

FOURTH PLENARY ASSEMBLY: WORKSHOP DISCUSSION GUIDE**THE ASIAN LAITY IN THE WORLD OF HEALTH SERVICES****INTRODUCTION**

We are all aware that a large proportion of miracles performed by our Lord Jesus Christ were related to the healing of the sick in body and mind. The Church from its inception has been rightly credited for its developmental work in the field of health. This work, however, has been the result largely of the activity of clergy and religious in most countries, or at any rate, in the developing world. Involvement of the laity has not been prominent even in this highly specialized area, which should rightly belong to the laity because of their expertise. Moreover, Church hierarchies in most countries — it would appear to a layman — have given a low priority to the development of a laity engaged in the healing mission of the Church. Traditionally, it is true that Church authorities, probably for good pragmatic reasons, have concentrated and directed their energies on crisis after crisis — a form of governance by crisis. If this is so, we can state that in Asia today we are fast heading to a crisis point in the field of health, particularly with regard to bio-medical issues, which pose serious moral and ethical questions and raise a multitude of pastoral problems.

I. THE REAL WORLD OF THE HEALTH SERVICES

Catholic laity in the health services live every day in the presence of the marvelous advances of medicine, and for these we praise Almighty God for his gifts of human ingenuity and endeavor. But we also are confronted every day by developments which tend to overthrow his reign on earth. And it is these latter which are for Catholics at once challenges and problems, and give a changing moral cast to the lay vocation in medicine. We consider only a few here.

This discussion guide has been prepared for the workshop sessions of the Fourth Plenary Assembly of the Federation of Asian Bishops' Conferences (FABC), convening at the Major Seminary, Tokyo, Japan, September 16-25, 1986. The theme of the Plenary Assembly is: "The Vocation and Mission of the Laity in the Church and in the World of Asia."

1. Abortion

The moral malignancy of abortion is being ignored to a greater extent day by day. Catholic health workers in most Asian countries are increasingly aware of the high incidence of abortions in their countries. In India, abortion clinics are advertised in trains and buses. Even young school children are no longer ignorant of such matters. Abortion is now available on demand for all practical purposes.

Does this general acceptance of abortion affect our Asian Catholic brothers and sisters? The answer is a most emphatic affirmative. To give some examples. Careful studies in two Indian cities have shown that comparatively more Catholics had resorted to abortions than have members of other religious communities. This was attributed in large measure to the purported liberal and Westernised attitude on the part of Catholics. In another study it was observed that while ten years ago a large percentage of those Catholics who availed themselves of abortion facilities in a public hospital belonged to a low social class, in recent years these are young Catholic families, where both partners find it necessary to work, who are reluctant to start a family soon and prefer to postpone pregnancies. Should their methods of birth spacing fail, recourse to abortion is frequently the chosen option. Inquiries among the young couples resorting to abortion early in marriage indicate that both partners cannot afford to discontinue working, which would be necessary if the pregnancy was allowed to proceed uninterrupted. Under these circumstances, it is likely that such couples would not resort to abortions if they could be assisted in the care of their infants through day-time creches at the parish, diocesan or community level. Such a development would be welcome in many developing countries.

Hearsay evidence from other Asian countries has it that a "liberal" attitude to abortion or its acceptance also prevails widely, but precise data is hard to obtain.

Abortions are readily performed in most public or governmental hospitals in Asia, as may be expected. Unexpected, however, is the fact that an occasional Catholic hospital, managed by religious, or a nursing home run or owned by Catholics, also permits abortions by their staff. What is surprising in these institutions is that no heed is taken of the bishop's advice.

A matter for anxiety and concerted action internationally is the compulsion that is exerted on medical post-graduates wishing to specialize in obstetrics and gynecology to perform abortions. If such specialists-in-

training refuse in conscience to conduct abortions, they are denied facilities to specialize. This being so, it is not difficult to foresee that ten to fifteen years from now there will be an extreme shortage of adequately trained Catholic obstetricians and gynecologists. This situation already prevails in many countries of Asia, Europe, Australia and elsewhere. Apart from reiterating that no Catholic may perform direct abortions, what positive action should be taken to allow Catholic medical post-graduates to specialize in this sensitive field of medical services? This serious difficulty has been studied for the past two years in some places and international cooperation requested among Catholic institutions, but to no avail. Do the bishops of Asia share this concern? What solution do they offer? Can they really influence the religious congregations who own the hospitals to come together for a greater good, to "merge" their beds in order to qualify and meet the requirements of universities and medical licensing bodies for the purpose of obtaining recognition as institutions for post-graduate training.

2. Natural Family Planning (NFP) and Contraception

Despite the wide publicity and scientific advances made in NFP, it is surprising that the majority of Catholics is still ignorant of its reliability and reluctant to use this method. Under these circumstances it is only natural that non-Christians will remain ignorant or sceptical of NFP. In some quarters, NFP is associated too closely with the Church and is often called the Catholic method of family planning. Certainly, more needs to be done to promote this method among the huge number of non-Christians who also resent artificial methods of contraception for family planning.

It is observed by many that the main obstacles to the spread of NFP are the clergy and the medical profession. While doctors may change slowly, it is sad that the clergy should even constitute an obstacle. So often one hears of penitents being told to follow their own conscience — more often, an unformed conscience — without any attempt made at informing the individual conscience. Is it then any surprise that an increasing number of young married Catholic couples are turning towards artificial contraception, and when it fails, to abortions, followed by permanent methods of contraception.

In some countries where NFP activities are multiplying, an image has been created in laity circles that there is much competition and internal criticism among the NFP promoters or organizations themselves. Competition between groups is often healthy and stimulating, but destructive criticism helps no one.

3. Euthanasia

Whereas the legalization of abortion has been a topic of discussion and demanded action in the past twenty years, euthanasia should now be our preoccupation. Unfortunately, many in the Church were taken unaware by the pro-abortion lobby and tried to shut the stable door after the horse had bolted. History is likely to repeat itself if the Church is not vigilant. George Bernard Shaw rightly said that "if men learn anything from experience, it is that they learn nothing from experience."

The euthanasians have been increasingly active since the 1930's. Their programs, started in Britain, spread to the U.S.A., and have now extended to all the continents, including Asia. Initially these groups were easily identifiable by their titles, which included the word "euthanasia"; but since the 1950's, when these groups were revived, their names have been changed to "Societies for the Right to Die." These are found in Europe, North and Latin America, Australia, South Africa, as well as in Asia (e.g., in India and Japan). With the increase in their activities, they have founded a World Federation of Societies for the Right to Die. Theirs is an international stereotyped campaign. First, they try to show the creeping dehumanization in medicine in relation to the problems of dying and death, which can be solved by appropriate legislation. The second stage consists in showing that medical practitioners are reluctant to stop ineffective treatment of the terminally ill for fear of litigation, and, therefore, legal immunity from lawsuits should be provided doctors who choose to discontinue all treatment. The avowed purpose of the promoters of the Right to Die Societies appears, from a review of their own statements and publications, to move progressively in this way: a) death with dignity; b) immunity for doctors stopping all treatment for the terminally ill; c) negative euthanasia; d) acceptance of voluntary euthanasia; and finally; e) active euthanasia itself.

In the following paragraphs, some thorny issues requiring attention are presented, but this is by no means a comprehensive list.

Surveys in India and Japan have confirmed that the public, as well as the religious and clergy, are often confused about the terms used, i.e., active and passive euthanasia, mercy killing, dying with dignity, right to life, right to die, allowing to die, etc. Moreover, it is also probable that some of the confusion has been deliberately created. A pointer in this direction is evident from the two different meanings given to "passive euthanasia" in recent years. In the distant past, passive euthanasia, which was morally acceptable, was akin to "letting die" or "allowing to die." In a sense, death was produced by the disease process. In recent years, the term "passive euthanasia" is used for that form of medical management of a patient, born seriously defective or a terminally ill individual, in which no

active measures are used. In this case, death occurs as a result of an omission of effective, and readily available, treatment. In fact, this "negative act" or "omission" constitutes in reality direct euthanasia. The euthanasians, despite being aware of this basic medical distinction, proclaim as widely as possible that they are only for "passive" euthanasia and to select audiences emphasize that the Catholic Church, as well as the Pope, accepts it. Thus they imply that their movement is supported by the Catholic Church.

At the last World Congress of the Federation of Right to Die Societies held in 1984, it was reported the delegates advised that the distinction between active and passive euthanasia in the minds of philosophers and doctors be finally put to rest. This would presumably represent an advance for their campaign, again under camouflage, and many more will be hoodwinked. A second fact that emerged from the 1984 Congress was the "gradual acceptance of active euthanasia by organizations and members, if not yet by the public; passive euthanasia had already proved generally acceptable in 1982." These few facts surely suggest that some of the confusion is deliberately created and does not happen accidentally.

A particular expression which frequently causes confusion is the "right to die." This expression was introduced by the euthanasians and is used explicitly by the Holy See in the "Declaration on Euthanasia" of 1980, but the two meanings are contradictory. Understandably a conflict of understanding arises when this term is used. The simple man in the street is impressed when the euthanasian states that the right to die is acceptable to the Church. Much instruction and counselling is therefore needed from our pastors, especially since a plurality of opinions among Catholic theologians seems to exist in the euthanasia debate.

4. Suicide

According to our Church teaching, suicide is "equally as wrong as murder" (Declaration on Euthanasia, 1980), excepting for a "sacrifice of one's life for a higher cause such as God's glory, the salvation of souls or the service of one's brethren, when a person offers his or her own life or puts it in danger." On the other hand, St. Augustine castigated those who toyed with the idea of suicide on the excuse of safeguarding virginity and other ethical virtues, as fools and madmen. We now have some theologians who argue that there may be good reasons for self-killing. They say it cannot be considered always objectionable, and therefore each case should be considered on its own merit, to determine whether it is permitted for not. This argument is extended simply to state that suicide may not be immoral, and this is precisely the thrust of the euthanasians, who demand the acceptance of voluntary euthanasia.

5. Proportionate and Disproportionate Methods of Treatment

This terminology was used in the Declaration on Euthanasia (1980) in preference to the older terms — ordinary and extraordinary measures of treatment. It is well accepted universally among moralists, ethicists and the medical profession that there is no obligation to use disproportionate or extraordinary treatments in dealing with the terminally ill. Differences, however, of opinion arise with regard to the meaning of the words themselves, i.e., proportionate or ordinary, and disproportionate or extraordinary. Here again, the dispute can be limited to the meaning or content of the words “proportionate or ordinary measures.” What do these words imply? Do they refer to the discontinuance of all nursing and medical measures, such as relief of pain, prevention of bedsores, the supply of oral food and drink, or the provision of nutrition and fluids through a stomach-tube (Ryle’s tube) or by means of an intravenous drip, or at a more intense level of treatment, by the maintenance of “parenteral hyperalimentation,” which can be expensive, tedious, uncomfortable and frankly painful? Some hold the view that for the truly terminally ill every one of these measures can be ethically withdrawn. This position is very close to that adopted by the promoters of the Right to Die Societies. For them a stage may come in the process of dying of some individual that the discontinuance even of nutrition and basic medical treatment may be permitted in some community or other at a particular moment in time. Therefore, we can admit that judgments of what is morally or ethically right or wrong may vary from one patient to another. Nevertheless, no one can generalize that the basic maintenance of medical and nursing assistance may be withdrawn from the terminally ill; and on this basis, set up legal measures to provide legal immunity to medical practitioners who stop all maintenance treatment because of a previously announced request of the patient (living will) or at the demand of authorized relatives during the terminal illness (proxy). But this is precisely what the euthanasians hold. The thin edge of the wedge!

It is precisely this approach of some moralists and ethicists that lends support to the international campaign of the euthanasians all over the world. There is no doubt that the ardent promoters of the pro-euthanasia societies or the Right to Die groups in the developed world intend in reality to force society to permit active euthanasia. This is evident from a perusal of their own publications.

Many public opinion surveys have been conducted in different parts of the world. With the exception of a few from the U.S.A. and a recent one of the FIAMC Bio-Medical Centre in Bombay, the vast majority have been imprecise and poorly conducted from the scientific point of view. Yet these have been given much publicity in the media on behalf of

the euthanasians. From their studies one would conclude that almost all individuals would welcome a "good death." This has been equated quite wrongly with euthanasia. Contraindications of these conclusions are not, however, published for a variety of reasons by the majority of newspapers and other periodicals, since apparently such comments are not "newsy." This lacuna needs special attention, since it is our obligation to inform not only the Catholic community but also others in our pluralistic societies, most of whom are believers in a Divine Being, and therefore affected by these transgressions against humanity.

Influencing public opinion has always had a high priority for the euthanasians. Much money is collected internationally and spent for this purpose. They try to show that the "social establishment" in different countries, and particularly the various religious groups, such as the Catholic Church, support their point of view. For instance, news headlines, such as "Cardinal Benelli resorts to euthanasia," and "the Pope overruled his doctors," are published in their newsletters. Of course, crucial details are not provided and the undiscerning are misled. It is the opinion of many observers that the Right to Die Societies and very many of their members are anti-Church.

It may appear that this section on euthanasia has only been one of carping criticism. Attention must also be directed to the many positive actions for assisting the chronically or terminally ill. In this way we will be adding to our list of "do's." We need the establishment of more old people's homes, hospices for the terminally ill, homes for severely retarded or disfigured children and homes for the chronically ill. These institutions are extremely necessary in our Asian communities and will represent our concern and contribution towards the loving care of the chronically and terminally ill. However, a word of caution has been sounded in the U.S.A. where, it appears that many members of the Right to Die Societies are also active in the hospice movement! We should be alert to this in Asia.

6. Advances in Genetics

The science of genetics has made great advances in the last twenty years and the future holds even greater promise for the benefit of mankind. However, it is in this area especially that young scientists in our recent past gave up their quest for this new knowledge, when they realized the great potential also for harm to the human race. Genetic engineering has already helped us in devising new methods of cultivating more effective varieties of drugs, such as insulin. Other simpler genetic procedures have for some time been in use even in our Asian countries such as Japan, Korea, India, and perhaps elsewhere.

The simpler procedures in vogue in some Asian centers include amniocentesis and chromosomal studies. During pregnancy, the fluid surrounding the growing foetus in the amniotic cavity is tapped (amniocentesis) and the chromosomal contents examined. Such a study will enable a determination of the sex of the unborn child or the presence of some serious congenital or familial genetic disorder.

In many Asian countries, it has been reported that the most common use of amniocentesis is to determine the sex of the foetus. If it is a male the pregnancy is nurtured; but if it is a female, an abortion is often procured. Clearly an immoral use of a good scientific procedure.

Amniocentesis is often used also to ascertain prenatally the presence of inherited genetic diseases which may result in the birth of retarded infants or those with serious long-term defects, which may cause extreme hardship to the families. In such situations, the parents are generally counselled to abort the pregnancy, obviously for eugenic reasons. Occasionally, the parents (frequently Catholic) decide to continue with the pregnancy and make arrangements to look after the affected infant. It is here that our Catholic parents and families have to be supported in caring for their burdens.

A much publicized development of the giant jump in knowledge and expertise is what is popularly called "in vitro fertilization." This is a recent development, with progress being made almost daily. The permutations are many, i.e., use of the sperm and ovum of a married couple with implantation in the wife; use of donor (vendor) sperms for fertilization and location in the wife's uterus; husband's sperm and use of a surrogate uterus for the furtherance of the pregnancy; implantation of a donor zygote in the wife's uterus, and so on. A variety of situations have to be considered here and in the view of the complexity of the subject, no easy formula can be offered for a determination of the ethical nature or morality of the act.

Yet another aspect of genetic disorders which has been with us for some time relates to sex-change operations in those with true "mixed sex" codes or transvestite trends, wherein the affected individuals have an intense desire to present themselves as members of the opposite sex.

7. Rehabilitation of Alcohol and Drug Addicts

The incidence of addiction to alcohol or drugs is steadily increasing in some of our Asian countries. These individuals come from all strata of society and professions. They need assistance — particularly that of our Church which, from experience, is well positioned to assist successfully institutions and committed personnel.

8. Non-Christian Asian Medical Organizations

From the turn of the century, the laity have been increasingly advised to participate actively in matters political and social, for temporal interests are truly the domain of the laity. It is here that the laity is especially called to give witness. In a similar manner, the Asian health worker is required to participate in a "like to like" apostolate among non-Christian health workers in our part of the world. This is particularly true when it comes to working in organizations which aim to safeguard the human dignity of the individual and ensure that the fundamental rights of all are safeguarded. We know doctors have been known to be involved in the administration of torture to prisoners or to use their medical expertise to resuscitate prisoners so that they may be tortured again. In some countries doctors have also devised means of torture. Moreover, torture has been used not only on "prisoners" but also sometimes on health professionals.

In 1984 an International Commission of Health Professionals was founded in Geneva for the preservation of health and human rights. This embraces men and women of all religious beliefs and would be an area where our Catholics could profitably exercise themselves. This type of activity needs to be encouraged.

9. Bio-Medical Ethics

There is little need to emphasize how essential this is today.

Our Catholics need to be updated on bio-medical advances which affect the lives of men and women and often present serious pastoral problems. It is certain that if the public had been vigilant, some of the unethical practices of our medical colleagues would not now be permitted. On the other hand, the Catholic laity needs also to be informed what is right and wrong. For instance, some years ago, under pressure to reduce the increasing population, active members of some Catholic organizations joined others in calling for the sterilization of those suffering from leprosy and tuberculosis, in the mistaken view that the practice was ethical.

CONCLUSION

A general comment would at this point not be out of place. For far too long have we of the Church discussed such topics in homilies, articles, seminars or the like and concluded that the issue in question is immoral or unethical and added it to a list of "don't's." It is only on rare occasions that the implications of our moral judgments have been considered in detail and positive action subsequently proposed. It is therefore suggested that the participants in this workshop, when dealing with specific issues, attempt to formulate a list of "do's" in addition to the traditional "don't's." This approach will certainly be more helpful and pastoral in content.

II. HOW CAN THE CHURCH HELP THE LAITY IN THE WORLD OF HEALTH SERVICES?

We have considered the challenges and problems facing our laity where they can fulfill their Christian mission in the health services. Our principal aim in listing these areas which create true "crises" of conscience is to sharpen the understanding that the Catholic dimension — beyond the needed professional competence — is the moral dimension — how to bring the saving power of Christ to transform and fulfill this part of the Kingdom of God.

We offer here in a brief way some areas for Church activity, much of which the Church has undertaken, but offered now with a plea that more be done, the quality of what has been done be upgraded, and that new undertakings be made.

1. Moral Formation

For those intimately involved with matters of birth, life and death, as health workers are required to be, medical knowledge and expertise are undoubtedly necessary in their chosen professions. Such professional formation, however, is beyond the scope of the Church's work. Nevertheless, health workers — be they medical students, doctors, nurses, pharmacists or hospital administrators — must know and be committed to what is morally right or wrong, according to the Gospel. As we look at it, the moral formation of health workers is above all else essential. This does concern the Church. What indeed is the reality?

We are fortunate that, in spite of the dearth of formal courses or programs of moral and spiritual formation for health workers, there are many outstanding examples of upright Catholic medical students, doctors, nurses and administrators, but their number could be considerably increased. Some interesting examples will suffice to bring home this point. In a South East Asian country many Catholic doctors were convinced that abortion in the first three to six months of pregnancy was permissible according to the teaching of the Church, and that under certain circumstances euthanasia ("active euthanasia") was also permitted. On close questioning about a variety of professional situations, according to a theologian, the doctors, students and nurses simply were not aware that any moral responses were involved, and did not distinguish between right and wrong, even in matters of false medical testimonials and certification.

In another country, some Catholic doctors, like some of their Western counterparts, refused to accept papal teaching on matters of contraception, and proceeded at a meeting some years ago to pass a motion of "no confidence" in the Pope. Fortunately, a vigilant chairman suc-

ceeded in adjourning the meeting before any business could be transacted.

Other examples include the performance of sterilization in hospitals run by the religious in some countries — not out of a commitment to an “avant garde” theology, but simply out of sheer ignorance of the pertinent moral values.

More recently, an example was given of an especially bright young medical graduate involved in research on human embryos, but totally unaware that any moral principles may be transgressed. What was surprising was that this lady was otherwise a committed Catholic.

Much time and space could be wasted in relating so many “horror stories,” all of which go to prove the lack often of a basic Christian moral formation among many health workers in our continent. Certainly, such a lacuna is worthy of urgent attention, for how otherwise can health professionals give a true witness among their colleagues, who may come to know what is right or wrong only by observing the actions of their Catholic associates?

2. The Teaching of Medical Ethics

The teaching of ethics to medical students has by and large been nonexistent in most parts of the world. This does not detract from the fact that medical students were usually taught ethics informally by other doctors at the bedside of an ill person. In recent years, even this has not been progressively possible owing to the tremendous increase of medical knowledge that has to be communicated to the student in well-packed formal sessions of study.

Moreover, medicine as a career has now been increasingly influenced more by a “business ethic,” rather than by the traditional professional or “vocation ethic,” for a variety of reasons. Despite this trend to medicine as a business, it can be said that the medical students themselves are interested in discussions about ethics, if we judge by their comments whenever such occasions have been organized. Unfortunately, there is a paucity of qualified teachers. Let us say here, a similar situation prevails among Catholic medical students.

At a meeting of Asian Catholic doctors, in late 1984, it was indicated that in most parts of Asia the teaching of medical ethics to medical students was generally of a low order or next to nothing, although some courses had been started at the National University in Thailand. In the Asian Catholic world a modicum of teaching of ethics was provided at Catholic medical schools in Seoul, Manila and Bangalore, but there was

still great room for improvement. Among the reasons advanced for this lack were the usual ones of shortage of time and of qualified personnel. Another, perhaps amusing, cause advanced was the reluctance of some to teach ethics to medical students, since they were thought usually to be bright intellectually and did not need to be taught ethics.

The absence of interest in ethics, for whatever reason, even among Catholic medical students, can be measured by the lack of entries for an ethics essay prize in two centers of a large country over a period of a few years.

Nurses and Ethics

The teaching of medical ethics to nurses regarding issues pertaining to their work and attitudes is still more dismal. As far as we can find out, the formal teaching of ethics to nurses is either nil or negligible. Some courses on ethics and specialized books have been provided to Catholic nurses on a limited scale in Hong Kong and Korea; there is no information about other Asian countries. What does cause concern, however, is that in India, where information is available to us, there is a reluctance to teach ethics in Catholic nursing schools. One wonders about the situation in other Asian countries where the Catholic medical and nursing infrastructure may not be so well developed.

3. The Mass Media

In most Asian countries, health professionals are in urgent need of media support to inform the public of their particularly Catholic programs, to assist in the formation of health workers, and Catholics in general, in Catholic morality and medical ethics, and to publicize health work and its moral dimensions in our pluralistic societies. To achieve these goals at the diocesan, national and continental levels, some structures may have to be created to promote Catholic ethical practice. The Church must make use of Catholic periodicals to reflect faithfully the teachings of the Church and to form health services personnel.

4. Chaplains or Ecclesiastical Assistants

Professional, spiritual, moral and ethical formation is required at all levels, i.e., diocesan, national and continental; and fortunately, Church organizations already exist at these levels. However, the number of trained chaplains dedicated to the work of formation is small. Moreover, doctors, nurses and hospitals are, at the present time, often looked after by whatever priest may be available. Should this practice continue? Or should we rather consider it a requirement for competence that well-

trained individuals be dedicated in every diocese solely to the apostolate of health workers. Such a person's responsibility would be to supervise other chaplains, and to work with doctors, nurses, medical students, hospitals, NFP promoters, etc. We envisage a full-time assignment,—indeed a life-time involvement — with a continuity of personnel, and a co-ordination among all these groups in health work. This is very much an opportunity for a lay person.

5. Catholic Hospitals

Some general comments concerning hospitals will not be out of place at this juncture. Our Asian bishops are aware of the aims, objectives and performance of Catholic hospitals in their regions. In view, however, of the ownership or management of these institutions being solely in the hands of the religious or clergy, some questions may be asked here:

1. Should Catholic hospitals continue to be controlled by the clergy or religious? Should the laity be given control or a measure of control?

2. Can and should the bishops be able to influence significantly the conduct and management of Catholic hospitals? This consideration does arise at times when an occasional Catholic hospital chooses, after due consideration, to permit immoral and unethical practices, such as sterilization, abortions and the promotion of artificial methods of contraception. We have already spoken to the need Catholic hospitals to cooperate among themselves in order to combat the difficulties faced by medical specialists-in-training who are compelled to perform abortions during training at university or specialised centers in obstetrics and gynecology.

Other circumstances requiring the Church's guidance may include implementation of fair salary scales for the laity employed in Catholic hospitals; the preferential inclusion of Catholic doctors and nurses on the staff, subject to their being professionally qualified and willing to work effectively and harmoniously with the true Christian spirit in the institutions.

3. It may also be worth asking what is being done to encourage and form the laity to assume responsibility in Catholic hospitals, in order to counter the impression that the Church maintains hospitals solely for the purpose of proselytization.

6. Diocesan Health Services Commissions

The need for co-ordination at the diocesan and national levels should be recognized. It is only efficient that a health commission should exist at

diocesan and national levels where all health workers and institutions are brought together for a more effective apostolate. These commissions may also include moralists, theologians, ethicists, lawyers, economists and media specialists — all of whom are required to work together for God's Reign on earth. It is in such groups that the plurality of theological or ethical opinions on a particular subject can be profitably discussed and a united stand taken on a controversial topic. These health commissions at the diocesan or national levels may then effectively engage themselves in attending to the various issues of concern to the Church.

7. International Catholic Organizations in the Health Services Field

At this stage it would be helpful to outline the origin, history and present status of the professional Catholic organizations engaged in the field of health, even though the data may be limited. Hopefully, the participants in this workshop will be able to provide precise details of the health organizations in their respective countries and dioceses which would incidentally be well-worth disseminating.

At the present time, three groups are recognized as Catholic organizations involved in the field of health by the Holy See. These are:

1. The International Federation of Catholic Medical Associations (FIAMC in French).

2. The International Committee of Catholic Nurses and Paramedical Workers (CICIAMS in French).

3. The International Federation of Catholic Pharmacists (FIPC in French)

a. The International Federation of Catholic Medical Associations (FIAMC)

Pope Leo XIII, in 1884, in the encyclical *Humanum Genus*, suggested practical remedies for the evils of the times, which incidentally still exist. These included the formation and revival of guilds or associations of professionals, "under the auspices and patronage of the bishops" for the individual formation of the members and the welfare, both spiritual and moral, of society. We are faced today with the "secular Marxism" of the East and a "secular humanism" of the West, both of which are an accentuation of the conditions prevailing in the time of Pope Leo XIII.

The encyclical was followed in the same year by the establishment of the first Guild of Catholic Doctors in Paris. During the following year, similar groups were formed in Europe and U.S.A. Soon continental

(Europe) and intercontinental congresses were held and a need for co-ordination of the many national Catholic medical groups was felt. This resulted in the establishment of the first international secretariat in Paris in 1924, which was in contact with thirteen European groups, and one each in U.S.A., Africa, Asia and Latin America.

The large international congresses started in 1935 and dealt with the issues of the day. These congresses were interrupted by World War II but were resumed in 1947 and are continued to the present time at four-year intervals. The next is scheduled for August, 1986, in Argentina, which will deal in depth with three topics, i.e., euthanasia, ethical issues in genetics and the teaching of ethics.

FIAMC has a three-tiered structure. The first is the broad base of many national Catholic medical associations in different parts of the world. The continental groupings of these national groups form the second or intermediate tier. There are six such regions, i.e., Europe, Asia, Africa, North America, Latin America and Oceania.

The third tier at the apex is the International level of FIAMC with the general assembly of national federations and the executive committee. The Holy See appoints an ecclesiastical assistant from a panel presented by FIAMC.

FIAMC has four aims:

1. Co-ordination of the national Catholic associations of medical doctors for the study and spread of Christian principles in the medical profession.
2. The development of new national Catholic medical associations to assist the doctors in their professional, moral and spiritual development.
3. Participation in the general development of the medical profession in consonance with Christian principles and to promote health and social work in general.
4. Establishment of a counseling center for those in need in regard to bio-medical ethical problems and the teachings of the Church.

These aims of FIAMC are achieved by the organization of meetings and congresses at national, regional and international levels and by representation of FIAMC at international congresses and the forming of international organizations.

Other objectives include the publication of journals, reviews, bulletins and the exchange of scientists. FIAMC established in 1981 the

FIAMC Bio-Medical Ethics center in Bombay, which is a rapidly growing and active center.

The second tier of FIAMC comprises the continental or regional groups. These embrace all the national federations affiliated to FIAMC and located in any particular continent. Expectedly, these committees should co-ordinate the activities of the local groups, evaluate situations in their areas, represent them internationally in FIAMC as well as in other professional, non-denominational continental groups. The continental groups meet once in every four years, as a rule. It is of interest that the Asian group came into existence in the 1950's.

In view of the expected concern of the Asian Federation of Catholic Medical Associations (AFCMA), greater detail is provided without apology. National federations of Catholic doctors exist today in Japan, Korea, Hong Kong, Thailand, Philippines and India, where Catholic doctors are active to a greater or lesser extent. It is undoubted that much more can be achieved even in these countries for the professional and Christian formation of the individual, the giving of witness in the community and the spread of Christian principles in the respective medical circles. Associations, or national guilds of Catholic doctors, affiliated to FIAMC, are probably dormant in Sri Lanka, Nationalist China and Burma, and silenced in Vietnam. Formal groups of Catholic doctors are known to exist and work in Singapore and possibly Malaysia but they have for some reason been reluctant to join FIAMC. As far as is known, Catholic doctors have not grouped themselves in Pakistan, Bangladesh, Nepal and Indonesia, possibly because of their small numbers, and also because of restrictions on the formation of sectarian associations in their countries.

Assistance can be provided not only by way of funds but also in the form of personnel or an office establishment. This is borne out by the fact that the AFCMA has a secretariat in name only and comes alive every four years at the time of a continental congress when good meetings are held, resolutions passed and intentions to meet again proposed. Between conferences, nothing occurs usually at the continental level. Some form of communication needs to be established. Some training or formation programs must be initiated.

As indicated earlier, the first tier of FIAMC embraces all the member national federations. These include all the local guilds or associations in a particular country. The statutes are of the usual type but almost always include a statement that members conform to the teachings of the Church and that the local guild have the seal of approval from the local Ordinary.

Much of the work of FIAMC and the Catholic medical world is performed at the local and national level. Meetings (lectures, debates, workshops, symposia) on various topics are held at regular intervals, including occasions for social contact, which cement the bonds of friendship among Catholic doctors. It is these groups that often publish valuable journals, such as the *Linacre Quarterly* (U.S.A.) and the *Catholic Medical Quarterly* (England), and similar publications are produced in India, Korea, Philippines and possibly Japan. The national meetings which attract doctors from different areas in any particular country would ordinarily meet only yearly or every two years. Nevertheless, meetings at the local level are held between once a month to once in four or six months.

Programs or the nature of local activities take numerous forms. Some guilds adhere to practical activities, such as running medical clinics at weekly or more frequent intervals, aimed at the indigent. Others are engaged in intensive Natural Family Planning services or the promotion of sex education in schools. Many local guilds engage in academic or scientific sessions which assist in the professional formation of Catholic doctors by arranging talks or symposia on advances in some aspect of medical science, such as genetics, in vitro fertilization, respiratory medicine, sexually transmitted disease, determination of death, imaging systems, and so on. The Catholic professional must keep abreast of the advances in his field, especially if he is to consider thereafter the ethical implications. Nevertheless, the step from the purely professional scientific aspects to the moral and ethical dimensions is necessary. It is reasonably certain that there is no area of medical service which does not have its share of ethical problems needing consideration in this day and age.

One particular activity that appears to be universal and worthy of promotion is the celebration of St. Luke's feast each year on the nearest Sunday to 18th October. This is indeed the practice in many countries. It takes the form of participation in the Holy Eucharist, followed by some academic discussion or social activity. Yet another example of local programs includes a yearly "recollection," retreat, meditation or pilgrimage. Despite these many types of activities, organisers are often faced with a paucity of topics for discussion. But inspiration may be found in the perusal of annual programs of guilds (local or national) that are often advertised in FIAMC or national journals and bulletins.

Most of us resent change or innovation. Suggestions, such as "start a guild" or "organize a national federation," will extract responses such as: "How can we?" or "We are only a small group in a backward or developing country," or "We are too few." These are statements that are often heard. But it does not matter if we belong to a small group or are citizens

of a backward country. So were the Apostles — we are in good company. If the members are truly small, it may be worth joining with Catholic nurses or paramedical workers, as they probably face similar difficulties. The two groups could then stimulate and support each other. The juridical matter of affiliation to parent organisations such as FIAMC or CICIAMS, which is the parent Catholic organization of nurses, can be amicably settled later, if necessary.

Such a pragmatic approach should, however, be considered with caution when the formation of an ecumenical group or association is proposed. This is said advisedly because an ecumenical group must respect the feelings of all members and firm ethical opinions cannot always therefore be expressed. The ethical stance of some Christians varies from the Catholic in matters of sterilization, abortion and contraception, to name only a few areas. It will thus be apparent that an ecumenical group may not permit adherence to the teaching authority of the Catholic Church.

During the past ten years it has been suggested that FIAMC should represent Catholic doctors in the international corridors of power. On the other hand, we have had experience of a rejection of our interventions on the grounds that FIAMC does not represent many countries. True, we cannot openly have members in Communist or Islamic countries, but there is no such hindrance in the many other secular democratic nations, where there is a feeling that the group is too small, immature or whatever else. This reluctance to associate with FIAMC must be overcome if we are to speak out internationally in such circles as the World Health Organization and others.

It is often said internationally that in matters of life and death the wishes of those with strong principles, such as Catholics, should not be entertained. Instead, the opinions of those without such affiliations should be considered. Does this apply to those professing the Islamic faith or to those presenting themselves as atheists or humanists? As members of society we have as much right, indeed a duty, to present as strongly as possible our beliefs on basic or humanitarian issues and to be heard. All of us are well advised to recall the words of the well-known demographer, Dr. R. A. Gallup:

“Once you permit the killing of the unborn child, there will be no stopping. There will be no age limit. You are setting off a chain reaction that will eventually make you the victim. Your children will kill you because you permitted the killing of their brothers and sisters. Your children will kill you because they will not want to support you in your old age. Your children will kill you for your homes and estates.

If a doctor will take money for killing the innocent in the womb, he will kill you with a needle when paid by your children. This is the terrible nightmare you are creating for the future."

What will we do to avoid this nightmare?

b. The International Committee of Catholic Nurses and Paramedical Workers (CICIAMS)

We draw on the experiences of others, and in particular of Sister M. Ella, S.C.M.M., to describe what a contribution such an organization can make to the ideals of lay witness in this part of health work.

Sr. M. Ella, who is the vice president for Asia (CICIAMS), and the National Executive Secretary for India, reports:

After the First World War professional nursing standards in Europe fell very low and the whole idea of spiritually-based and vocational nursing seemed to dwindle away. Materialism and secularism invaded the nursing world and nursing became a profession, and money-making became its end for hundreds, if not thousands, of nurses. Then a group of Catholic nurses in Europe formed a small dedicated core to try and rescue the profession from its degradation, and reaffirm the spirit of commitment and its expression of Christ's compassion to the needy sick of the world. Gradually this came to the attention of the Holy Father himself and he encouraged it and wished it to spread over the whole world. With his help and backing it did spread to many countries in both East and West, and became an international organization, still with its center in Europe, but including many countries in the old and new worlds.

In the mid-fifties, due to this backing by the Supreme Pontiff, a new phase of its growth started. The Holy Father himself appealed to various countries to become part of it. For instance, in 1956 he sent the Pro-Nuncio of India to speak to the bishops of India assembled in council, to explain the aims and ideals of the organization and definitely requested them to start and develop a diocesan branch in every diocese in India and to have a National Catholic Nurses' Guild of India (CNGI) affiliated with CICIAMS (the international organization in Europe.) The bishops went back to their dioceses enthused with the message of the Pro-Nuncio. Catholic nurses were called together in diocese after diocese and urged to join such an organization. I was then a nurse in the well-known private European Hospital in Bombay at Breach Candy, one of Bombay's residential areas. Our parish priest certainly enthused us and explained how we were called to share in Our Lord's own apostolate

of healing the sick, and through that healing to learn and accept Our Lord's compassionate love for each of his human children. About half the dioceses started branches, in some cases using Catholic groups of nurses which already existed, and now we are organized on a national basis with national and diocesan officers helped by diocesan and unit ecclesiastical advisers — all Catholic priests.

The guild went from strength to strength and helped both to build up the lives of the Catholic nurses spiritually as well as to help them to realize and work as ones filled with Christ's healing love, which he wanted to give to the sick through the work of these dedicated nurses.

The guild has had its ups and downs like all organizations, but like the Church itself, of which it is a part, has survived crisis after crisis.

Now many new dioceses have been formed in India or former dioceses bifurcated, while bishops have died, retired and been replaced, as also the ecclesiastical advisers. Now there are new bishops who know little about the CNGI's origin or ideals, as there are ecclesiastical advisers. The latter are sometimes transferred and not replaced immediately, or if replaced, the new ones know little about their job.

c. The Federation of Catholic Pharmacists

This is a less well-known organization. It is interested in bringing Catholic principles of ethics into the pharmaceutical and pharmacy professions which deal with the production, promotion, sale and prescription of drugs. FIPC is not well known in Asia and it is therefore keen on furthering its activities in this continent. Inquiries may be directed to the secretariat at 59, Bergstrasse, B-4700 Eupen, Belgium. It is hoped that in the near future the FIPC will have closer links with both CICIAMS and FIAMC.

d. International Association of Catholic Hospitals

Two decades ago, an international association of Catholic hospitals existed but became dormant or extinct over the years, until October 1985, when an international congress of Catholic hospitals was convened by a small select international committee with the patronage of the Holy See. It is hoped that this group will soon proceed to establish and revitalize a recognized international federation of Catholic hospitals, with its own special mission and one which will work harmoniously with the other three existing Catholic bodies in the field of health, i.e., CICIAMS, FIAMC and FIPC.

The Asian region was well-represented at the Rome congress of Catholic hospitals by many delegates from some twelve countries, who elected India and Korea to represent Asia on the ad hoc group promoting the international federation of Catholic hospitals. There is little doubt that we shall soon have the Catholic hospitals represented on the world scene by an international organization recognized by the Holy See.

e. A Proposed International Catholic Health Services Center

Since 1982, Dr. Robert Walley of Canada has been promoting around the world the foundation of a professional center for Catholic health services. In October 1985, an international group of experienced Catholic health professionals met informally in Rome to consider this subject in detail. The participants included members of the clergy, religious and laity from different parts of the world.

The first question discussed was whether the Church was doing enough to meet current international problems in health care? It was clear to all that the Church had a fundamental commitment to the provision of health care, especially at the grassroots level through the development of community health. The focus should be on the dignity of all human beings and their families with primary health care as the method. This was seen as important not only to the Third World but also to the First World also.

The second question raised was whether a new international body was necessary within the Church? There emerged a general agreement on the need to provide a structure which would enable Catholic health care professionals to integrate their professional roles with their faith. A clear need was identified for a body of health professionals who had the ability to train others to undertake the Church's health care ministry in their own countries.

The lack of communication between the Church's health care ministry and the international health care world was seen as a major weakness. There has to be a means for health professionals in general and physicians in particular, as Catholics, to speak to other health care professionals, whatever their beliefs may be. Obviously this will be extremely valuable in developing the Church's objectives in health care. An example of this was natural family planning and its lack of acceptance by health care professionals in general because very little is said about this subject by health professionals. Physicians, for example, whether they be Catholic or non-Catholic, simply do not listen to lay religious organizations.

Questions for Discussion

The few following questions are presented in an attempt to collate data and indicate areas requiring attention in the immediate future.

- The Church has issued a call to the bishops to guide professionals in the health services. What have the bishops of Asia indeed done for health workers in general and those of the laity in particular regarding the health apostolate?
- What is the comparatively low level of apostolic activity among the laity in the field of health due to? What should the priorities be for the future and what methodologies should be used? Should the intimate connection of Church structures to the present health services be extended to all health professionals? How can this be done?
- Should the hierarchies at the national level in Asia appoint select full-time clergy or religious to ensure Christian spiritual, moral and professional formation of Catholic medical doctors, nurses, pharmacists working in the healing ministry? What would be the basic requirements? What training will be required for such individuals and where will it be delivered?
- How can the Church contribute to the lay person assuming roles of responsibility in Church-connected institutions for health services? In diocesan, national, and international Church structures?

