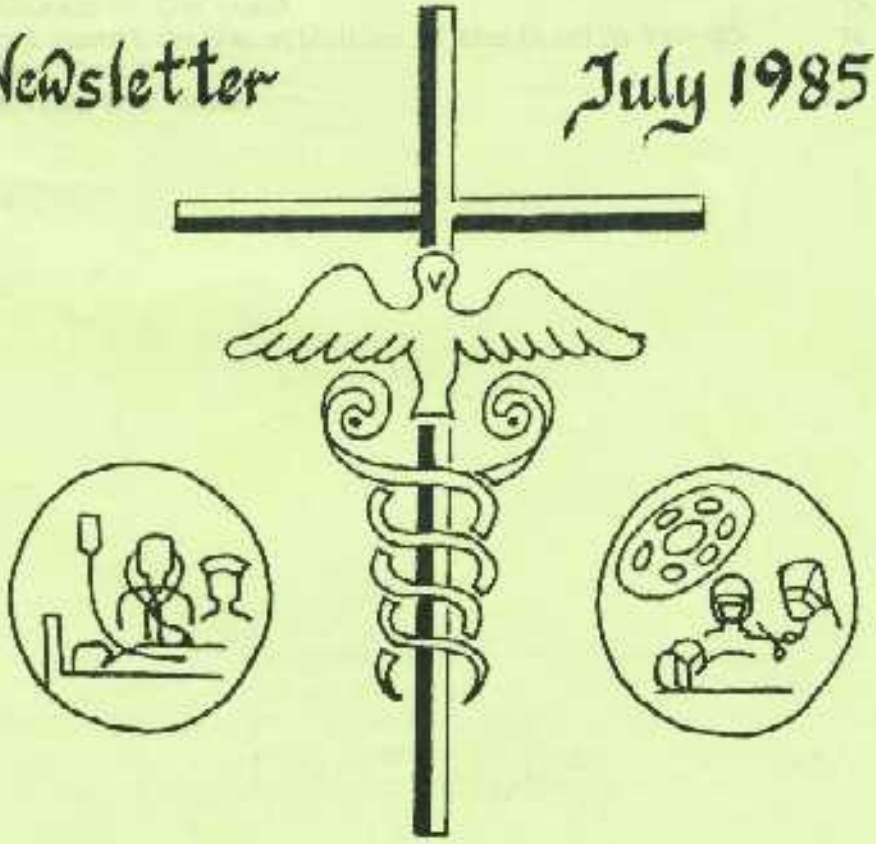
Guild of Saints Luke Cosmas & Damian

Newsletter July 1985



THE NEWSLETTER vol.1, no.3
of the Guild of St. Luke, Sts. Cosmas & Damian

CONTENT

FEATURE:

....a child is God's greatest gift

to a married couple, but ....

? TEST-TUBE BABIES?

We were . . . bound to take very seriously the feelings expressed in the evidence. And . . . it would be idle to pretend that there is not a wide diversity in moral feelings, whether these arise from religious, philiosophical or humanist beliefs. What is common (and this too we have discovered from the evidence) is that people generally want some principles or other to govern the development and use of the new techniques. There must be some barriers that are not to be crossed, some fixed limits, beyond which people must not be allowed to go. Nor is such a wish for containment a mere whim or fancy. The very existence of morality depends on it. A society which had no inhibiting limits, especially in the areas with which we have been concerned, questions of birth and death, of the setting up of families and the valuing of human life, would be a society without moral scruples. And this nobody wants.

From the Forward to the Report of the Committee of Inquiry into Human Fertilisation and Embryology, 1984.

IN VITRO OR EXTRA-CORPORAL FERTILIZATION

Every few days we see in the medial references to a child born as a result of methods designed to find a way around blocked fertility, call in vitro fertilization (IVF) or extra-corporal fertilization. Within the past year we have observed the debate on what to do about the "orphaned" frozen embryo in Australia, the legal problems associated with surrogate mothers in England, the submissions to and the findings of the Warnock Commission, and so on. This paper will briefly trace the development of IVF and give a brief outline of some of the steps involved.

THE STEPS IN IVF:

1. Monitoring the follicular phase of the prospective mother.
2. Recognition and control of the LH surge.
3. Obtaining and preparation of the father's sperm or 'capacitation of sperm' by incubation in a suitable medium for 1½ hours.
4. Laparoscopic oocyte recovery under general anaesthesia.
5. In vitro fertilization by exposure of the sperm and egg in a suitable medium.
6. Monitoring the growth of the zygote.
7. Trans-cervical implantation into the uterus at the 8 to 16 cell stage.
8. Monitoring the luteal phase.
9. Monitoring the pregnancy, i.e., quality control of the foetus.

EARLY HISTORY:

In the 1940's Dr. John Rock of Harvard Medical School attempted extra-corporal fertilization, but no special medium was used and no zygotes survived beyond the 4 cell stage.

In the 1950's Dr. Landrum B Shettles of Columbia University used a special medium composed of follicular fluid, pieces of fimbriae, mucosa of the fallopian tube and fertile type cervical mucus and succeeded with development to the 64 cell stage.

In the 1960's Dr. Patrick Steptoe of Oldham Hospital and

Dr. Robert G. Edwards of Cambridge University began their experiments. By 1968 they had succeeded with development to the blastocyst stage.

In the 1970's Shettles succeeded in implanting an embryo in a woman who was to have a hysterectomy for cancer of the cervix, thus establishing the ability to achieve implantation but in circumstances in which the ensuing pregnancy would not be allowed to continue. By 1973 Steptoe and Edwards began attempts at implantation in both natural and hormonally stimulated cycles. How many attempts were made before success is hard to determine, but it has been reported that out of 32 natural cycles implanted there were 4 pregnancies, 2 of which ended in spontaneous abortion, one was ectopic and required surgical intervention, and the fourth was the world famous Louis Brown. In this limited part of the series the success rate was 3%.

MRS. BROWN'S CLINICAL HISTORY: When the mother of Louis Brown was referred to Steptoe and Edwards in 1976 she had a 9 year history of infertility and had undergone bilateral salpingostomy in 1970 for blocked tubes. In February 1977 she had a laporoscopic survey to determine the pelvic pathology. She had grossly distorted tubal stumps and adhesions. In Ausust she underwent laporotomy to remove the remnants of the fallopian tubes and the adhesions around the ovaries in order to facilitate oocyt recovery. She then monitored her basal body temperature.

In November 1977 during an unstimulated cycle, assays of blood and urine indicated the approach of ovulation. She underwent laporoscopic examination under general anaesthesia with intubation. An ovum was aspirated from a follicle and mixed with her husband's sperm which had undergone capacitation. After 12 hour exposure and a change of medium it was found that there was a developing embryo. This was implanted at the 8 cell stage through a small catheter placed in the endocervical canal. Mrs. Brown remained at bed rest for 24 hours and was discharged from Oldham Hospital 18 days after the transfer. At 16 weeks ultrasonic scan and amniocentesis was done to determine if the fetus as developing normally.

Mrs. Brown was admitted to hospital at 33 weeks for closer observation. At 35 weeks pre-eclamptic toxaemia with moderate hypertension, oedema and occasional albuminuria developed. At 38 weeks, with a blood pressure of 140/95 and legs and lower lower abdomen markedly oedematous an ultrasonic scan and amniocentesis was done to determine the maturity of the foetus. The mother was escorted to the operating theatre by security guards and the caesarian section was filmed by a crew from the Government Office of Information. A few minutes before midnight on July 25, 1978 Louise Brown came into this world weighing 2.6 kg.

SUBSEQUENT DEVELOPMENTS:

Since then Steptoe and Edwards reported in the Lancet 3 December 1983, that of 1200 implantations, 320 or 26.6% resulted in 'clinical pregnancies'. Of these 126 pregnancies went on to the birth of 139 babies (67 boys and 72 girls, including 13 biovular twins).

Professor Carl Wood and his team at Melbourne was the first to repeat the success of Steptoe and Edwards and the first to succeed with an embryo that had been frozen.

ASSESSMENT OF SUCCESS RATE:

Persons concerned with the high rate of embryo loss look upon IVF with less enthusiasm than those who concentrate on the end product for some infertile couples of having their own baby as being the justification of all the risks encountered along the way. The press notes a high rate of success with normal babies as the ressult but we are not told about the process of triage along the way. Stress is placed upon the rate of loss by spontaneous abortion in the normal population.

The published rates of success with IVF indicate that of 1,000 couples presenting for treatment, 850 to 900 will have an egg retrieved at the first attempt. These ova will be successfully fertilized in 80-90% of the cases (680-810 fertilized eggs), of these 50-70% will have satisfactory development to try implantation (340-578 developing zygotes). Of the implantations there will be a 15-30% rate of pregnancy, depending on many factors including the number of embryos implanted together. For example if 3 embryos are implanted

the rate of pregnancy can rise as high as 29% with an also increasing chance of multiple births. If we include all starters in the statistical evaluation the overall chance to achieve their desired child is 5-10%. It would appear that 85-90% of all fertilized ova do not reach the point of birth. the continued growth of embryos after being frozen and thawed varies in relationship to the cell stage at which they are frozen; at the 2 cell stage 20% will continue to grow while at the 8 cell stage 50% will resume development. We are told that freezing causes no harm to the embryo but it does cause a 50-80% loss.

For comparison the latest figures on the loss in the natural setting come from the Lancet, 21 May 1983 in which 91 normal women were studied by HCG and progesterone levels during 226 cycles in which no contraception was practiced. There were 85 pregnancies and 7 cases in which menstruation occurred at the expected time although a rise in HCG had been detected. Of the 85 pregnancies there were 74 live births and 11 spontaneous abortions. Thus the successful pregnancy rate was 80%, with a 12% loss in spontaneous abortion and a 7.6% unsuspected fetal loss. In fact every one of the 91 women went on subsequently to have a live birth.

CONCLUSION:

If we accept two scientific facts that life begins at fertilization and that possession of 46 chromosomes is the hallmark of humanity, then we must conclude that IVF constitutes human experimentation with a high rate of risk for the subject of the research. It is of course impossible for the subject of the research to give consent to the research. There is in addition potential for abuse in terms of unwanted surplus embryos, rented wombs, abandoned frozen embryos, cultivation of excess embryos for purposed of research only and many other problems of social and legal nature. Enthusiasm for a scientific breakthrough can blind us to the fact that we are accepting something which horrified the medical community and the general public at the Nuremburg Trials, namely putting human subjects at hish risk for the purpose of experimentation.

-Rev. Sr. T. Howard

IVF IN HONG KONG? HOW ETHICAL?

When in 1972 the Hong Kong Government introduced draft legislation concerning induced abortion, the Catholic community here was caught unprepared. Today the question is asked: Should we not begin now to study and discuss what form of IVF legislation would be desirable and morally acceptable here? In this way we could prepare to make a positive contribution to the common good.

The question is not merely theoretical. 'Test-tube' babies are now being made in many countries. England will have successfully produced its thousandth this year. Taiwan has recently produced its first. Sooner or later, Hong Kong will follow suit.

Public opinion in many of these countries is putting pressure on the government to introduce legislation to prevent blatant disrespect for human life. For instance, the Warnock Committee was set up by the British government in 1982. It was a Committee of Inquiry into Human Fertilization and Embryology, and its specific task was to examine the social, ethical and legal implications of recent and potential developments. It presented its Report in July 1984, exactly two years after it had been set up. The Report contained 63 Recommendations for legislation.

From an ethical point of view, the most far-reaching Recommendation, when all the implications are considered, is No. 12. It states: "No human embryo derived from in vitro fertilisation, whether frozen or unfrozen, may be kept alive, if not transferred to a woman, beyond fourteen days after fertilisation, nor may it be used as a research subject beyond fourteen days after fertilisation ..... " .

Dr. John Marshall, a member of the Warnock Committee, together with two other dissented, and their Expression of Dissent recommended that experimentation on the human embryo be not permitted, and that the embryo of the human species should be afforded special protection in law.

The Joint Committee on Bio-Ethical Issues is a standing committee appointed by the Bishops' Conferences of Scotland and of

England and Wales. It submitted evidence to the Warnock Committee while it was in session, and published Comments on the Warnock Report after it was published. In regard to Recommendation 12, it had this to say: "Here the Inquiry's good intentions, allied to confusion in reasoning, have produced a shameful recommendation... For the first time in the history of our civilisation, deliberate killing of the harmless is to be made not merely permissible, but actually obligatory."

LIFE is a humanitarian organisation ("Save the Unborn Child"). It also made submissions to the Warnock Committee while it was sitting, and published a commentary after, called "Warnock Dissected". In its commentary, LIFE says: "...we share the Committee's concern to relieve human suffering by every legitimate means. Nonetheless we reject the Committee's central proposals.....We cannot accept the approval of such practices as selecting the 'best' embryos for transfer to the mother, and throwing away or freezing the 'spares'. We cannot accept the recommendation that human embryos should be used for research." It says: "Warnock is another betrayal of human life at its earliest stages."

Many wonder what the British government will do with the Warnock Report and its 63 Recommendations. The British government is still pondering on them. In the meantime, a former Health Minister, Mr. Enoch Powell, introduced a private Bill to ban research on living embryos. When he introduced the first reading in February 1985, MPs voted in favour of it by a majority of 172. Then a bitter debate began in parliament which lasted three months, and which resulted in the Bill being finally rejected by the House of Commons in June 1985. Is this to be interpreted as a victory for some medical researchers? Or simply the desire of the British government to introduce its own Bill later on? We do not know.

As in England, so in the U.S.A. there is considerable public concern about the moral implications of IVF and associated practices. The House of Representatives has a standing Committee for Sciences and Technology. In 1984, it set up a sub-committee to study the possibility or necessity of legislative measures to govern the practice in these matters. Amongst those experts called to give evidence was Fr. Richard A. McCormick, S.J., Professor of Ethics at the Georgetown University. Fr. McCormick is highly respected in the

U.S.A. as a liberal moral theologian. He appeared before the sub-committee on August 9th, 1984.

Fr. McCormick in his evidence distinguished between the function of government, which is to legislate in matters concerning public order, and the function of moralists, which is to distinguish netween human acts which are morally good and morally bad. Public order and morality are intimately linked, but at the same time distinct. Legislation concerning IVF must not disregard morality, but must also consider what is feasible. AIH in certain circumstances may be morally good, whereas AID is always to be considered immoral. To prohibit experimentation on human embryos by legislation is feasible at the moment, but it is not feasible, for example, to prohibit AID by legislation in today's society. Fr. McCormick in his presentation implicitly or explicitly listed some practices which he considered ethically unacceptable: experimentation on human embryos, AID, IVF in which the ovum and sperm did not come from a husband and his wife, renting of wombs (surrogate motherhood), freezing of embryos which might be implanted in a rented womb, and the commercialisation of any of these procedures.

We now come to the main question in this article: How ethical is IVF in itself (i.e. prescinding from other moral problems which arise in the practice)? Some experts within the Catholic community who defend AIH are also willing to justify IVF if (1) it is limited to married couples who cannot otherwise have a child; (2) it can be proved comparatively safe for the child in its future life; and (3) deliberate wastage of embryos can be excluded. Fr. McCormick would most probably agree with this opinion.

IVF as a solution to the problem of infertility in marriage appeals to all who support and encourage family life because a child is God's greatest gift to a married couple. But the many moral objections to IVF cannot be easily answered. The procedure may become relatively common in the future, much as contraception, sterilisation and even abortion have. But this will more likely indicate the attractiveness of modern secular sexual ethics than the compatibility of IVF with official Catholic teaching.

What is the official Catholic teaching? Pope John Paul II, apart from a condemnation of experimentation on human embryos,

has not explicitly addressed the morality of IVF. However he has strongly reaffirmed the teaching of Pope Paul VI on the inseparability of the two meanings of the conjugal act, the unitive and the procreative. Paul VI denied that man could retain the unitive meaning while denying the procreative. He would presumably also consider as immoral the eliminating of the union altogether, placing the fertilisation in a laboratory setting.

Pope Pius XII in various addresses in the 1950s rejected artificial insemination precisely on the basis of the inseparability of these two meanings. He too explicitly condemned experimentation on human embryos when he said: "On the subject of experiments in artificial human fecundation 'in vitro', let it suffice for us to say that they must be rejected as immoral and absolutely illicit."

In this article, which is meant merely to introduce the subject, the focus is on morality rather than legislation. Before entering into a debate about suitable legislation, we have to consider the morality of IVF in itself. In all the literature on the subject available to the present writer, much is said about human rights: the right of a woman to have a child: the right that human embryos have to protection from the law. But nothing is said about love which is the foundation of Christian morality. The question we should first be discussing is this: For an infertile married couple, can IVF be an authentic expression of married love?

-Rev. Fr. Edward Collins, S.J.

TO PONDER ....

Rev. Fr. Deignan succinctly summarised Dr. E. K.-R.'s talk for us.

CARING FOR THE TERMINALLY-ILL

Notes on a talk by Dr. E. Kubler-Ross

Dr. Elizabeth Kubler-Ross is a world famous Swiss American psychiatrist who does pioneering work with the terminally ill, young and old. She has written the famous book "Death and Dying" which gives new insights into relationships and experiences at time of death.

The Catholic Doctors' Guild of St. Luke, SS Cosmas and Damien were very fortunate to have her as a guest speaker on the evening of 30th April 1985 at Ruttonjee Sanatorium. The lecture room was crowded. People were obviously eager to listen to her. Unfortunately the amplifying system was not perfect and so some people at the back found it difficlut to hear every word clearly. Her talk which was a sharing of her own experiences and reflections on caring for and understanding terminally ill patients was very interesting.

The following are some of the ideas she shared with us :-

Terminally-ill patients and unfinished business

We may not be able to do much, medically, for terminally ill patients, but we can sit at their bedside, talk with them, hold their hands and give them the opportunity to share their lives with us. They may have much piled-up "unfinished business". There may still be in their hearts a lot of resentments, bitterness, anger, hate, revenge or guilt. We can help them to get rid of these by listening to their painful feelings and to find ways of healing. For example a terminally ill woman may not have talked to her mother-in-law for ten years because she opposed the marriage to her son. The painful feelings of resentment or even hatred have remained. Could the patient be encouraged to say one nice word to her mother-in-law, to admit her feelings and ask for forgiveness or send her mother-in-law some flowers?

Talking about dying

Some terminally ill patients have worked through their fear of dying and will just say to you in plain English "I am going to die". Others

are afraid to talk about it often because we shy away from the subject or become distressed. Yet they need to communicate with someone. Often they need to use symbolic language or even a parable. We may intuitively say "I know you are trying to tell me something" and give the patient an opportunity to share. When they are trying to put their feelings into words do not nod or pretend that you understand if you do not really understand. Let the patient try to explain in another way. Drawing a picture or a symbol often helps. Once the patient has communicated there is freedom. acceptance and relief.

Dying at home

Most patients wish to die at home surrounded by their children or family -- surrounded by what is familiar. There is such a difference between dying at home and dying in an intensive care unit where visits are few and short; where the patient is isoslated, hooked up to tubes, etc. Of course we need to prepare families to take the patient home to die. There is now a lot of oral pain relief medication to enable us to keep cancer patients pain-free and conscious.

Children and Death

Children are not born with a fear of death. We pass on our fears to them. A child who has been really loved up to the age of six -- unconditionally loved and has received enough firm, consistent discipline will neither be afraid of living nor of dying. He will face whatever windstorms come in life with great equanimity and ultimately, he will learn that the tragedies and the pain of life are really gifts that teach us to grow, to get deep roots and to be prepared for whatever life brings us. The peole who die sadly are those who have not experienced unconditional love. Love cannot be bought; it is not got after bargaining "I'll love you if .....".

Children, human beings, consist of a physical, emotional, intellectual and spiritual quadrant. A five-year old child with a brain tumour does not understand intellectually what a brain-tumour is, but the child, because of the physical quadrant deteriorating, develops very early in life a stronger spiritual and intuitive quadrant. Our job is to sit with the child and maybe start playing a game with them and then ask them to draw a picture of themselves. In that picture

their developed intuitive and spiritual quadrant will reveal knowledge of their sickness -- the brain tumour and even when they are going to die. Often for the child, dying may be expressed as flying home to the Father in Heaven in the sky. There is joy and excitement.

AIDS

One of the most isolated and lonely groups of terminally ill patients today are little children with AIDS. Because of the great fear people have of contagion no one wants them -- no one wishes to touch them. They are the "lepers" of the modern world. Dr. Kubler-Ross said that we as Christians should be the first to help these children. As Christians we know that "Greater love than this no man has than to lay down his life for his friend". She even suggested that we should think of setting up an AIDS Centre in Hong Kong where people could receive care and love which is unconditional.

* * * * * * * *

Dr. Kubler-Ross is inspiring and experienced. We hope that we can have more opportunities of listening to her. She can inspire us with her attitudes, insights, dedication and love for the terminally ill.

-Rev. Fr. A.J. Deignan, S.J.

GUILD REPORTS

At the Annual General Meeting held on 25 June 1985 officers and Council members for 1985-86 were elected, and the Council of the Guild is as follows:

Spiritual Director: Rev. Fr. John Russell, S.J.

Master: Dr. George Chan
Hon. Secretary: Dr. Robert Yuen
Hon. Treasurer: Dr. Stephen Law

Council Members:

Dr. Chan Wai Kai
Dr. Emmanuel Chang
Dr. Samuel Choi
Dr. Stephen Foo
Rev. Sr. M. Gabriel
Dr. Ku Kwok Wai
Dr. Henry Leung
Dr. Diana Siu

Immediate Past Master: Dr. Vincent Tse

Liasion and Hospitality Officer: Rev. Sr. M. Aquinas

The Master and the Hon. Secretary can be reached at the following:

Dr. George Chan: Haematology Unit, University Dept. of Pathology, Queen Mary Hospital. 5-8192180
Dr. Robert Yuen: Paediatric Unit A, Princess Margaret Hospital. 3-7427111

A SHORT REPORT ON THE ACTIVITIES OF THE GUILD IN 1984-85

The year is over and it is time to review what the Guild has done. As usual, we carried out our activities quietly, but we like to think that those who attended found themselves tightly knitted into the occasion. We have also introduced new activities which I hope will meet with your approval.

1. Masses for Special Occasions:
   a. Medical Sunday Mass - held on 21 Oct. 1984 at 10:30 a.m. in St. Joseph Church. We were honoured by the presence of the Bisohp, Most Rev. John Baptist Wu.
   b. Family Mass - on 6 Jan. 1985 at Diocesan Centre, Waterloo Road, Kowloon.
   c. Thanksgiving Mass for the medical graduates of 1985 - this was held on 25 May 1985 at 4:30 p.m. in Ricci Hall Chapel. The Mass was celebrated by Rev. Fr. Russell and was attended by several members of the Guild and about 30 medical students from various years from both universities, in addition to the graduates.

2. The Annual Retreat:
   This important annual event was held on 31 May 1095 at Wah Yan College, Kowloon, with Rev. Fr. Edward Collins as our Retreat Master.

3. Combine Meetings:
   This is a series of meetings attended not only by Guild members but also by nurses and medical students on topics of common interest. These meetings were held usually bi-monthly on the last Friday in Ruttonjee Sanatorium at 7 p.m.

   In the year, these meetings were held:
   *Rev. Fr. George Zee and Mrs. Grace Cheung (CMAC) - - Responsible parenthood
   *Rev. Fr. Jack Sullivan and Dr. Antony Tam - Communication in the hospital wards
   *Rev. Fr. Anthony Cheng and Rev. Fr. Thomas Kwan - Faith and 1997
   *Dr. Elizabeth Kubler-Ross - Care of the dying.

Dr. Kubler-Ross gave a most stimulating and instructive talk on 30 April. This can be considered highlight of the year for this series, and the meeting was attended by about 100 people.

Other meetings were held with an attendance from 30 to 50. With this smaller group, mutual sharing of feelings and experience by members present was very successful. Often a gathering had to be halted because it ran into late hours of the night.

In the coming six months, the venue of the meetings will be the 'glass room' of Wah Yan College, Kowloon, and the date will be the 2nd Fridays of alternate months (i.e., 12/7, 13/9, 11/11) from 7 p.m. to 9 p.m. We hope this place is more convenient for everybody.

4. Newsletter:

This is a new attempt to privide some information and material for thought on topics of our concern, and a forum for members. The plan is to start with 4 issues per year. Publication is under the management of a subcommittee headed by Robert Yuen, with Fr. Russell, George Chan, Antony Tam, Stephen Law and myself forming the team.

It is costly for the Guild (considering the meagre annual income from membership fees) to publish the Newsletter; but thanks to a handsome donation from a member (who prefers to remain anonymous and only allowed us to reveal that he is a past master of the Guild), we are relieved of the worry for funding and can continue with our plan and concentrate on working on the Newsletter. (A note added by the editor: at the AGM, Dr. George Choa also pledged support for the Newsletter for a year. Thanks!)

This is early days for the Newsletter and we are still searching for our direction. Comments, articles and prayer from you are necessary and highly appreciated.

Before I end, I must thank all friends and members of the Guild who have given us their help and support -- for praying for us, for speaking at our meetings, for allowing us to use their properties, and in many other ways have made possible the smooth running of

the Guild activities. The Council also joins me in expressing our deepest thanks.

May the peace of Christ be with us all.

-Vincent Tse

MEMBERS' FORUM

**In my opinion, the Newsletter is a great contribution of the Guild and helps to bring the readers in medical practice closer to God. I shall be very sorry if we have to cease publication because of shortage of funds. Please accept the enclosed cheque as my donation to this publication.

-A Past Master

**I wish to share with our members the following statement which was published in 1974 by the Catholic Health Association of the United States. It is not a legal document but one for reflection and meditation, and is consonant with the Feature of last issue:

I, _____, request that I be informed as death approaches so that I may continue to prepare for the full encounter with Christ through the help of the sacrements and the consolation and prayers of my family and friends. I request that, if possible, I be consulted concerning the medical procedures which might be used to prolong life as death approaches. If I can no longer take part in decisions concerning my own future and there is no reasonable expectation of my recovery from physical and mental disability, I request that no extra-ordinary means be used to prolong my life.

I request, though I wish to join my suffering to the suffering of Jesus so I may be united with him in the act of death-resurrection, that my pain, if unbearable, be alleviated. However, no means should be used with the intention of shortening my life.

I request, because I am a sinner and in need of reconciliation and because my faith, hope, and love may not overcome all fear and doubt, that my family, my friends, and the whole Christian community join me in prayer and mortification as I

prepare for the great personal act of dying.

Finally, I request that after my death, my family, my friends, and the whole Christian community pray for me, and rejoice with me because of the mercy and love of the Trinity, with whom I hope to be united for all eternity.

-Luke S.G. Chua

(Letters from members are welcome and should be sent to Dr. Robert Yuen, Paediatric Unit A, Princess Margaret Hospital, Kowloon. Letter submitted may be edited.)

WORD FROM THE MASTER

Dear members,

It is with trepidation that I pick up the pen and write. I, one of the youngest among the members, am writing to you in this column. You have entrusted me an important task, and I hope with your support, with the combined effort of the Council, and above all with the guidance of the Holy Spirit, I will not disappoint you too much.

At the last AGM, it was agreed that the membership fee should be raised to HK$100 per year. This is to cover the expenses of projected activities. If you were not at the meeting, I hope this increase will meet with your approval too. Our Treasurer is looking into ways which will make payment of membership dues less cumbersome to you, and you will hear from him soon.

At the same meeting it was also decided that members within 5 years of graduation pay a reduced fee of $50. This is not to create disparity among members but intended as a means of encouraging more young Catholic doctors to join the Guild. This is but one of the ways to attract the attention of young graduates. At the first Council meeting we will have a full-fledge discussion on this problem and I will keep you informed of this.

A question which has been in my mind is, what is the role of the Guild in this changing world? It is no light problem, and I do not pretend that I know the answer. But I would like to see the Guild at least working as a source of information on aspects which we should be concerned, such as in-vitro fertilisation outlined in this issue, so that we will not be 'caught unprepared', but are rather '(prepared) to make a positive contribution to the common good'.

I would also like to see the Guild as reminders to act, or sometimes even to act, on issues meriting our attention. This is more difficult and may land us in troubled waters. But with the light of

the Spirit and pooled opinion from everyone, may we be kept at the right path. And this is where your participation is most important. For the start, let us remind ourselves that it is our duty to vote at the Legislative Council election, to find the most suitable representative of the medical community in which we are a part.

And all these are, of course, in addition to the established role of the Guild in the Church and for its members.

May God bless and guide us all.

Yours in Christ,

George Chan