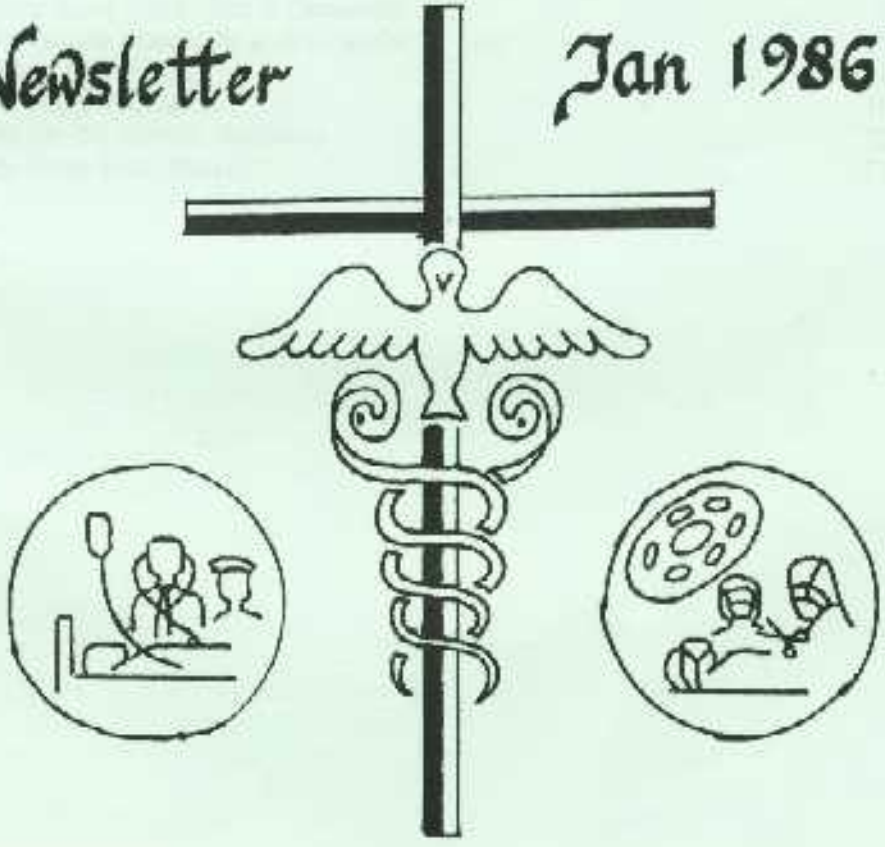
Guild of Saints Luke

Cosmas & Damian

Newsletter Jan 1986



THE NEWSLETTER vol.2, no.1
of the Guild of St. Luke, Sts. Cosmas & Damian

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THE SERMON

THE SPIRITUAL DIRECTOR'S MESSAGE

The sermon preached on Medical Sunday, 1985.

The Church throughout the world today is celebrating Mission Sunday. It might therefore seem a little odd that right in the Cathedral of the diocese we should be following a different liturgy and celebrating this Mass in honour of St. Luke. The reason is that St. Luke - more familiar to us perhaps as the author of one of the gospels - was also a physician: "Our dear doctor", St. Paul calls him, and so is looked upon as the heavenly patron of doctors and of all those who, according to their different callings, cooperate in alleviating suffering and in restoring the sick to health. Every year, on the Sunday nearest to the feast of St. Luke, we celebrate Medical Sunday. In most years it coincides with Mission Sunday, and very appropriately, I feel. For this is an occasion for all of you whose mission in life is to care for the sick or who share this vocation on a part-time basis, to renew your dedication to the high ideals of selfless service that has always been the glory of the medical profession.

In the years immediately following 1945, as the world was recovering from the terrible destruction of war and trying to come to terms with the appalling atrocities committed by supposedly civilized men - some of whom, alas, were members of the medical profession - various world bodies felt the need to establish codes of conduct. The United Nations, for instance, published its Universal Declaration of the Rights of Man, and very soon afterwards the World Medical Association published its International Code of Medical Ethics. Here doctors were told that they must always bear in mind the importance of preserving human life from the time of conception until death. This was in 1949. Much has happened since then and the principle of preserving human life from the moment of conception has been seriously eroded by the very widespread acceptance of abortion both within and outside the medical and nursing professions.

In the 1960s when a number of state legislatures were considering draft laws to decriminalize abortion, many voices were raised in warning: Be careful! once you weaken respect for human life at any one point you necessarily weaken it across the board. Once you allow reasons of convenience to justify the taking of life

even in its embryonic stage - life that can be nothing else than human life - you are opening the way to a similar justification for the taking of life in its closing stages: the life of the incurable, of the terminally ill, of those who suffer intolerably or who have experienced a grave diminishment of their mental or physical powers. That those who sounded these warnings were not imagining unreal dangers is clear from the increasing groundswell of opinion urging changes in the law, where necessary, to permit people to put an end to their own life and to assist another in the achievement of this aim.

Here in Hong Kong within the past few weeks articles have appeared in magazine and newspaper bringing this topic of euthanasia or mercy killing to the attention of the public. Now Christian tradition has always opposed suicide and the intentional taking of innocent human life. This is based on our understanding of who God is and who we are. God is the Lord of life who bestows life on us as his greatest gift; and with that gift goes the responsibility of our making the best possible use of that one life we have. Under God we enjoy a very large degree of autonomy in how we live our life, but this autonomy is not absolute. There are limits to our freedom which we may not cross. To take one's own or another's life has always been understood to go beyond these God-imposed limits. And Christian tradition has never made an exception even for the person suffering intense pain.

To many this seems to be in conflict with Christian love. Human compassion would seem to urge that the sufferer be put out of his pain. The very term 'mercy killing' makes this point. It would be a great mistake, I believe, to shake one's head sadly and dismiss these views as one more indication of the speed with which modern society is departing from traditional moral standards. There is a real problem here. Pain can be intolerable and the diminishment of physical and mental powers pitiable. Besides, not everyone shares our way of looking on man and his relationship with God his Creator. Simple condemnation of those who advocate mercy killing is not enough. The Christian here is faced with a challenge. In a number of places in recent years this challenge has been met through providing hospice care for terminally ill patients and those suffer-

ing great pain. A hospice in Europe of the Middle Ages was a place where the helpless and the pilgrim on his journey were offered shelter and hospitality. The modern hospice is a place where incurably ill patients are welcomed with love, where the dying in the last stages of their pilgrimage on earth are helped to face death without pain, with humanity and dignity, and in peace. Facing death without pain: pain control is the scientific ground on which hospice care is founded, and hospice-care doctors have been especially successful in this whole area of medicine. Nothing can be done perhaps to cure the sick person but much, very much, still remains to be done in terms of care and loving kindness and in providing an atmosphere from which the dying person can draw strength and support to prepare himself to pass out of this world with dignity and in peace.

"Do you have an intensive care unit?" the Director of a hospice was once asked. "Here there is nothing but intensive care," came the reply. With pain well under control and with appropriate care given in an atmosphere of love, the hospice strives, if not to add years to the terminally ill patient's life, at least to add life to his last years or weeks or days.

The Good Samaritan in today's gospel passage did not feel he had discharged his obligations when he had bound up the wounds of the man who had been attacked by brigands. The story describes how, moved with compassion, he lavished love and care on his suffering neighbour and without thought for his own convenience gave generously of his time and energy.

Our celebration of Medical Sunday today is an invitation to you to keep before your eyes the example of the Good Samaritan as you re-dedicate yourself to your mission in life, which is to place your whole selves - your gifts of heart and humanity, as well as your professional skills - at the service of the sick entrusted to your care.

We pray for you today. We ask God's blessing on you. May you be inspired and helped in your work by the Lord Jesus who came on earth and shared our pain and had compassion on the multitudes.

ON THE SLOPE TOWARDS EUTHANASIA

Between 1974 to 1980, a strange phenomenon occurred in France. After a long period of silence, we suddenly noticed multiple declarations and related publications on the problem of death and the conditions accompanying the event. This happened rather suddenly in Western society. Let us recall only three significant event, still present in the minds of many people: in 1974, the "Manifeste des Prix Nobel en faveur de l'Euthanasie"; in 1977, the publication of the book of L. Schwartzenberg and P. Viansson-Ponte, "Changer la Mort", which public opinion considered as a plea for euthanasia. In 1978, the tabling of the proposed law of the M.H. Caillavet aiming to obtain legal approval of "life wills" through which people in good health or the ill could demand that their lives be not artificially prolonged as soon as a diagnosis of incurability was established. All these declarations and propositions aroused numerous debates in schools of philosophy and spirituality and groups of religion.

In France, this period was marked by the discovery of two foreign experiences, which were incomparably rich and precious contribitions. First, the works of Elisabeth Kubler-Ross who had for many years attempted to form a close relationship with very sick patients or the terminally ill and secondly the establishment of the English "Hospices", small reception centres for treatment of cancer patients, terminally ill and suffering acute pain.

Thus all has already been said about the actual conditions of dying and what decisions to take when facing a serious illness. There is nothing else to be said. Yet still, these last few months, I feel compelled to return to the same subject.

THE TREATMENT FOR PAIN

All has been said. But what has been done? The present experience of the English hospices, together with those PALLIATIVE CARE UNITS in Canada and similar USA institutions, show clearly that it is now possible to give relief from nearly all kinds of pain in the pre-terminal or terminal illnesses. And that can be done by very simple means: precise and minute utilization of pain killers, and especially when necessary morphine, paying attention to the

discomforts of the patient, as well as creating a favorable atmosphere of welcoming and listening to the patient. Such methods of taking care of the suffering does not alter their personality nor their lucidity, and often gives them the chance to recover their autonomour existence, if not active life. The pain linked to a forthcoming death can thus be not only treated but even totally prevented.

Such a statement, based on the experience of the last fifteen years and on the observation of results concerning the treatment of pain in several thousands of cancer patients, still meets with scepticism and incredulity by the majority of medical professionals in France. It contradicts the current teaching going on in the medical faculties and the nursing schools, as well as articles in medical reviews. Yes, it is true that from now on, in France, more attention is given to the suffering of the patients. "Consultations on pain" are now created in hospitals. They are experimenting with new methods, such as electrical anaesthesia. Acupuncture is being developed. They can now remedy certain kinos of pain that formerly held people invalid or chronically ill. Nevertheless, most doctors are still defenceless before a suffering patient who is dying.

Certain hospitals and a few doctors are now trying to utilize the methods carried on in the English hospices. The results are disappointing. Perhaps there is not enough analysis of pain and the prescription of pain killing doses to be prescribed to each patient yet. Too few doctors have given enough time and study yet to master this therapy. Some have taken up the task in their leisure time or have paid their own expenses to follow up some courses abroad, in order to become more competent. But these are few and far between.

THE RELATIONSHIP WITH THE VERY SICK PATIENT

The writings of Elisabeth Kubler-Ross and the daily practical experience of those nursing these patients -- the hospital chaplains and relatives of hospitalized persons who were not afraid to listen to these very sick patients, have illustrated that most of them are fully conscious of the seriousness of their condition. The heavy treatments borne, the mutilations, the various symptoms felt in

their own bodies, their weight loss, fatigue, difficulties in breathing, disgust for all food, growing pain and suffering have made the patients realize that their sickness is more serious than they thought. The change of attitude of nurses who quickly leave their bedside after treatment, or those who are unduly optimistic or jolly, also show the patients that the remedies have become ineffective. This normally provokes a very deep anguish in the persons suffering. They may feel bitterness, anger, aggressivity or else turn in on themselves in a mute despair or fall into a state of depression. These reactions are amplified by the solitude and the lack of communication.

Experience has shown that anguish, once expressed, becomes less difficult to bear. That a discreet human presence, attentive and understanding, will allow these persons suffering so intensely to evolve and gradually to fully accept their condition, often with serenity. Some will be reconciled with their relatives after years of misunderstanding, or separation. Others will bid farewell to the ones they love, often in tears and sadness, yet not without a deep feeling of happiness in being surrounded by so much love, and perhaps a very deep spirit of communication. Others go beyond a feeling of failure and of guilt, and manage to discover in their past lives a meaning which had evaded them. The last days of life (of conscious life, that is, for death can be preceded by a more or less long period of coma), may then be for certain patients the most important period of their lives. And for the family accompanying them until the end, it may mean a period of great family feeling and will thus lead everyone into a period of mourning where there is less guilt.

Even when medicine can no longer bring about a cure, when all the therapeutic means have been exhausted and death seems inevitable, life has not necessarily lost meaning. Those who remain near the patient can testify to this fact. But this affirmation arouses much incredulity in many hospitals. To live with the prospect of a near death seems to many people to be unbearable. As soon as medicine can no longer relieve or sustain a minimum state of health it is preferable to let the person die or at least to render him unconscious of his condition because we can no longer help him to live the last phase of his existence. I believe that this

is the conviction of most of our society, a symptom of an attitude of fatalism, even despair.

• But surely such a state of mind is not universal. As I already mentioned, a certain number of doctors, nurses, aides, hospital visitors, pastoral teams and relatives of patients have succeeded in overcoming their despair and fear of having any relationship with very ill patients. They can therefore sit by the bedside of the very sick patient and enter into communication with him through silence, body language, pressure of the hand, simple gestures, a few well chosen words, and often a shared prayer or the gift of the sacraments.

But their presence often cause much uneasiness. Oftentimes, for so-called medical reasons, they will meet with obstacles to their tentative efforts to humanize death. Let me point out that today there are volunteers who are aware of the solitude of the very ill. These have tried to regroup themselves in associations and receive some training. They are ready to help the hospital staff and the families accompanying the dying. In the past, this was always done by sympathetic persons; it is only within the last decade that it has stopped in the technically developed countries. So these hospital volunteers are not always well accepted.

"COCKTAILS" PLUNGING THE PATIENT INTO UNCONSCIOUSNESS

There are now numerous attempts to humanize the last moments of life; but they aer meeting with many obstacles. People do not understand the meaning of this research, or have a fatalistic attitude or worse yet, are afraid of entering into a relationship with one who feels he is dying. We must accept the fact today that the condition of many incurable sick people having reached the terminal part of their life is dramatic. The health institutions have raised a wall of silence or use falsely assuring words, preventing real communication which would be the only remedy against so much anguish. This non-expressed anguish can serve only to intensify the pain which itself is not well treated. Anguish and pain are mutually amplified and the patient is involved in a vicious circle of "total suffering" which soon becomes intolerable not only to himself but also to those around him.

This explains why doctors resort to "releasing cocktails", a mixture of drugs in large doses which plunges the patient into unconsciousness and only accelerates the process of dying. This is surely not the way to take care of a patient. Instead of catering to the physical, psychic and spiritual need of the patient, they manage to "disconnect" him from all reality, from awareness of what is happening within himself and with others, Formerly this was done only in extreme cases, where the patient implored for help through his moans, and begged that he be "put to sleep". In those years, we could call this recourse to "releasing cocktails" the desperate answer to a situation of distress.

What is happening today? The use of these drug mixtures is being adopted constantly and systematically in certain hospital units. They have become the common medication for the last days of life. Even when the patient does not ask for it. Even when he is not suffering too much physically or is not in deep anguish. Sometimes this is done uniquely because the patient has started asking embarrassing questions. Then, where is the respect due to the patient or to his freedom? And what can we say when we hear statements such as these given to nurses: "I do not wish to see Mr. X here after the week-end." We can well ask ourselves whether the ultimate reason behind these practices is not to wish to avoid the questions or the looks of the one about to die, and whether there is not a conviction today that the life of this patient has no more meaning. The development of the use of these "releasing cocktails" would then be the sign, if not the proof, of the difficulties of the nursing staff and the failures in supporting relationship with the dying person and of the desperation described above.

EUTHANASIA

In any case, plunging the patient into an unconscious state and renewing the doses of drug until death ensures means that they are deliberately putting an end to the conscious life of the victim. And this causes a certain number of health professionals to raise the question openly about the legitimacy of the social interdict on euthanasia. Why still condemn, in our days, the act of provoking death in the dying? Isn't this pure hypocrisy? For the patient, what difference can it make between a voluntarily provoked death and

an end to his conscious life? This last idea is the current thought of several hospitals. Therefore can we not accept the fact that the nursing staff has a right to kill the dying?

Does such questioning or rather such reasoning lead to a growth in the number of acts of euthanasia in the strict sense of the word, i.e., of deliberately provoked deaths? I dare not assert it. Personally I am very much impressed by more and more confidential reports received about homicidal acts carried out. Each year I meet a larger number of medical professionals and perhaps that explains the increase. However I do notice a change, the social interdict on homicide is losing its force and the question of accepting or refusing euthanasia is more considered one of personal option for each person.

So today, we cannot perceive so clearly the serious reasons for the social interdict on euthanasia, formulated especially for medical professionals. The image of these professionals would be greatly affected if those who had the mission and power to care for the sick has also the same power to put an end to life. The semi-conscious patient could well fear that the injection given is a lethal one. And all those who have become useless and who feel they are a burden to society such as handicapped, the incurables, the elderly, could well feel a certain guilt, in spite of their desire to live, in not asking for the benefit of tolerated euthanasia. They would feel guilty to be so selfish in living and imposing their presence on their near ones.

THE NECESSITY OF A CHANGE OF ORIENTATION

The preceding pages evidently raise serious questions about the practice in certain hospitals. They were not written without knowledge of some of the difficulties met by medical professionals and the dramas into which are plunged certain patients. It was therefore with much hesitation that I undertook to write this article. It is sometimes easier to remain silent than to raise certain questions which have no answer.

But today, we have at our disposal all the necessary elements to rethink in a more human way the orientation to be taken in medicine regarding pre-terminal and terminal cases. We now know for a fact that it is medicine itself that brings about many of the dramatic situations, that it is that stubbornness in wishing to cure, that leads to conditions which are extremely painful, and difficult to bear both for the patient and for those around him. We have discovered that taken in time, before the patient is submerged by it, the suffering of the dying can be overcome and even prevented quite easily. And we also know that much can be done for the one whose life is coming to an end and that the nurses are not helpless and condemned to an inactivity which would be difficult for them to bear. The answer to the multiple physical, psychological and spiritual needs of the seriously ill patient demands other means than medication oriented toward seeking a cure.

It is therefore possible to discover wise methods in utilizing medical resources. This wisdom has not always been put in practice in France (or in other developed countries). And that is not too surprising. Modern medicine is very new. It can use powerful weapons against disease only within the last 40 years or so. And modern technology has been introduced in hospitals only within these last 25 years. We are not yet accustomed to such a sudden revolution.

Some changes of orientations, it seems to me, should be coming in as soon as possible.

1. Reframing the ethical question.

Actually, many doctors raise only one ethical question: "Do we have the right to abstain?" when the feeble probability of success makes one hesitate to use aggressive therapeutic methods The boldest doctors succeed in convincing their confreres "that there may be a chance yet" and "we must not give up". The patient is then involved in an escalation of treatment. Thus, in certain hospitals, we end up with two successive attitudes: during the medical activity phase, none of the wishes of the patient are listened to (such as that of resting, returning home, communicating with his relatives...) because of the therapy. Then brutally, when all hope is

lost, the patient is left to himself to cope. When his anguish and his pain become intolerable, they plunge him into an unconscious state. In neither of the two phases did they ever attempt to respond to the fundamental needs of the person bearing such a heavy burden. "we wanted to prevent him from dying; in reality, we prevented him from living in a human way the last phase of his existence." Strange paradox!

This invites us to ask ourselves whether the ethical question has been properly put and whether it is not hiding an implicit affirmation that should be questioned. Again let us ask" "Do we have the right to abstain?". It evokes almost automatically an answer from the doctor phrased in terms of his duty. If he still has the chance to arrest the process of the illness, everything must be done to avert death. This means that the patient is obliged to keep on having his life prolonged, whatever the price to himself, to his family, to the nursing staff and to society. All that has value in the eyes of the patient, such as reducing the discomfort, appeasing the anguish and the suffering, the relationship with his family either in the hospital or at home, the possibility to pray and search for a reconciliation with God, all is subordinated to the means used to prolong life. Thus only one fundamental value is recognized: the length of life.

Such a supposition is contested by a large majority of the public. The proposition of the Caillavet Law made it clear to the public, thanks to the debates carried on in France. For a long time Christian moralists have already acknowledged that a patient has the full right to refuse to pay too heavy a price in order to safeguard his health or even to prevent death. And jurisprudence in France follows the same line. So it is becoming more and more clear that alongside the rights of a patient to have the benefit of treatment and the correlative duty of the doctor to provide it, we must also accept the fact that the patient has full right to refuse treatment.

The doctor must thus respect the life of the patient as well as his freedom to choose his own conditions of living according to his own hierarchy of values.

To acknowledge this means to re-state the ethical question. The doctor has no longer to ask himself only "Do I have the right to abstain?" but also and firstly, "Do I have a right to proceed?". Would such a therapeutic means correspond to the expressed will of the patient or interpreted by his relatives or as formulated by those who try to speak in his name? To ask these questions honestly would lead to much more prudent interventions and would not subject the patient to sufferings out of proportion to the benefits that he might get out of them.

2. Facilitating companionship for the dying.

After this long development of what is convenient to call "relentless theraqpy", we can be brief on the two following points. It may be enough to resume what has been said above.

Our society has lost the habit of standing near the dying: henceforth to do this brings about reactions of fear and anguish that makes us avoid the terminally ill. And this is why the dying are often immured in their solitude. But many persons today have become aware of the distress of these dying patients. As we have said before, these people agree to take some training, or are already prepared to assist those who are at the last phase of life.

Unfortunately, hospitals often lay obstacles in the way. Quite contrary to the official texts defining the functions of the nursing profession, we do not yet consider as an integral part of care of the sick "actions that are considered as assisting the dying in their last moments of life". Nurses who sit at the bedside of dying persons are often told not to waste their time. Numerous volunteers would be happy to spend this time with the dying and "waste it freely". But we frequently bar their way, by telling them that it is the job of the professionals to care for the sick.

It is urgent to resolve this contradiction and to acknowledge that the care of the sick has multiple dimensions: medical treatment, but also anything to comfort the patient and to give a response to his psychological as well as spiritual needs. The nurses who feel the urge to do so and who feel they can cope with it, should be encouraged to assist the sick by their presence, and to be helped

by volunteers who are desirous of participating in this important social task.

3. Tackling resolutely the problem of relieving suffering.

We have seen that it is henceforth possible to prevent the terminally ill from suffering without putting him in a semi-conscious state or having recourse to "releasing cocktails". The pain-relieving methods moat adequate seem to be those adopted by the English hospices. They have been used in France by certain doctors but the results were not satisfactory. Why is that? By a lack of precision in the use of pain-killers, as we have mentioned before. We must therefore see whence comes this inaccuracy and where the obstacle is that prevents the treatment of pain in the dying. The principle which the methods use is simple: adapt the doses to the needs of each patient. It is sufficient to observe the patients, to question them, to monitor closely the effects of the medication, in a word, to remain close to the patient. If the treatment is inefficient it means that this closeness has not been achieved. Indeed this meets with great difficulties: lack of time and availability of nurses, caught up with numerous tasks, but also as we have seen, the testing nature of the relationship with the dying person, especially if he is suffering. The medical team therefore has a tendency to keep a certain distance from the patient. This leads them to offer standardized treatments insufficiently adapted to the peculiar nature of each pain. They notice that the pain killer is inefficient and that the patient continues complaining, and so their own uneasiness increases.

It is urgent to get out of this vicious circle. The only remedy will be serious formation and training. It is only when the nurses themselves see the possibility of relieving the suffering in a satisfactory way that these nurses will gain that confidence that will allow them to stay near the patients. Relying on a completely controlled technology, confident in the efficiency of their treatments, knowing how to respond to the first request of the patients which is not to suffer more, doctors and nurses will then be able to overcome their anguish and experience that a relationship with the dying is possible.

The creation of some care units who can provide accurate treatment of pain in dying patients has thus become an imperative necessity in France. It is not desirable to admit all the terminally sick patients into specialized institutions, but we ought first of all to organize stages of formation for doctors and nurses who would like to acquire mastery in the treatment of pain in terminal cases. Also if the French medical publications published the results attained in the country, it would allow an evolution of the teaching given to the doctors and nurses.

The creation of three or four small palliative care units could have big repercussions. The Canadian experience testifies to the fact. Is it unthinkable that we could find 30 to 40 beds in hospitals or clinics, divided among three or four towns and that some doctors and nurses would be assigned to undertake such an urgent task?

The last decades have shown us a prodigious development in medical science and health institutions. We all benefit from it. But this progress has a reverse side to it. Man today is much less familiar than previously with illness and death. He no longer knows how to behave in front of a dying person. Most of the hospitals, orienting their research toward recovery, have become inept facing the situation of anyone whose remedies have lost their usefulness. Without our renouncing any of the benefits of modern medicine, it is now time to recover attitudes of simple humanity and to search for adequate answers to the needs and the requests of those whose lives are coming to an end.

- An English version of an article by Rev. Patrick Verspieren, S.J., which appeared in ETUDES, Janvier 1984. Translated by Rev. Fr. E. Collins, S.J.

A REFLECTION

1. Some time ago the Guild held a discussion meeting with a title of "Who takes care of the caretakers" in Wah Yan College, Kowloon.

The topic sounded very attractive to me as a caretaker, as a junior working in an acute hospital with considerable stress.

My fantasy before attending the meeting was that I might get some bright ideas from it to help me to alleviate the stress. Perhaps this was the expectation among the large attentive audience too.

The speaker was very skillful in conducting the meeting and individual members of the audience was encouraged to come up and tell their experience of stress in their work. Although I was never so brave as to share my experience with others in words, my spirit was in complete consonance with the others.

Vast material was presented in the lecture. To me the most impressive was the tabulation of difficulties, even complications, encountered by a group of American psychiatrists in their career. Some of the complications to stress was indeed fatal (suicide), others were detrimental (alcoholism, marital problems...etc.). This brought the audience to a point of excitement and everyone was longing for the solution. However, the lecture just ended after this presentation -- almost an anticlimax, but enough to stimulate our thoughts!

2. After the lecture small groups were formed to join the discussion and every member was stimulated to say something. I learnt that there was some disappointment in the audience that eventually they had to accept the fact that this "Who" "who takes care of caretakers are the caretakers themselves". Then I began to wonder how I take care of myself....and suddenly I seemed to get the answer.

3. I imagined that my conscience can be divided into two modes - kind and cold (calm perhaps?), and I could switch on the mode which is most appropriate to the confronting situation. I may choose to be kind to the weak and fragile, the interesting and lovely, but may be cold to the stubborn and demanding, particularly if the workload is demanding too. I do not consider such mode selection as totally infallable but very practical. Those who have been working in busy wards will understand this very well - one cannot be KIND always; but to be cold always is in contradiction to our faith. I have to find something in between.

4. When I returned home I was thinking that only after listening to such a provoking lecture could I get the enthusiasm to examine myself in depth on such spiritual problems. It helps me to become more mature. Perhaps it is time for me to take a further step to find out the way so that I can switch myself to KIND more often.

-Anonymous

IN MEMORIEM: SISTER MARY AQUINAS

Sister Mary Aquinas was born to the Monaghan family in Ballinaslow in Galway, a town in the western part of Ireland. After her primary and boarding school in Ballinasloe, she went to Dublin and joined the Columban Sisters. Later she took up medicine and qualified in 1947 with M.B. B.Ch. B.A.O

Sister Aquinas wanted to become a missionary in China, and so she set off from Ireland in 1948 and arrived first in Hong Kong. Because of the tumultous situation and the change of government in China, however, she was not able to proceed further, but stayed in Hong Kong. She then took up the task of combating against chest diseases especially tuberculosis, which became a major health problem in Hong Kong with the influx of refugees from China. This remained her life-long medical devotion. In 1953, Sister Aquinas was awarded a World Health Organization fellowship to further her studies of chest diseases in the University of Wales, and obtained the further qualification of T.D.D. She became a Fellow of the American College of Chest Physicians in 1955, and later a Regent. In 1973 she took her membership of the Royal College of Physicians of Edinburgh, and in 1977, her fellowship of the same College.

Sister Aquinas was honoured by the University of Hong Kong with the award of the Doctor of Social Sciences honoris causa in 1978, and was awarded the Officer of the British Empire medal in 1980, for her achievements in treatment of chest diseases and her contribution to the community of Hong Kong.

Sister Aquinas was also deeply involved in teaching and uniting the medical community of Hong Kong. She was appointed Honorary Clinical Lecturer in Medicine of the University of Hong Kong in 1952, and held that post ever since, and she was a member of the Board of Faculty of Medicine of the same University. She served on numerous medical 'regulatory' bodies including the Hong Kong Medical Council, Medical Development Advisory Committee, the Hong Kong Medical Association, the British Medical Association (Hong Kong Branch), the Federation of Medical Societies of Hong Kong, and the Pharmacy and Poisons Board. Her participation in

these bodies helped shape medicine in Hong Kong of today and into the 90's. She was active in learned societies including the Society of Community Medicine and the American College of Chest Physicians.

Sister Aquinas, of course, always maintained close link with the Guild since its inception, and was our past master and many years a Councilmember and our Liasion and Hospitality Officer.

She died on 28 November 1985 after a course of tragic illnes.

Her death was a tremendous loss and was acutely felt by the community and medical profession of Hong Kong, by the Guild, and those who have known and loved her.

-G.C.

A TRIBUTE TO SISTER AQUINAS

The passing away of Sister Mary Aquinas on 28th November 1985 was a sad loss to the medical profession and the community of Hong Kong. To those who had the privilege and good fortune of knowing her in person over the years, it signelled the end of a happy and memorable era. Her long and successful fight against the scourge of tuberculosis as the most feared infectious disease in Hong Kong in the 40's and 50's when she first arrived is now legendary. She gave Hong Kong not only the most up-to-date advances in the treatment and prevention of tuberculosis but also her cheerful, presevering and persuasive personality which convinced the Government and the public to accept the challenge of wiping out tuberculosis as their first priority. In the later years when tuberculosis was no longer a threat in Hong Kong, she turned her attention to other areas in heart and lung diseases and to the important task of uniting and guiding the medical profession. The former she achieved by serving on the Board of Governors of Grantham Hospital and the latter as member and office bearer of various medical associations, Medical Advisory Committee and more recently the Medical Council. It came therefore as no surprise when Sister Aquinas was made a Fellow of the Royal College of Physicians of Edinburgh in 1977, awarded a Doctor of Social Sciences honoris causa by the University of Hong Kong in 1978 and honoured with an OBE by Her Majesty the Queen in 1980.

Her long and memorable association with the University of Hong Kong began in 1952 when she was appointed as Honorary Clinic Lecturer in the Department of Medicine. I must have been one of her first students then. Over the succeeding 33 years we had been seeing each other often as friends and colleagues and it was this relationship which gave me a glimpse of the person whom I have come to respect, admire and love. Sister Aquinas possessed all the qualities which make a doctor a good doctor and a Catholic a good Catholic. I am referring not so much to her professional expertise or even the excellent care that she delivered to her patients but her genuine kindness, optimism, modesty, her extraordinary ability to understand human nature and human weakness and her moral generosity. The Public Orator of the University of Hong Kong once remarked that he had a most difficult task in composing a citation for Sister Aquinas on the occasion of her honorary degree confer-

ment. When interviewed and asked to provide more information on her achievements and contribution to Hong Kong, Sister Aquinas tried her utmost to play down their importance. What to any of us is a unique personal accomplishment to be proud of and to boast about is to Sister Aquinas an act of God in which she only played her dutiful role. Such was the extent of her modesty. Her optimism was contagious. In the last year or so before his retirement the late Professor McFadzean was often taken ill and admitted into hospital. His natural impatience was compounded with mental anguish at the slow recovery. It was Sister Aquinas' visit and her ringing laughter which brightened the days for him and helped him along the road of recovery. I always felt reassured when Sister Aquinas was present at meetings when thorny issues were on the agenda. On many an occasion, the deadlock was broken when her commonsense prevailed and her timely sense of humour brought both parties to their senses and enabled them to search afresh for a common solution. Her optimism, moral courage and faith in God sustained her throughout her last illness and despite the physical discomfort she always showed a smiling face and appreciation to any visitor to her bedside.

For the past 33 years, Sister Aquinas had attended every Christmas Party hosted by Professor McFadzean and since 1974 by Professor Todd for the Department of Medicine. On these occasions we had taken for granted the happiness she imparted. It would have been appropriate for us to cancel the Christmas Party of 1985 as a sign of mourning for her. But we decided otherwise. Sister Aquinas enjoyed and made the best of every moment of her life and she would expect us to do the same. Yet, to many of us in the Department of Medicine in the University of Hong Kong Christmas Party would never be the same.

-Professor R. Young

WORDS FROM THE MASTER

Dear members,

The Guild received with regret the sad news of the death of Sister Mary Aquinas on 28 November 1985. To each of us, this meant the loss of a teacher, a colleague, a friend and a legendary figure in the community. To the Guild, loss of a beloved member, a past master, and (in the words of our immediate past master) a guardian angel. Sister Aquinas left us to join the Church Triumphant, and for this, paradoxically, we thank the Lord. We cannot enjoy Sister's pleasant company and her sage counsel any more, but the loving memory of Sister Aquinas will stay with us always.

For us in the Church Militant we are in dire need for God's grace and guidance, and to reconcile with Him for our weakness and failures. This reconciliation is highlighted in the community of the Guild in our annual retreat before Easter. The Palm Sunday is still a long way from now, but I urge you to look out for announcements of the retreat and join us at this spiritual exercise.

May the grace of God be bestowed upon us.

Yours in Christ,

George Chan