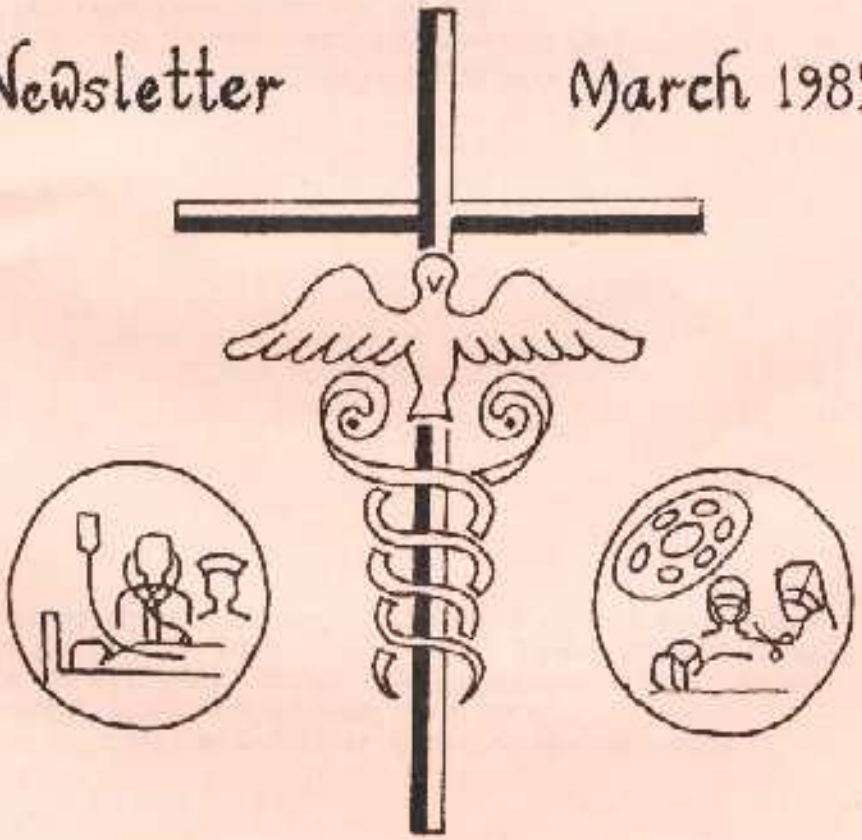
Guild of Saints Luke

Cosmas & Damian

Newsletter March 1985



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CONTENT

The Newsletter is published by the Publication Subcommittee of the Guild of St. Luke, Sts. Cosmas & Damian of Hong Kong. Editor: Robert Yuen. Correspondence address: c/o Ruttonjee Sanatorium, Queen's Road East, Hong Kong.

A PHYSICIAN'S PRAYER

Dear Lord, Thou Great Physician, I kneel before Thee. Since every good and perfect gift must come from Thee.

I PRAY:

Give skill to my hand, clear vision to my mind, kindness and sympathy to my heart.

Give me singleness of purpose, strength to lift at least a part of the burden of my suffering fellowmen and a true realization of the privilege that is mine.

Grant that those who come into my care suffering from the infirmities which beset human frailty may be restored to health of body and mind and strengthened in their desire to serve Thee.

Amen.

FEATURE:

...ADD LIFE TO THEIR DAYS,

IF NOT DAYS TO THEIR LIFE...

THE DYING PERSON'S BILL OF RIGHTS

Workshop of "The Terminally Ill Patient and the Helping Person", Lansing, Michigan.

I have the right to be treated as a living human being until I die.

I have the right to maintain a sense of hopefulness however changing its focus may be.

I have the right to be cared for by those who can maintain a sense of hopefulness, however changing this might be.

I have the right to express my feelings and emotions about my approaching death in my own way.

I have the right to participate in decision concerning my care.

I have the right to expect continuing medical and nursing attention even though "cure" goals must be "comfort" goals.

I have the right not to die alone.

I have the right to be free from pain.

I have the right to have my questions answered honestly.

I have the right not to be deceived.

I have the right to have help from and for my family in accepting my death.

I have the right to die in peace and dignity.

I have the right to retain my individuality and not be judged for my decisions which may be contrary to beliefs of others.

I have the right to discuss and enlarge my religious and/or spiritual experiences, whatever these may mean to others.

I have the right to be cared for by caring, sensitive, knowledgeable people who will attempt to understand my needs and will be able to gain some satisfaction in helping me face my death.

AN EXCERPT FROM
DR. J.F. HANRATTY: HOSPICE CARE OF THE DYING PATIENT

Despite enormous advances in medical expertise, treatment of the dying is often sadly mismanaged and many people die with unrelieved pain and distressing symptoms inadequately controlled. This is especially sad as we have readily available various therapies and medications which if correctly used will give patients significant and, in most cases, complete relief from their suffering.

The mainstream of modern medicine is directed towards a cure. There is nothing wrong with this aludable aim, but by constantly striving to cure, doctors, when confronted by a patient who cannot be cured, sometimes have a sense of failure, defeat and even guilt. They are also personally distressed by the plight of the patient yet feel helpless and embarrassed. At this stage it is common for doctors to withdraw ("There is nothing more I can do for this patient") and delegate continuing care to juniors, to nurses, to the family or to nobody in particular. The patient and family are isolated and suffering ensues due to distancing of medical care.

The converse may also occur when intensive and sophisticated treatment is continued unthinkingly long past the time when it is obvious that the patient is dying. This may prolong dying rather than prolong living. It is never easy to decide when to cease efforts to cure and each patient poses unique problems.

Hospice care postulates that having established that the diagnosis is accurate and death is not far distant, the management of the patient's illness requires a change of role and attitude - there is nothing more to be done by further attempts to CURE the patient but there is an enormous amount to be done by CARE to ensure that the remainder of the patient's life is free from pain and discomfort. This is a recognition that dying just the same as being born is a process requiring skillful medical and nursing care.

-Dr. J.F. Hanratty
Medical Director
St. Joseph's Hospice
Hackney, London.

THE HEART OF THE CARE OF THE TERMINALLY ILL PATIENTS, AND THE CARETAKER

Illness may precipitate a spiritual crisis. Since crisis may mean a danger or a chance, depending on the free choice of the person, it could mean a danger to be farther away, or a chance of getting nearer to God. The care-takers are to facilitate the patient to make that choice more freely by reducing the undue pressures against that freedom and by relating to his true needs as a whole person. When the crisis is more profound, the patient needs a team to help him and to be with him at various times and for different needs.

For the terminally ill patient, it is a time when he is brought face to face with his ultimate concerns of his life. He will turn to his source of life somehow and sometime. He knew, most of the time, even if he was never told, that he is progressively getting more seriously ill. In such time, assessment of spiritual needs, along with the psychosocial and biological needs of this patient, is essentially in order to care most effectively for this whole person.

This raised two questions in me ten year ago, then fresh from the medical school:

To know the patient as a whole person. Does this mean that my time and energy is going to thin out in finding out all those complexities of a person's life, which the medical school somehow did not "include" in the syllabus? It took me a few years to really know how to use the great tools of learning to do that effectively. The tools are time and acceptance. My attitude: Time I choose to invest in the learning process called encounter, and my accepting attitude of others' lifestyles, so that I culd listen and hear.

Every doctor remembered how short of time were his medical school days. Attitude is something very difficult, if not impossible, to teach (verbally). It is something to be transmitted through modelling, living it out. It is much easier to find good lecturers than good mentor-models. Over the years, I have learned to paint a good picture of a person by looking at his "four pillars" of support, namely, family, job, friends and leisure. These four pillars make a good base for him to rest on. If he is single or widowed, jobless or

retired, or worse still, fired, recently moved or having deficits in communication: deaf, blind, hard to walk,or that he seldom enjoyed hobbies, his life is less well supported, and the care team has to be and do more. "I do not have time" is not a good reason not to encounter him as a person.

The second question is "Will I be too personally involved, overly emotional and thus jeopardizing my professional objective capacity?" This is a question practitioners apt to ask - who care for the care-takers?

In fact the International Work Group on Death, Dying and Bereavement (1979) stated in its staff-oriented pronciples that, as emotional committment to good terminal care will often produce emotional exhaustions, effective staff support systems must be readily available.

To cultivate a professional posture, open yet protective, intimate yet objective is the art of medicine. Honest empathy is not sympathy. I used to think that this is reserved for great clinicians. A little of my humble experience may convince better than word or create more resonance to share, that every doctor is called to this greatness (if you choose to call it so) as all man is called to holiness and our profession is unique in facing men in their most human - situations of crisis, suffering, searching for meaning, and leaving (death), and encountering. I had the experience in taking part in a team caring for more than 400 terminally ill patients and their families in the last two years. I have come to learn to live more meaningfully through my relationships with these patients, families and staff. They might be my models "negatively" more than "positively", but the lessions I learnt worths more than the time and effort I voluntarily put in. Many times the patient is our teacher because it is his life, not our sciences, that matters.

I unabashedly wish you fruits of many folds from taking this challenge. Peace be with you while you toil before the first crop. But I assure you once you tasted the first crop, you would not want even to turn your head while ploughing, for this is real satisfaction.

Attitude towards the dying person is that towards life, for, after all, dying is LIVING TO THE (EARTHLY) END. Care for the dying is thus a privilege, grace not for many professions. In facilitating him to encounter Christ in the ways that fit him, i.e., to live more

meaningfully, I could learn to live more deeply in Christ, FOR JESUS IS LIFE. As Christians, we are pro-life. So let us add life to their days, if not days to their life, so that he may choose to live better to the end, leaving a "legacy" for his family in that mourning is shorter, less painful, fewer reproaches, more relief. Memory is then a tribute, not a burden. This is good bereavement service, good preventive medicine for the bereaved family especially the spouse-survivor. The higher mortality and morbidity within years of bereavement of these survivors are filling up volumes of research works.

Having addressed the issues of the inner tools a doctor may need to use himself as "therapy", and that of energy replenishment: satisfaction, let us take a few highlights in the daily working of the care of the dying. Over the years, observations from the hearts of patients have helped to formulate the following essential features in the care of the dying patient:

Competence of the staff.
Concern: the secret of care of the patient is in caring for the patient.
Comfort: pain control, mouth care, etc.
Communication: the real question is not "what do you tell your patients?" but rather "what do you let them tell you?". Genuine listening is very much valued.
Children: investigators unanimously agreed their presence (suitably prepared) is likely to console and relieve. A useful rule of thumb of whether that child should visit is to ask him whether he/she wants to visit.
Cohesion of family: a shared burden is one made lighter.
Cheerfulness: gentle and appropriate sense of humour could bring much relief to all relieved.
Consistency and perserverance: the staying power often requires hearing out complaints, a capacity in staff that was frequently singled out for appreciation.

I do not choose to write about how to reveal the diagnosis and prognosis, use of opiates, the whole book on symptom control, techniques of communications, or the environment and set-up of the hospice, because I believe, one your heart is set, appropriate knowledge and skill will soon come.

-Antony Tam

WHAT HAS BEEN DONE? WHAT CAN WE DO?

Hospice service was started in the late 1960s in the United Kingdom. Its aim is to provide palliative and supportive care for the terminally ill, usually cancer patients. This movement has since spread all over the world. Such service may be hospital based or free standing, and may include home care as well.

In Hong Kong hospice care is still a new concept. Cancer patients at their terminal stage may be cared for in wards in different public hospitals. Some such patients may afford staying in private hospital wards. In addition there are a few places which specially care for terminal cancer patients. These include Nam Long Hospital at Wong Chuk Hang run by Hong Kong Anti-cancer Society, two cancer wards at Caritas Medical Centre of So Uk Estate, and the palliative care ward of Maryknoll Hospital. It is also heard that the extension of United Christian Hospital may include a palliative care ward in its plan.

Since the main emphasis of hospice service is on spiritual support in addition to medical and nursing care, special institutional care is not essential. Any medical practitioner so motivated can offer their help in their own ways, whether in specialised wards or in private practice.

We Catholic doctors, gifted with faith, charity and knowledge, perhaps should have a great interest in providing such service.

-Vincent Tse & Stephen Law

INTRODUCING....

THE HONG KONG CATHOLIC MARRIAGE ADVISORY COUNCIL (CMAC)

Address: 502 Caritas House, 2-8 Caine Road, Hong Kong.
Tel.: 5-242071 ext. 259/260

This council was launched in 1965. At present it has some 150 members.

With the assistance of a team of dedicated volunteers and a small salaried staff, it operates in three main areas:

1. Counselling for couples and individuals with marital difficulties,
2. Education programmes in the art of human relations for those preparing for marriage,
3. Medical counselling in family planning, fertility and psycho-sexual problems.

It provides a service to all irrespective of creed or nationality, creating opportunities through counselling for people

-to meet their growing needs
-to understand themselves, and
-to understand each other.

For in the final analysis, it is the happy family life that can mould and create happy, mature, well-adjusted people within the family circle and in the community.

The two areas in their service which specially welcome the participation of doctors working as volunteers are:

1. Premarriage curse for young cuples - here a doctor can give an hour's discussion on the medical aspect of family planning, especially the practice of natural family planning,
2. Natural family planning clinics. These clinics are operating in the evening of weekdays, where doctors help clients to learn the NFP method. In addition, clients may come for infertility and marriage problems.

All the services are provided free of charge. If you want more information, it may be easiest for you to contact Rev. Fr. Russell, S.J., who is the Ecclesiastical Director and Vice-Chairman of CMAC and also the Spiritual Director of the Guild.

-Vincent Tse

TO PONDER ....

In this issue Fr. Russell has traced and summarised for us a controversal issue. What is your stand?

CONFIDENTIALITY AND PARENTAL RESPONSIBILITY

A fifteen-year-old girl asks her doctor to put her on the Pill, insisting that her parents not be told. What is the doctor to do? Refuse, unless she allows him to contact her mother or father? Or conclude that he must help her at all costs to avoid a pregnancy that she will almost certainly want to abort? If he does prescribe the Pill for her, will he seem to be condoning - encouraging, even - an illegal act? For it is against the law to have sex with a girl not yet 16.

Doctors in the United Kingdom, wrestling with this problem, were assured in a 1980 circular from the Department of Health and Social Security that, although they should try their best to get the girl to talk with her parents, nonetheless medical practitioners are breaking no law by prescribing contraceptives for a girl under 16 without parental consent, should the girl absolutely refuse that her parents be told.

This may have clarified the legal position for the medical profession. It enraged, among others, Mrs. Victoria Gillick, a mother of ten, who saw it as a further erosion of parental rights. She claimed that the DHSS guidelines encouraged under-aged promiscuity. In her view, when contraceptives are prescribed by doctors without the knowledge of parents, the family structure is undermined. "If my children want help and advice," she said, "they must come to me. I don't want them to be able to go to a doctor who, after five minutes' chat, can dish them out contraceptives without concern for the family medical history or moral guidance." She therefore sought an assurance from her Area Health Authority that her five daughters, aged from 2 to 15, would not be given contraceptives or abortions without her knowledge and consent. The Authority refused to give this assurance. In June 1983, she took them to court.

The case was heard in the High Court in July of that same year. Judgement, however, was given against Mrs. Gillick, and the court ruled that, though it was illegal to have sexual intercourse with a girl under 16, it was not illegal to give her contraceptives if he did so in an attempt to protect her from an unwanted pregnancy, having made up his mind that, despite his own disapproval,

intercourse was likely to take place.

Mrs. Gillick's campaign provoked a good deal of feeling, both for and against. Lord Devlin, one of the most respected judges in the United Kingdom, was quoted as saying that the issue brought to public attention by Mrs. Gillick may well be socially the most important of this decade. Mrs. Gillick has some powerful allies. The leaders of the main Churches have stated their support for her. She claims to have the backing of some 200 members of parliament. Even the Prime Minister, Mrs. Thatcher, is reported to be on her side. And among the public at large her cause seems to have touched a deep chord. A petition, circulated soon after the High Court judgement went against her, raised 250,000 signatures. However a lot of professional opinion, the BMA, some nursing organisations and - predictably enough - family planning groups, oppose her stand. These people are convinced that it is sometimes necessary to put young girls on the Pill without telling their parents.

Though bloodied by her defeat, Mrs. Gillick remained unbowed. Drawing on family savings and availing herself of State legal aidd, she appealed against the High Court's verdict. The Court of Appeal handed down its decision just before Christmas last year. The three senior judges in their ruling overturned the judgement of the High Court. They declared that, having studies the relevant statutes dealing with the legal rights of parents in respect of their children under 16, doctors should be obliged, in nearly every case, to obtain parental consent before prescribing contraceptives to, or performing an abortion on, under-age children. The exceptions are either cases of emergency (when an immediate abortion might be required or where treatment was necessary after an assault) or with leave of the court. They also declared the guidelines in the 1980 DHSS circular to be unlawful.

Mrs. Gillick and her supporters have of course been delighted with this turn of events. Many others have been less enchanted. The Government and the BMA are understandably embarrassed. Amid angry warnings of a surge in unwanted pregnancies and backstreet abortions - the familiar spectres raised by the pro-abortion lobby - as well as anxious appeals from doctors fearing they risked jail sentences - a not-very-likely eventuality - the Government has said it will appeal to the House of Lords to overturn the judgement

of the Court of Appeal.

An interesting aspect of the case has been the attitude of the English Bishops. Mrs. Gillick, a Catholic, has expressed her disappointment at their lukewarm support for her cause. But traditionally Catholic moral theology has placed much stress on doctor-patient confidentiality, since there is a close parallel between it and the confidentiality that must be upheld between confessor and penitent, priest and the one he counsels. It is the Bishops' fear that the weakening of the right to privileged communication in any one area will be bound, sooner or later, to have an effect on other areas as well. Moreover Mrs. Gillick's case in its universal application (for she initially brought her case only in respect of her own daughter) seems to rest on the premise that all parents are perfectly capable of exercising their responsibilities towards their offspring, and that children at 15 years of age are able to communicate easily with their parents on matters of sexual behaviour. This may be the ideal situation: alas, it is very far removed from reality.

The breach in the traditional doctor-patient confidentiality sought by Mrs. Gillick might now make some girls frightened of approaching a doctor, so that the doctor has no chance of persuading them to consult their parents, as presumably the vast majority of conscientious doctors have hitherto been doing. As a result, though some girls may be deterred from under-age sex, others will resort to a black market in contraceptives with evident danger to health. Yet others will have sex without contraception: of these some will have to cope with early motherhood, some will opt for an abortion.

If the House of Lords upholds the judgement of the Court of Appeal, the British Government will be faced with the dilemma either of accepting the ruling with good grace and withdrawing the DHSS guidelines, or trying to get the law changed. They will be under a good deal of pressure to adopt this second course. That, however, could involve fighting off charges that they are encouraging promiscuity and attacking the family, an uncomfortable prospect for a Conservative Party administration. As an editorial in the conservative Daily Telegraph commented: "Mrs. Thatcher could face two years of parliamentary mayhem over this."

The debate continues. There is much to be said for the views of Mrs. Gillick as well as for those of her opponents. One commentator summed it up well: "For once I find myself wholeheartedly on both sides of the argument."

-Rev. Fr. John Russell, S.J.

WORDS FROM THE MASTER

Dear members,

After reading the first issue of our Newsletter, I hope you will not mind receiving this second issue. Can I expect that in fact you look forward to receiving this second issue?

We have heard a few favourable comments on the first issue. All favourable comments - too good to be true. If you really appreciate the Newsletter, do give us your comments and suggestions. Spur us to improvement. Make the Newsletter a real forum for dialogue and not just a publication by the Publication Subcommittee of the Guild.

Dr. Emmanuel Chang has sent us a copy of "A Physician's Prayer" which we have reproduced elsewhere in this issue. The author of this prayer is not known to us, but Emmanuel has been using this prayer for over 25 years. Thank you for sharing this treasure with us, Emmanuel.

The Annual Retreat is coming again. This is a very good opportunity for us to refresh our ailing souls, to strengthen our spirit. Your presence will also give mutual support to the Guild members attending this event. Details of the retreat are given in a separate notice.

May our Lentern exercise bring us reconciliation with God, and the Easter celebrations the joy of renewal.

Yours in Christ,

Vincent Tse