Cf. P. Ramsey, The Patient as Person, cit., 47-48
112 Cf. L. Kass, "Keeping Life Human, Science, Religion and the Soul" cit., 31-46
for that. What the bible does is it helps man confirm these truths through an act of self-reflection. The bible expresses the truths of life not only in the level of knowing but also in the level of action: that field where the moral virtues properly come in. It expresses truths of life in action such as the wonder and awe in face of the transcendent, love, procreation, civil life, and free, responsible deeds in responding to the call to righteousness (justice), love of neighbor, and perfection. What is seen in this part is the strong influence of one’s religious insights in complementing and reinforcing all the other means of humanistic formation. Kass himself, a strong believer of the powers of liberal education, recognized that humanistic education cannot alone provide the moral foundations of persons; especially if they are already eroded from the start. It cannot by itself, produce virtuous doctors, empowered with practical wisdom; who are especially needed in this age. The complementary role of the formation of religious insights and convictions, in the families and in the religious communities, is indispensable. And this conviction is embodied in his phrase: "[It is] not for nothing that the good book says that the beginning of wisdom is the fear [awe, reverence] of the Lord".

Conclusion:
Basically, this study presents the foundations that support the promising role of humanistic formation in the challenge of humanizing medicine. As to its practical application, the possibilities can be endless (promoting family life and religious worship, promoting medical societies and associations, including humanistic courses in the medical curriculum, offering extracurricular activities/ classes/ talks/ seminars, promoting reading of literature and study of history, etc). These possibilities can serve as topics for future studies. What we know is that whatever intervention or means that can be utilized for the true promotion of the particular institutions and the particular education, will be instrumental in helping the medical professionals educate the affectivity, grow in virtues and in religious insights, hence leading them to the acquisition of practical wisdom.

Going back to the problem that was intended to be solved in this study, the loss of the sense of what is human in medicine, I admit that the definitive solution is not simply humanistic formation. We know, as the encyclical Evangelium Vitae affirms, that the loss of sense of man and loss of sense of sin is ultimately due to the loss of sense of God. When the creator is not considered, the creature vanishes, the creature is neither considered. The definitive answer is to bring back the sense of God. The definitive solution on how to humanize medicine is then Christian Formation: upholding one’s “sense of God” through a life of prayer, sacraments, doctrinal formation, ascetical struggle, and the practice of the supernatural virtues.

However, this does not take away any merit or importance to the role of humanistic formation. This is insofar as Christian formation needs human formation. Just as the supernatural virtues presuppose and perfect human virtues, and just as grace presupposes nature.

The road of human formation is not unconnected to the road of Christian formation. They are both, continuous, mutually-related roads, which, trodden together, will help the physician in putting modern medical science in its proper place, and hence contribute in the promotion of a truly human and humanizing medical practice.

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XIV. Final Resolution

On October 1-4, 2014, the FIAMC and CPGP held the 24th FIAMC World Congress and the 78th Annual CPGP Convention which focused on the theme, « The Catholic Doctor in an Era of Secularization and Technology ». Two hundred seventy five (275) participants attended the International Conference held at the Manila Hotel, Manila. Lectures, prayers, fraternal agape combined harmoniously to make this gathering of Catholic Doctors, clergy and healthcare providers, a fruitful and joyful one.

We proudly and publicly manifest our catholic identity through these Resolutions:
• to work together for what is right no matter what it costs;
• to promote human dignity and the rights of every human being;
• to defend freedom of conscience and religious conscientious objections;
• to protect life from the moment of conception amidst the culture of death;
• to be loyal and faithful to the teaching magisterium of the church;

• to recognize that despite cultural differences, our approach to science is guided by ethics and faith;
• and to promote the joy of service to God through caring about His poor.
Resolved that the FIAMC adapt the aforementioned resolutions on this fourth day of October in the year of our Lord two thousand fourteen.

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**XV. First message of the New FIAMC President**

*John Lee, MD (Singapore)*

« Dear brothers and sisters in Christ,

I would like to thank all of you for it is indeed a great honor to be elected as the President of FIAMC. Thank you for your trust in me but I feel totally inadequate for the task in hand. However I am comforted by the thought that Jesus chose an ignorant fisherman rather than a learned rabbi to lead the Church. The phrase “Be not afraid” which Pope John Paul uttered at his election to the papacy echo in my mind alleviating some of my apprehension.

The role of FIAMC in today increasingly secular society in becoming more and more important. We, the Catholic doctors are probably one of the last line of defence against the strident anti-family and anti-life forces, or what St Pope John Paul II called the “Culture of Death” which he prophesied would afflict society.

Perhaps it is providential that I should bring my term of office with a pilgrimage to Turkey in the footsteps of St. Paul the indefatigable missionary. I promise to pray for each and every one of you and in return I hope that you will pray for me and all the officials of FIAMC.

I am grateful to Dr Jose Simon, the immediate Past President and the Secretary General Dr Ermanno Pavesi for agreeing to assume most of the ceremonial functions especially in Rome which I would find difficulty attending because of the geographical distance and language barriers.

This would free me to concentrate on what I consider to be the most important task facing FIAMC which is to continue developing FIAMC into a truly international family and to help individual especially the younger members and medical students grow spiritually and be formed as Catholic doctors. I have established a committee to be lead by one of the pillars of FIAMC Dr Kevin Murrell comprising of young doctors from every continent. The committee has already met and have thrown up several interesting suggestions. The Asian Federation at its EXCO meeting at the 24th FIAMC Congress has also enthusiastically embraced the formation of the younger doctors and is considering organizing a parallel Congress for younger members and medical students.

I have also discussed with Dr Robert Walley the institutionalization of Matercare International as the obstetric and gynaecological wing of FIAMC and tasked him to set up a committee to crystallize how FIAMC as an organization can promote motherhood and protect life from the very beginning. Together with Dr Elvis Seman and Dr Chazan he has promised to submit his recommendations soon. In the meantime to demonstrated your support for the dignity of human life I urged every one of you to sign the Declaration of Faith which can be found on the Matercare website ([www.matercare.org](http://www.matercare.org)).

This important document declares our belief that life begins from the moment of conception. At a meeting of the Presidency with Dr Jose Simon, we have also agreed to set up a Bioethics Committee which will invite experts on various issues like contraception, lesbian gay rights, abortion to set up task for to develop position papers and gather supporting studies so that any member organisations facing these issues to use as resource material. We will also be setting up a Missions Committee to support the development of mission work as an expression of our Faith in Action.

The Presidency will also work to expand the membership of FIAMC from its present membership of 78 countries. At present some EXCO members are tasked with developing Catholic Medical Guilds in countries like Cambodia, Papua New Guinea and the Solomon Islands.
All these projects will necessitate upgrading of communications between member organisations and FIAMC through the social media like internet, face book, blog sites etc.

The task of developing FIAMC as an effective international voice for the Church cannot be the responsibility of the FIAMC EXCO alone and is the duty of every Catholic doctor. No contribution is too small or meaningless. As blessed Mother Teresa said, “we may feel that what we are doing is just a drop in the ocean but the ocean will be less because of that missing drop”. If you wish to contribute in any role or have any ideas or suggestions please write in to the FIAMC secretariat. I promise you that we will take your offer of help and suggestions seriously.

I implore each one of you to be the salt of the earth and not to just file away the resolutions of the Manila Congress until we meet again in 4 years time.

I would like to thank the previous EXCO especially Dr Jose for their services to FIAMC and their continued guidance. A special note of thanks to Cardinal Oswald Gracias for making the tremendous effort inspite of his busy schedule to spend time with us and for his support of FIAMC. We are inspired by the encouragement from our beloved Pope Francis in his message to us on the occasion of the 24th FIAMC Congress. I would also like to thank the organizers of the Manila Congress for fantastic job which they have done at short notice and their warm hospitality. I don’t think that any of the participants will forget this Congress. Most importantly I would like to thank God our almighty Father for all His providence and pray for His continuous blessing upon all of you. May our blessed Mother Mary protect you and the Holy Spirit guide you in your effort to be a true Catholic Physician. Thank you and God bless.”