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JOURNAL OF THE CATHOLIC MEDICAL ASSOCIATION (UK)



CATHOLIC MEDICAL ASSOCIATION (UK)

PRAYERS BEFORE MEETINGS

Come, O Holy Spirit, fill the hearts of Thy Faithful,
and enkindle in them the fire of Thy Love.

V. Send Forth Thy Spirit and they shall be created.

R. And Thou shalt renew the face of the earth.

Let us Pray,

O God, who hast taught the hearts of the Faithful by the light of the Holy Spirit, grant that by the gift of the same Spirit we may be always truly wise and ever rejoice in His consolation. Through Christ our Lord

R. Amen

V. S. Luke

R. Pray for us.

V. SS. Cosmas and Damian

R. Pray for us.

V. St. Elizabeth of Hungary

R. Pray for us

PRAYER FOR OUR DECEASED MEMBERS

Out of the depths I cry to thee, O Lord hear my voice!

Let thine ears be attentive to the voice of my supplication!

If thou, O Lord, wilt mark iniquities, Lord, who shall stand it?

For with thee there is merciful forgiveness, and by reason of Thy law, I have waited for Thee O Lord.

My soul has relied on His word, my soul hath hoped in the Lord

From the morning watch, even until night, let Israel hope in the Lord.

Because with the Lord there is mercy, and with Him plentiful redemption.

And he shall redeem Israel from all his iniquities.

Eternal rest give to them O Lord

And let perpetual light shine upon them.

May they rest in peace

Amen.

PRAYERS AFTER MEETINGS

O Mother of God

we take refuge in your loving care.

Let not our plea to you pass unheeded in the trials that beset us,

but deliver us from danger,

for you alone are truly pure,

you alone are truly blessed.



TRANS:-
ABBOT PATRICK BARRY, OSB,
MONK OF AMPLEFORTH

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Submitting articles to the CMQ

CMQ is an open access medical journal set up to discuss key issues in medicine as they relate to and support doctors, nurses and other health care professionals in their practice. It is the journal of the Catholic Medical Association (UK). Views expressed are those of the authors and do not necessarily reflect the views of the CMQ editor or those of the CMA(UK).

Two editions of the Catholic Medical Gazette were published in in 1914 and 1920. From 1923 to 1941 the Catholic Medical Guardian was published quarterly. After 1947, the Catholic Medical Quarterly has been published.

We welcome articles on all aspects of Catholic health care. Articles will be subject to editorial review and may be reviewed by external peer reviewers. Where articles discuss matters of faith, peer review may not be by medical or other Health Practitioners. Articles should generally be between 400 and 1600 words.

We prefer references to be in the Vancouver style. Articles should be submitted to the editor electronically at:
Editorial email: editor@catholicmedicalassociation.org.uk

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THE CATHOLIC MEDICAL QUARTERLY

The CMA has produced its own journal every 3 months for the last 100 years since January 1923. The editorial team are always open to receiving new articles to include. If you enjoy writing and feel inspired to write an article for the journal, please contact the Editorial team to express an interest and we can provide you with further information:
editor.cmq@catholicmedicalassociation.org.uk

Further information together with the team's additional contact details can be found via the following link:
<http://cmq.org.uk/Contact-us.html>

Welcoming Pope Leo XIV and our new President.

We welcome Pope Leo XIV. May God bless him in his new role and may the Holy Spirit guide him. May his Catechesis of the world strengthen faith, devotion and hope across the world.

And may Pope Francis rest in peace enjoying his eternal reward. Eternal life grant unto him O Lord. May he rest in peace.

We also thank our ex-President Mike Delaney. Under his guidance the CMA has held ethics

conferences and many meetings for younger healthcare students and workers. His work and his encouragement of all this, including, of course, the effort of the people who actually made these events happen has been huge. Membership has increased and we very much hope that this will carry on.

And we welcome our new President, Dr Adrian Farrell. Adrian is a rheumatologist and we are very blessed to have him as our new President.

EDITORIAL

The Summer of Shame



Dr Pravin Thevathasan

It all happened within a week. On the 17th of June, 2025, the BBC headlines was: "MPs vote to decriminalise abortion in England and Wales." Actually, it was decriminalisation up until birth. The debate took less than an hour. There were hardly any speeches. Labour MPs cheered when the vote was passed. A celebration of legalised killing.

On the 20th of June, the BBC headlines was: "MPs back legalising assisted dying in England and Wales." Once again there were cheers. Another celebration of legalised killing.

Sometimes, words fail. I understand Christians who are personally pro-life but who prefer to focus on other issues. We in the Catholic Medical Association will never give up.

Biology Matters

The Supreme Court of the United Kingdom has unanimously declared that there is a real difference between a biological woman and a "transgender woman." Biology matters. We can now say this without fear of punishment. But the Supreme Court needs to be consistent: biology ought to matter when it comes to the definition of marriage. There is a real biological difference between a man marrying a woman and a man "marrying" a man. Biology matters.

Decriminalizing abortion



Dr Adrian Treloar

In the midst of the debate upon Assisted Dying amendments to the Crime and Policing Act were tabled that decriminalise abortion. When passed, this will mean that it is not a crime for a woman to procure an abortion if she is more than 24 weeks, or to procure abortion pills by phone if she is more than 12 weeks pregnant. Medical professionals open letter to MPs on proposed changes to abortion legislation.

Two amendments that proposed extreme changes to abortion legislation were tabled to the Crime and Policing Bill.

MPs, Tonia Antoniazzi and Stella Creasy, tabled amendments that change the law so it will no longer be illegal for women to administer their own abortions right through to birth. Both these amendments will not only lead to an increased number of babies' lives being ended beyond the current 24-week time limit, but would also likely lead to serious risks to women's health because of the dangers involved with self-administered late-term abortions.

In an open letter to MPs doctors wrote that rather than changing the law in this way, MPs ought to reinstate in-person medical appointments in order to accurately assess a woman's gestational age, any health risks and the possibility of coercion before abortion pills can be prescribed. Doctors wrote the following:

Dear Members of Parliament,
We are writing as medical professionals to express our grave concerns with Tonia Antoniazzi and Stella Creasy's amendments (New Clauses 1 and 20) to the Crime and Policing Bill that would change the law so it would no longer be illegal for women to administer their own abortions right through to birth. Instead of supporting these amendments, we urge MPs to protect women by reinstating in-person appointments before abortion pills may be prescribed in order to accurately assess a woman's gestational age, health risks and the risk

of coercion.

If offences that make it illegal for a woman to administer her own abortion at any gestation were repealed, such abortions would, de facto, become possible up to birth for any reason including abortions for sex-selective purposes, as women could, mistakenly, knowingly or under coercion, mislead abortion providers about their gestational age. If either of these amendments were to become law, it would also likely lead to serious risks to women's health because of the dangers involved with self-administered late abortions.

A November 2023 government review of abortion complications in England from 2017 to 2021 found that the complication rate for medical abortions that happen in a clinical setting is 160 times higher for abortions at 20 weeks and over compared with medical abortions under 10 weeks.² The complication rate is likely to be far higher for women administering their own abortions at home without medical supervision well beyond the current 24-week time limit.

Quite aside from the increased number of viable babies' lives being ended beyond the 24-week time limit, there would likely be a significant increase in such complications if Tonia Antoniazzi or Stella Creasy's amendments were to pass as they would remove any legal deterrent against women administering their own abortions late in pregnancy. The current law permits flexibility and compassion where necessary but, for these reasons, we believe a legal deterrent remains important.

Rather than making matters worse by passing either of these amendments, as medical professionals, we, the undersigned, call on MPs to vote against New Clauses 1 and 20. We also urge Parliament to reinstate in-person appointments before women may be prescribed abortion pills in order to accurately assess their gestational age and health. This is an important part of safeguarding (to protect against coerced abortion) and would enable healthcare professionals to ensure that abortion pills are only prescribed in cases when it is both medically and legally compliant to do so.

Yours sincerely,

Reference

1 HC, 'Crime and Policing Bill (Amendment Paper)', https://publications.parliament.uk/pa/bills/cbill/59-01/0235/amend/crime_policing_rm_rep_0609.pdf.

2 Office for Health Improvement and Disparities, 'Complications from abortions in England, 2017 to 2021', <https://www.gov.uk/government/statistics/complications-from-abortions-in-england-2017-to-2021>

The two key amendments that decriminalise abortion did indeed pass with huge majorities. But an amendment that sought to protect women by requiring a face to face consultation before pills are posted out to patients was defeated. The unborn child is even more vulnerable than ever

before as a result of these changes. Which is, of course, terrible news for unborn children.

June brought devastating setbacks for vulnerable people in our country. The work of protecting people, especially the unborn, the very sick and elderly must be redoubled. Never have a Catholic voices been so needed in healthcare.

A new pro-life medical professionals group, Healthcare for Both Lives, has just launched. If you would like to receive updates from this group, contact Right to Life.

Killing is wrong- but Assisted Dying Bill passes its second reading

Dr Adrian Treloar

Despite huge and heroic efforts by organisations such as Care not Killing, Right to Life, SPUC and Our Duty of Care etc, the Assisted Dying bill brought forward by MP Kim Leadbeater was approved in the Commons with a majority of 23. That majority was half what was seen at the first reading and it appears that concerns about safeguards persuaded many MPs to vote "No". The Bill now passes to the Lords where it will be scrutinized and where some attempts may be made to strengthen the safeguards, but it is rare for legislation voted for in the Lower Chamber to be stopped by the Upper Chamber.

It must be said that the safeguards appear thin, circumventable and bound to fail at least some vulnerable people.

Clinicians are powerful people and can be very coercive. I recall how upset my 93y mother (who had heart failure) was when two consultants walked into her room and said (well my mother said they shouted at her) "you must consent to be 'not for resuscitation. If you don't consent we wont resuscitate you anyway". She felt bullied and coerced. After discussion we agreed full ongoing care but not for resuscitation. Which seemed sensible and right. But despite that agreement, within an hour, despite unstable O2 sats, she was moved to a low dependency bed and within 8 hours she was dead. She had been bullied by doctors, had been afraid of the senior doctors and agreed under duress to limit care and died. How much more so will frail older people feel the pressure to "consent" to Assisted Dying. It seems impossible to think that that vulnerable people will not feel coerced into "consenting" to being killed.

But that is not, I think, the greatest problem.

Killing is wrong

What worried me most about the debate was not the issue of coercion and safeguards. Many MPs stated that with proper safeguards they would be in favour of legislation being passed. No one seemed to question the notion (explicit in the draft Bill) that with informed consent it may be ok to kill yourself or to be killed. "Give me choice over my death" and "It's my choice, allow assisted dying" were the slogans. As Christians, we do not agree with that. Life is a gift of God and to take life is wrong. We should not have the "choice" to kill ourselves. Just as we do not have the right to choose to kill others, or to rob a bank etc. Nor do we have the right to offer poor quality healthcare. Some things are always right. More things are always wrong. Killing is always wrong.

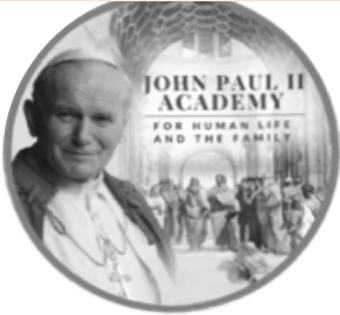
In the debate on Assisted Dying concepts of "right and wrong" were left out, replaced by "choice". The concept of choice depends upon choices being legitimate ones.

But it is God who gives life and takes life away. Killing is always wrong. We should not be able to choose Assisted Dying. The problems of safeguards, poor care, coercion and negative effects on the rest of healthcare are all effects of legislation that makes death a choice. But they are not the core argument.

Sadly, in our current non-religious society, the argument that we should not be able to choose death because life is given by God could not and cannot be heard. Many will lose their lives because the debate on assisted dying was lost.

When assisted dying becomes law in 2027, the need for doctors who will not kill will be greater than ever. As will doubtless be the attempts to marginalise and silence us.

The Culture of Death and the Failure of Catechesis



You are the salt of the earth. But if the salt lose its savour, wherewith shall it be salted?

Matthew 5:13

Coming just days after British MPs granted legal immunity to any woman who procures her own abortion (even up to the moment of birth), the House of Commons voted to legalise physician-assisted suicide. On 20 June 2025, the Terminally Ill Adults (End of Life) Bill passed its Third Reading by 319 votes to 291. However, these figures fail to reflect the true scale of the defeat.

During four hours of debate, most MPs who spoke against the Bill insisted that they were in favour of assisted suicide in principle but had serious concerns about this particular piece of legislation. Only a tiny handful of those who took part in the debate opposed a change in the law as a matter of principle.

The Bill's supporters invoked choice, autonomy and compassion while presenting consequentialist and utilitarian arguments. The counterarguments were based on fear of coercion, a lack of real choice, and unintended consequences. These criticisms were not persuasive, while arguments based on fundamental principles were largely left unsaid.

The principled objection to physician-assisted suicide, embodied in the Fifth Commandment, is also discernible through the Natural law. Five centuries before the birth of the Lord, the Hippocratic Oath enjoined doctors to do no harm:

"I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly, I will not give to a woman an abortive remedy."^[1]

The Natural law, which, in the words of His Holiness, Pope Leo, "constitutes the compass by which to take our bearings in legislating"^[2] is

written in men's hearts. (Romans 2:15) It is this universal law that shaped seminal international agreements such as the Universal Declaration of Human Rights when it recognised the inviolable integrity of the human person. Nevertheless, the truth proclaimed in such treaties is jeopardised by the moral collapse now afflicting formerly Christian nations. This moral confusion reflects the failure over the past 60 years of Catholic teachers, catechists and theologians to promote both the spiritual and "the anthropological reasons upon which respect for every human life is based."^[3]

Pope Leo, in his address to the International Inter-Parliamentary Union, recalled the example of St Thomas More, who, though Chancellor of England, was prepared to sacrifice his life rather than betray the truth. Having lost sight of this truth, too many of today's political leaders are prepared to sacrifice the weakest and most vulnerable to the culture of death.

We appeal, therefore, to His Holiness and to the bishops of the world to renew the church's catechetical instruction of the faithful so they can fulfil the Lord's exhortation to be the salt of the earth and a light to the world.

Only through an authentic catechesis that teaches the supremacy of God's law and equips the faithful to recognise intrinsic evil can we convince wider society that all innocent human life deserves equal protection under the law.

References

1. Ludwig Edelstein, *Ancient Medicine: Selected Papers of Ludwig Edelstein*, O Temkin and C Lilian Temkin, (eds) (trans from German) C Lilian Temkin (Johns Hopkins Press, 1967) p 6.
2. Address of Pope Leo XIV to the Members of the International Inter-Parliamentary Union, 21 June 2025
3. *Evangelium vitae*. 82

Many submissions were made to the committee scrutinising the Terminally Ill Adults Bill and we publish here some of them. Time was short in that committee and we regret that the arguments here were not heard more loudly. We print them here so that they are not forgotten.



The Catholic Medical Association (UK) represents Catholic doctors, nurses, pharmacists, hospital chaplains and other healthcare professionals within the UK. It celebrated its centenary in 2011.

The CMA (UK) welcomes this opportunity to respond to the consultation on the Terminally Ill Adults (End of Life) Bill which was presented by Ms Kim Leadbeater MBE on 29 November 2024.

Purpose and significance of the Bill

The purpose of the Bill is “to allow adults who are terminally ill, subject to safeguards and protections, to request and be provided with assistance to end their own life.”

The Bill concerns the deliberate and intentional killing of those considered to be within six months of natural death at their request. Those requesting assisted suicide must have mental capacity and a fixed intention to end their lives through assisted suicide.

The debate around the Bill assumes that assisted suicide would only occur out of compassion for the dying. However, compassion is not mentioned in the Bill and the intentions of those assisting the suicide of patients are not specifically considered.

Definition of assisted dying.

The term “assisted dying” has caused considerable confusion, as the main issue in the Bill is assisted suicide, or more especially the direct deliberate killing of patients. When the issues are debated many people consider palliative care as a form of assisted dying, as it is a form of assistance to those who are dying. However, although assisted dying

is in the heading of clause 1, it is not defined in the Bill.

Nevertheless, even without a specific definition, under Clause 29 “*Registration and investigation of deaths*,” the Bill amends the Births and Deaths Registration Act 1953, by adding a new section “39B *Regulations: assisted dying*.” This will enable the Secretary of State to issue regulations and use the term “*assisted dying*” to register a death.

It is most unusual for a Bill not to specifically define new terms that are to be introduced into homicide law. In clause 24, entitled “*criminal liability for providing assistance*,” the Bill expressly excludes assisted dying from consideration under the Suicide Act 1961. The Bill modifies the Suicide Act by introducing a new subsection 2AA. In this amendment of the Suicide Act: “*a reference to an act that is capable of encouraging or assisting suicide or attempted suicide does not include the provision of assistance to a person to end their own life in accordance with the Terminally Ill Adults (End of Life) Act 2024.*”

What is of concern here is that any act capable of encouraging or assisting not only suicide, but also attempted suicide, is exempted from consideration under the Bill. However assisting a suicide remains a criminal offence under the current Suicide Act. Under section 2(1): “A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.”

The proposed Bill would allow assistance with actual and attempted suicide by healthcare professionals. The fact that the patient must be registered with a general practice, strongly suggests that assisted suicide should be provided within the NHS and not privately.

Instigation of a prosecution for assisted suicide

Whilst the definition of what constitutes a crime is a matter of statute law, the issue of bringing a

prosecution in particular cases rests upon two central considerations. First, that there is sufficient evidence to bring a prosecution and second, whether it is in the public interest.

Prosecutors must apply the principles of the European Convention on Human Rights, in accordance with the Human Rights Act 1998, which include Article 2, the Right to Life.

In considering the public interest, prosecutors should consider the seriousness of the offence and the level of culpability of the suspect. Culpability is likely to include issues around the person's involvement, premeditation, personal benefit from the conduct, the chances of repetition, the age and circumstances of the suspect, undue pressure and the vulnerability of the victim.

On the other hand, prosecution is more likely if the victim was vulnerable or where the perpetrator was in a position of trust or authority or serving the public, as in the case of a medical professional. The seriousness of the offence and its effect on the public should also be considered.

Fundamental right to life: Article 2 incorporated into the Human Rights Act 1998.

The right to life must remain central to our understanding of human rights and international law. Medicalised killing in the form of assisted suicide and active euthanasia are logically inconsistent with the fundamental principles and philosophy of the UN Declaration and Covenants on the right to life and the Hippocratic tradition. The fundamental right to life derives from our human nature as members of the human family and must be recognised and protected through the rule of law and professional codes of medical ethics.

Changes to the law on homicide.

Changes to the law on homicide are both difficult and rare as the right to life is regarded as sacrosanct. This is particularly true when the target population are seen to be frail, elderly, vulnerable or disabled without a voice for themselves either individually or collectively. Nevertheless, the Bill seeks to decriminalise assisted suicide when performed by healthcare professionals, with the support of the judiciary.

The Hippocratic Tradition.

The prohibition of both active euthanasia and assisted suicide is embodied within the Hippocratic tradition and Oath:

“I shall give no deadly drug to any, nor will I counsel such.”

Both euthanasia and assisted suicide involve the deliberate killing of patients. Doctors are responsible ethically and legally for the prescriptions they provide for patients. To allow assisted suicide is to cross the Rubicon regarding the fundamental ethics of Medicine. It would also cross the Rubicon for lawyers, as High Court Judges will be required to give their “consent” and authorise the deliberate killing of the patient.

Consent.

Attempted suicide is familiar to psychiatrists, general physicians and emergency care doctors since attempted suicide is a common reason for hospital admission. What is new, is that healthcare professionals will be asked to be involved in the actual suicide.

The decision to commit suicide is complex, is often prolonged and usually involves patients with mental health problems, including severe depression. It is difficult to understand that the law will simply assume that the patient will have made a “voluntary, clear, settled and informed wish” to commit assisted suicide. Those who survive a suicide or para-suicide attempt are currently referred for a psychiatric assessment and support.

A particular concern for physicians, who would normally refer those who have attempted suicide to a psychiatrist, is that the patient would then receive proper counselling and support to prevent a further suicide. It would be a matter of considerable concern if the referral then led to the assisted suicide of the patient.

Diagnosis of terminal illness.

It is not clear as to whether the prognosis of six months treatment is with or without treatment, even if the condition cannot be reversed. Hence, insulin dependent diabetes is a progressive condition which is likely to lead to death within a short period if insulin is withdrawn. The term “*reversed by treatment*” is ambiguous. Insulin will alleviate symptoms and prevent death from an underlying condition which cannot be reversed, although the rate of progression can be significantly reduced by adequate insulin treatment. Similar considerations would apply to heart failure and other conditions which are not normally regarded as imminently life threatening unless treatment is withdrawn. Non curative cancer treatment is another example.

Management of those who are dying

We must all face death. There are as many experiences of dying as there are individuals. Of all the areas of medical practice, the care of the dying is one which even experienced clinicians and nurses do not find easy. Doctors and nurses find dealing with patients who are facing death difficult and there is no easy and universal answer. Empathy and understanding of the individual patient in their particular circumstances is essential. All patients are different and experience death in unique and individual ways.

Roles of the coordinating and independent doctors.

The Bill puts forward a radically different approach to the management of those thought to have six months to live. It would introduce into law the possibility of deliberately causing the death of those who are terminally ill. The only requirement of the proposed approach is that two doctors agree with the procedure. This is irrespective of any doctors who may know the patient and their condition and would not consider assisted suicide as the appropriate option. Family and friends need not be involved. Witnesses to the declarations would normally exclude family members who might be seen to benefit from the death e.g. as beneficiaries of the Will.

It is clear that the assessments of the “coordinating” and “independent” doctors is to be judged subjectively. Hence, the only legal requirement is that the doctor has made an assessment which is correct in the opinion of the “coordinating” or “independent” doctor. The pupils are allowed to mark their own homework

The patient can only be assessed by an “*independent doctor*” after the “*first period for reflection*” of 7 days from the first statement of the coordinating doctor. This could therefore be only a short time after the initial diagnosis for some patients who will still be coming to terms with the diagnosis of a terminal illness. This could be a time when the patient is still in denial or suffering anger or frustration at the diagnosis.

Court approval

When it comes to judicial approval of the declaration for assisted suicide, it is not clear if the process will remain largely secret, or will be held in Court at an open hearing when additional practitioners, witnesses and interested parties may be called.

It appears that the judge would only be confirm-

ing that the conditions of the Bill were satisfied and the decision of the patient was deemed to be voluntary, uncoerced and fixed. This is to cross the judicial Rubicon. It would lead to the death of countless patients whose lives were considered as no longer worth living by virtue of terminal illness and its sequelae. The remedy would be suicide authorised by the Court.

Assisted suicide, if approved by Parliament, will authorise both the judiciary and the medical and nursing professions to deliberately cause the death of innocent patients.

Sir James Munby, Former President of the Family Division, recently summarised the situation

“It is fundamental that the court cannot authorise the administration of treatment intended to kill. Specifically, a judge cannot authorise the administration to a patient of a drug intended to bring about the patient’s death. The Falconer Bill, and it would seem also the Leadbeater Bill, stand this fundamental and unchallenged principle on its head. What is proposed is that a judge by court order should facilitate the administration to a patient of a drug intended to bring about the patient’s death.”

Conclusion

Health professionals who are involved in assisted suicide, will be directly involved in deliberately killing patients. This will have a profound effect on the trust and confidence of the public in the medical and nursing professions. The memories of relatives and friends of the deceased will remain with them. Their trust in the individual clinicians involved will be deeply affected in the long-term. The standard of our palliative care must remain a gold standard to determine the quality of our care. Cicely Saunders pioneered palliative care in this country. It is now difficult to comprehend the impression that would be left if this Bill regarding the deliberate killing of our patients were to pass into law.

Dr Mike Delaney,
President of the Catholic Medical Association (UK)
18.01.25

Submission on Assisted Dying from the Bios Centre.



BIOS
centre

21 January 2025

Response to Terminally Ill Adults (End of Life) Bill Call for Evidence

Summary

- (1) The Bill is vague on how eligibility will be determined e.g. how pressure is to be excluded by doctors who may be previously unknown to the patient.
- (2) Waiting periods are short and there is no requirement the patient be suffering, have made use of palliative care options or be unable to receive treatment for any pain or distress they may have.
- (3) The Bill allows the proactive raising of the topic of assisted dying and also the proactive advertisement of assisted dying services to those not actively seeking assisted dying.
- (4) Doctors with doubts about competence are not required to seek psychiatric advice.
- (5) The Bill encourages doctor-shopping and there is no clear pathway for GPs, carers or family to raise concerns with the Court.
- (6) There is no right to appeal if the Court grants (as opposed to refusing) a declaration.
- (7) Proxy consent is included, which is risky.
- (8) Conscientious objection provisions, including for institutions, are inadequate.

Introduction

The Bios Centre is a London-based bioethics institute and is a charitable company. The majority of Centre researchers are based in the UK, while two of our researchers are based in Australia. Bios researchers come from various professional/academic backgrounds: philosophy, law, medicine and medical research. Our research interests are wide-ranging but include end of life care and assisted suicide and euthanasia (assisted dying).

The current submission concerns details of the Terminally Ill Adults (End of Life) Bill; for a more general submission on assisted dying, see the Bios Centre's evidence to the Health and Social Care Committee Inquiry on Assisted dying/assisted suicide.

Concerns with the Bill

Specific concerns we have with the Terminally Ill Adults (End of Life) Bill include the following:

- (9) The Bill is vague on how eligibility will be determined. A prognosis of months left to live is notoriously difficult for doctors to make, and there is no obligation in the Bill for the coordinating doctor to consult with a specialist in the patient's medical condition.
- (10) It is also unclear how the coordinating doctor and the independent doctor, who may be previously unknown to the patient, are expected to determine that the patient has a settled wish to die and is not under any pressure to do so.
- (11) The waiting periods prescribed are short and the second period may be shortened still further if death is believed to be imminent, leaving a situation of great stress where little time may be taken for reflection, despite the gravity of the decision and the existence of alternatives.
- (12) There is no requirement that the patient be suffering, have made use of palliative care options or be unable to receive treatment for any suffering they may have. A patient who merely fears suffering and is sceptical about the reach of palliative care and feeling overwhelmed by a recent prognosis they have not had time to process may still be able to persuade doctors (especially doctors unknown to them) that they have a settled wish to die.
- (13) The Bill allows a doctor to raise proactively the possibility of assisted dying. For a person in a position of authority to do this may give a strong – even if unintended – impression that this is the recommended option, at a time when the patient is very vulnerable and may be pessimistic about the extent of help available to manage their condition. Even if the doctor is required by the Bill to discuss palliative care, the very fact that assisted dying is brought up proactively, as the Bill allows (Section 4 (2)), may suggest to the patient that palliative care may not be able to deal with symptoms such as pain or other distress (for example, the patient may be unaware of the option of palliative sedation even to the point of deep sedation if pain is otherwise refractory to treatment).

- 14) Just as a doctor should not, in our view, proactively raise the topic of assisted dying, we recommend that there be provisions in the Bill to prohibit the proactive advertising of assisted dying services e.g. via posters and internet publicity. By 'proactive advertising' we mean advertising directed to those (or partly to those) who are not actively looking for such services and who may in some cases be depressed or even suicidal without wanting such services offered to them. Paid boosting of assisted dying sites should also be prohibited. Even in the case of government websites or physical facilities as opposed to the websites/facilities of external providers or advisors, these should not publicise assisted dying services to those who have not demonstrated an interest in them but have merely searched for/ tried to access end of life care. This is important not only for terminally ill people but for wider society: legalising assisted dying in a number of legislatures has been associated with a rise in non-assisted suicide ('suicide contagion' or the so-called Werther effect).
- (15) The Bill refers in Section 3 to the Mental Capacity Act, according to which a patient is assumed to be competent unless shown otherwise. In the Bill, the doctor 'may' (3 (b)) contact a psychiatrist if there are doubts about competence, but is not required to do so. It is important that in cases of doubt such contact be made mandatory: such doubts should be acted upon, not ignored at the doctor's discretion.
- (16) In any event, a competent patient may still be under subtle or not-so-subtle pressure from people or circumstances to choose assisted dying. The chances of e.g. the coordinating doctor picking up such pressure may be minimal, especially if this doctor - who will probably be a GP - was previously unknown to the patient and was chosen as less likely than the previous GP to raise concerns. Requiring the patient to be registered with his/her current GP practice for a certain period (say, 6 months) to be eligible to apply for assisted dying would do some thing to address this issue of 'doctor shopping' - which, however, remains a concern.
- (17) The Bill encourages doctor-shopping not only in relation to the coordinating doctor but in relation to the independent doctor, whose refusal may be passed over in favour of a second opinion. The independent doctor who refuses to make the statement mentioned in Section 8 (5) should at least be invited by the Court to give evidence, rather than the bare fact of his or her refusal being simply recorded.
- (18) In general, there are few opportunities in the Bill for a doctor such as a GP or recent GP who is not involved in the assisted dying process to raise concerns. According to Section 9 (2, e) the coordinating doctor should 'advise' the patient to tell their GP that they are looking for assistance to die. We believe the coordinating doctor should be required not just to give the GP (and, we would say, the previous GP, if the current GP is of less than 3 months standing) notice of the making of a declaration or statement (as at Section 16 (2)) but actually to consult with the GP (or previous GP, bearing in mind that the patient may have changed GPs recently and/or the new GP may be the coordinating doctor). That way, any concerns the GP/previous GP may have - for example, about lack of competence and/or family pressure - can be addressed and recorded in the medical notes.
- (19) Moreover, there needs to be a clear and easy pathway for a GP/previous GP with concerns to take these further i.e. to the Chief Medical Officer (CMO) but also to the Court. We recommend that there be a requirement for the Court to give notice of the patient's application to the GP (or previous GP if the current GP is the coordinating doctor and/or of less than 3 months standing) and provide a clear process for them to give evidence to the Court if they wish to.
- (20) Similarly, the Court is not currently required to hear from other witnesses, such as family members, who may have highly relevant information for the Court to consider. There needs to be a built-in method for concerned third parties - whether family members or carers - to challenge a declaration, given that their knowledge of the patient and his/her circumstances (lack of capacity and/or fluctuating desire for assisted dying and/or pressure from some particular family member or other influencer) may far exceed any knowledge of the coordinating or independent doctor. To enable such an intervention, family members need to be aware of declarations and applications

made. The coordinating doctor should be required to advise the current next of kin (and, if this is a different person, the person who was next of kin up to 3 months previously) of an intention to make a first or second declaration. The Court should also advise the current next of kin (and, if this is a different person, the person who was next of kin up to 3 months previously) that an application is being considered and invite them to give evidence. (We recommend that a recent as well as the current next of kin also be informed since a controlling relative who is pressuring the patient to choose assisted dying may also pressure the patient to make them next of kin.)

(21) In the current version of the Bill, there is no right to appeal if the Court grants (as opposed to refusing) a declaration. This is unacceptable, given how little may be known by the Court and coordinating doctor and independent doctor about the patient's true state of mind and situation. At a minimum, it should be no less possible to challenge the granting of a declaration as to challenge its refusal, given that the former allows the patient and others further time for reflection that would otherwise be denied.

(22) We are alarmed by the provision for proxy consent in Section 15. This section allows a proxy whom the patient has known for 2 years – or alternatively, who is a person 'of good standing in the community' – to sign on behalf of a person who cannot sign him/herself, and who is perhaps unable to speak as well. The possibility of being a proxy as described would seem to apply to an 18-year old neighbour with little knowledge of the patient or skill in interpreting their wishes. It would also seem to apply to an assisted dying campaigner whom the patient has never previously met and who is known to be willing to act as a proxy in such circumstances. We recommend that Section 15 be deleted.

(23) Conscientious objection is inadequately protected in the Bill, where 'participating in the provision of assistance' (Section 23) may be narrowly understood, bearing in mind that Section 18 on 'Provision of assistance' concerns the actual provision of/help to administer the approved substance. There is no mention of the conscience rights of independent doctors, pharmacists or indeed judges. Doctors who do not wish to discuss

assisted dying with patients are required to refer to those willing to do so. Moreover, even doctors who are happy to discuss assisted dying with patients (or patients who raise the question themselves) may find themselves professionally and/or morally uncomfortable with a level of involvement with the assisted dying process that employers or regulators may come to expect. For example, the doctor may be expected to give the patient a form – or sign a form themselves – which kickstarts the assisted dying process in some way. There is no protection in the Bill against such pressure: those doctors who currently discuss suicidal feelings with their patients as part of their normal work should not feel they need to 'back away' from doing so in the case of assisted dying or else follow a tightly-controlled script.

(24) The Bill needs conscience protections not just for individuals but for institutions such as hospices and care homes. Section 23 (2), for example, is not reassuring on that front: there should be no attempt to force hospices and care homes to retain as employees doctors who facilitate assisted dying, any more than e.g. a faith school is forced to ignore questions of ethos in their employment decisions. Hospices, care homes and other institutions have the right to create 'safe spaces' for patients, many of whom will welcome the fact that assisted dying will not be facilitated in what may be their last place of residence.

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Lejeune Clinic for Children with Down Syndrome



Lejeune Clinic for Children with Down Syndrome

Regarding: Lejeune Clinic Evidence

Submission - Terminally Ill Adults (End of Life) Bill 20th January 2025

We at The Lejeune Clinic wish to submit evidence regarding the Terminally Ill Adults (End of Life) Bill 2024-25.

With decades of experience providing specialized care to children with Down syndrome, and supporting thousands of families worldwide, we are deeply concerned about the implications this Bill could have on vulnerable individuals with intellectual disabilities.

1. Our Expertise and Concerns:

The Lejeune Clinic has been running for over 30 years and in that time has offered expert medical support, speech & language and occupational therapy services to children with Down syndrome, addressing their complex healthcare and developmental needs. We have firsthand experience of the challenges they face in accessing appropriate care, ensuring their rights are respected, and making informed decisions regarding their well-being.

Based on our experience and existing research, we believe the Bill presents several risks to individuals with Down syndrome and other intellectual disabilities:

2. Vulnerability to Coercion:

People with intellectual disabilities are at a higher risk of coercion due to their reliance on caregivers and professionals, which raises serious concerns about the ability to ensure fully voluntary decisions in end-of-life matters. Studies have shown that individuals with intellectual disabilities can struggle to assert their autonomy in medical settings.

3. Informed Consent Challenges:

Effective communication and understanding of complex medical decisions require significant support and expertise. Our clinical experience indicates that individuals with Down syndrome often need specialized communication techniques to ensure they fully understand their options and consequences. Without tailored safeguards, the potential for misinformed decisions is high.

4. Risk of Reduced Healthcare Investment:

Evidence from countries where assisted dying is legalized suggests a shift in healthcare priorities, with reduced investment in palliative and long-term care services. We fear that individuals with disabilities, who require lifelong support, may face reduced access to necessary services as a result of the Bill.

5. Ethical and Societal Concerns:

Legalizing assisted dying risks reinforcing negative societal perceptions that devalue the lives of people with disabilities, potentially leading to discrimination and reduced support for their inclusion in society.

6. Conclusion

We urge the Committee to carefully consider the implications of the Bill on individuals with intellectual disabilities and to ensure that robust safeguards are in place to protect their rights, dignity, and access to quality care. The Lejeune Clinic for children with Down syndrome remains committed to advocating for their well-being and offering our expertise to inform future policy decisions.

Yours sincerely,

Rev Dr Michael Jarmulowicz –
Chairman of the Board of Trustees
The Lejeune Clinic



Fr James McTavish

The so-called “conversion therapy” has attracted much attention and publicity worldwide. The Human Rights Campaign defines conversion therapy as “a dangerous practice that targets LGBTQ youth and seeks to change their sexual or gender identities.”^[1] It is not always easy to define what practices actually constitute conversion therapy. The UK government highlights that it most commonly involves spiritual methods (for example, prayer ‘healing’ or exorcisms, and pastoral counselling) and psychological methods (for example, talking therapies).^[2] In general, most mental health groups agree that conversion therapy causes harm to the victims. Although suspicion often falls on religious and faith groups’ handling of gender confused young people, I would like to focus attention on what happened at the UK’s national gender clinic, the Tavistock, with its now defunct Gender Identity Development Service (GIDS).

The Tavistock clinic

The number of young people attending the Tavistock rocketed from less than 100 in 2009/2010, to finally having more than 8,000 patients on their waiting lists before it was dramatically forced to close in 2024. The majority of patients were adolescent girls, with no previous (pre-pubertal) history of gender dysphoria. What is alarming is the research that showed that a very high percentage of these girls (and boys) had same sex attraction (SSA), yet this does not seem to have been appropriately addressed. Instead because of diagnostic overshadowing – the tendency to focus on one diagnosis only to the detriment of other co-existing issues – many were railroaded into gender affirmative treatment.^[3]

What happened at the Tavistock?

In her book “Time to Think” Hannah Barnes meticulously documents the collapse of the Tavistock.^[4] The work of this clinic had been heavily influenced by various gender affirming LGBT groups who were vociferous in their support, despite the fact that the clinic was offering substandard medical care for years. The staff at the Tavistock had begun to notice that many young people who presented themselves at the clinic had an aversion to being gay or lesbian. Families sometimes made comments like “Thank God my child is trans and not gay or lesbian.”^[5] According to Anastassis Spiliadis, a psychotherapist and psychologist who worked at the Tavistock, there were many “negative comments about gay people ... I had kids telling me, ‘When I hear the word lesbian, I cringe. I want to die’ ... ‘I’m gonna vomit if I hear the word lesbian another time.’” A large number of the teenage girls seen in the Tavistock had SSA. “Initially, some of them identified as lesbian. And some of them had experienced a lot of homophobia and then started identifying as trans. It was almost like a stepping stone,” explained Spiliadis.^[6]

Matt Bristow, a gay psychologist working at the Tavistock was equally concerned. Hannah Barnes writes,

Matt Bristow came to feel that GIDS was performing ‘conversion therapy for gay kids’. It’s a serious claim. Some clinicians have relayed how there was even a dark joke in the GIDS team that there would be no gay people left at the rate GIDS was going. ‘I don’t think that all the children there were gay, by any means,’ Bristow tells me. ‘But there were gay children there – in my view I think there were gay children – who were being pushed down another path.’^[7]

How many children at the Tavistock had SSA? In the adolescents presenting to the Tavistock in 2012, 90% of natal females reported they were same sex attracted or bisexual, and for natal males 81% were same sex attracted or bisexual. From 2015, 60% of natal males were same sex attracted or bisexual, and for females over 50% had SSA.^[8] These rates of SSA are staggeringly high when compared to the general population, where according to the Office for National

Statistics, 3.3% of the UK population identified as lesbian, gay or bisexual (LGB) in 2022.^[9]
Conclusion

Whether they expressed SSA or not, the vast majority of the young patients presenting at the Tavistock were funnelled into gender affirming treatments. We can legitimately ask, “Why channel same-sex attracted adolescents into puberty blockers after only a few consultations?” and “Would it not have been better to work through and address the SSA in these young people?”^[10]

Already in 2015, Pope Francis warned of the dangers of gender ideology.

In Europe, America, Latin America, Africa, and in some countries of Asia, there are genuine forms of ideological colonisation taking place. And one of these – I will call it clearly by its name – is [the ideology of] “gender.” Today children – children! – are taught in school that everyone can choose his or her sex. Why are they teaching this? Because the books are provided by the persons and institutions that give you money. These forms of ideological colonisation are also supported by influential countries and this [is] terrible.^[11]

It seems like his warnings went largely unheeded. It is surprising how the work of the Tavistock was able to proceed with full steam. This raises some serious questions about the duty to safeguard the health and welfare of the young patients who were treated there. The fact that the rates of SSA in the adolescents presenting to the Tavistock were significantly higher than the national rates should have been a red flag. This should have called into question the excessive emphasis on only gender affirming approaches. In the light of the above, we conclude that in reality a kind of conversion therapy was carried out on thousands of young people who presented to the Tavistock clinic. Even as advocates of gender transitioning may be quick to point fingers at faith-based groups, they themselves may stand in need of removing a log from their own eye.

Fr James McTavish is a Scottish missionary priest of the Verbum Dei community. He is a member of the General council, is active in teaching moral theology and bioethics, as well as giving formations and retreats. He can be contacted at jamesverbumdei@gmail.com

Verbum Dei is an Institute of Consecrated life in the Catholic church. It was founded in 1963 by Fr Jaime Bonet, and received Pontifical approval in the year 2000. The community has three branches - missionary men (priests and brothers), missionary women and missionary married couples, all working together in a full-time dedication to the Word of God. The UK Verbum Dei website can be found at <https://uk.verbumdei.org/>

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- [1] HRC Foundation. “The Lies and Dangers of Efforts to Change Sexual Orientation or Gender Identity.” See <https://www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy>
- [2] UK Government. “Conversion therapy: an evidence assessment and qualitative study,” Executive Summary. 29 October 2021. See <https://www.gov.uk/government/publications/conversion-therapy-an-evidence-assessment-and-qualitative-study/conversion-therapy-an-evidence-assessment-and-qualitative-study>
- [3] Diagnostic overshadowing occurs when the reality of the patient is seen only through the single focus of gender. The tendency is then to zoom in only on gender and overlook other concomitant issues.
- [4] See Hannah Barnes, *Time to Think: The Inside Story of the Collapse of the Tavistock’s Gender Service for Children* (London, Swift Press, 2023).
- [5] *Ibid.*, 160.
- [6] *Ibid.*, 160.
- [7] *Ibid.*, 161.
- [8] *Ibid.*, 161-162.
- [9] Office for National Statistics. “Sexual orientation, UK: 2021 and 2022,” 27 September 2023. See [https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2021and2022#:~:text=An%20estimated%201.8%20million%20people,as%20bisexual%20\(Figure%201\)](https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2021and2022#:~:text=An%20estimated%201.8%20million%20people,as%20bisexual%20(Figure%201)).
- [10] The Catholic vision of accompaniment is healing and holistic, as the Catechism of the Catholic Church (n. 2359) expresses. Persons with SSA “are called to chastity. By the virtues of self-mastery that teach them their inner freedom, at times by the support of disinterested friendship, by prayer and sacramental grace, they can and should gradually and resolutely approach Christian perfection.” For some general resources on how the Catholic Church accompanies same sex attracted persons, see “Same Sex Attraction in Catholic Women who Desire to Live Chastely,” available at <https://www.hprweb.com/2024/01/same-sex-attraction-in-catholic-women-who-desire-to-live-chastely/> and “Spiritual accompaniment for persons with same-sex attraction,” *The Linacre Quarterly*, 82 (4) 2015, 1-9, available at https://www.researchgate.net/publication/326593982_Spiritual_Accompaniment_for_Persons_with_Same-Sex_Attraction, as well as the resources available through Courage International at <https://couragerc.org/>.
- [11] Pope Francis, *Address of His Holiness Pope Francis at the Meeting with the Polish Bishops*, 27 July, 2016.

Science and Vatican II

Fr Patrick Pullicino

The increasing pace of scientific discoveries including the race to put a man on the moon in the late 1950s meant that there was widespread enthusiasm and support for science. In addition, science produced the first oral contraceptive pill which started to be marketed in 1960. The pill showed that science could be a major ulterior force for changing society.

Pope John XXIII had made reference to the marvellous progress of science in his day and on the need for science. ^[1] The feeling was that through science modern society would be able to give a better life to all and that the Church had to keep up with this inexorable progress. This appeared to be the principal motivation for calling of Vatican II “aggiornamento” or the bringing of the Church up to speed.

Professor Roberto Mattei has revealed behind-the-scenes activity during Vatican II.^[2] Apart from “aggiornamento” John XXIII did not appear to have an agenda but sought input from all the participants about what needed to be discussed. The number of participants asking for Communism to be denounced at the Council was greater than any other request. This however never happened despite both John XXIII and Paul VI having read the secrets of Fatima and knowing Our Lady had warned about Russia spreading its errors. It was a major flaw of the Council. In the end the Council embraced ecumenism, religious freedom and inter-religious dialogue and state-church separation.^[3] Russia was effectively free to spread its errors, and the Catholic Church was no longer insisting on being the only source of truth. The demands of a secular world made the Church move from a position of motivation by spirit and truth to motivation by empathy and mercy.

If we go back to what motivated John XXIII to start a Council, it seemed to be the excitement that with science, the world was moving quickly forward and all problems could be solved. The major motivator of changes in the world in the 60s was scientific discovery: publicly everyone was excited about space exploration, privately about contraception. Through contraception however, science helped secularise society. Initially, many in the Church saw contraception as a science-driven advance for society rather than an improper use of

science. Pope Paul VI belatedly but bravely stood up against contraception but the Church did not see itself as having jurisdiction over the scientific world. Pope Paul rather gently chided scientists that they might have “peace of conscience” ^[4] if their methods did not stop the transmission of life. He also might have issued a stern warning to pharmaceutical companies and pharmacists if he realised the huge market that contraception was opening up for them.

The church has been repeatedly told it was against science. However, modern science arose out of the fact that in the Bible, God is shown to be very vested in the temporal world. This led to the development of calculus and inductive scientific reasoning ^[5]. Not only is the church not against science but science is the only source of truth aside from revelation - a gift of God to both religious and secular mankind. It should therefore be at the centre of the Church’s orbit, and in the Church’s dealings with the secular world, as a common trusted language. Also, church-state separation makes no sense if science can be used by both church and state as both should come to the same conclusions in keeping with natural law, since natural law is written in everyone’s heart. ^[6] It would seem that the aggiornamento of Vatican II might have been better for the Church, had it been centred on firmly co-opting science into the Church.

Fr Patrick Pullicino is a retired Professor of Neurology and a Catholic Priest in Malta.

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- [1] *Veterum Sapientia* 4.
- [2] De Mattei, R. (2010) *Il Concilio Vaticano II, una storia mai scritta*. Torino, Lindau. p. 492.
- [3] Cf. *Dignitatis Humanae* 15.
- [4] *Humanae Vitae* 24.
- [5] Pullicino, P. (2023) *The Science of Ezekiel’s Chariot of YHWH Vision*. Richmond, Tiger of the Stripe. p. 255.
- [6] Gilson, E. (1956) *The Christian Philosophy of St Thomas Aquinas*. Indiana, University of Notre Dame Press.



Alex Schadenberg,
Euthanasia Prevention Coalition

A study published in the *Journal of the American Medical Association* (JAMA) on March 26, 2025 looked at 3,764,279 Korean adults who are living alone. The study found that depression or anxiety was associated with a significantly higher risk of suicide, particularly among middle-aged individuals (aged 40 to 64 years) and men.



This is significant since people who live alone with depression or anxiety are also more likely to die by euthanasia or assisted suicide.

Canada's Fifth Annual MAiD Report found that there were 15,343 Canadian euthanasia deaths in 2023 with 4.1% of these deaths being (Track 2) people who did not have a terminal condition. For those who had a terminal condition (Track 1) 21.1% listed isolation and loneliness as a reason for their suffering and for those who did not have a terminal condition (Track 2) 47.1% listed isolation and loneliness as a reason for their suffering. (Figure 3.6a)

The Korean study found:

In this national cohort study of 3 764 279 individuals, we examined the association between living arrangements, depression, anxiety, and suicide risk. Our study yielded 3 primary findings:

1. individuals with depression or anxiety living alone were associated with an increased risk of suicide.

2. the highest risk was observed in individuals living alone with both depression and anxiety, and

3. males and individuals aged 40 to 64 years living alone with depression or anxiety faced the highest suicide risk. These findings remained consistent after adjustments for demographic, lifestyle, and clinical factors, as well as across different follow-up periods, highlighting the combined association of living arrangements and mental health conditions with suicide risk. In Canada, The National Institute on Aging (NIA) released a report on December 5, 2023 titled: Understanding the Factors Driving the Epidemic of Social Isolation and Loneliness among Older Canadians.

Based on the Canadian data almost 3,400 Canadians who died by euthanasia in 2023 listed loneliness and isolation as a reason for their suffering. I have stated in the past that the data on loneliness and isolation, in the euthanasia report, is low, since many people who are living with difficult health conditions will list other concerns, even when loneliness and isolation are prime reasons for their request.

When comparing the Canadian data to Canada's euthanasia data, at that time, I stated:

Loneliness and isolation are key issues for people who are considering death by euthanasia. When I have discussed the reasons with someone who is considering euthanasia or has already been approved for euthanasia, the discussion most often is about feelings of loneliness, isolation, depression or feelings of hopelessness.

More articles concerning loneliness

41% of older Canadians experience loneliness (Link).

Loneliness is an epidemic with profound risks to health and life (Link).

Loneliness as a root cause for symptom distress among older adults (Link).

A wish to die is most often linked to loneliness and depression (Link).

Study uncovers euthanasia deaths based on loneliness in the Netherlands (Link).

Alex Schadenberg is International Chair of the Executive Director, Euthanasia Prevention Coalition in Canada.

This article was first published online - Wednesday, April 16, 2025 at
<https://alexschadenberg.blogspot.com/2025/04/study-suicide-risk-increases-with.html>

Canadian study proves that the "suicide contagion" effect exists.



Alex Schadenburg,

Euthanasia Prevention Coalition

The study titled: **Association between exposure to suicide and suicidality outcomes in youth**, was authored by Sonja A. Swanson from the Harvard School of Public Health and Ian Coleman from the University of Ottawa School of Public Health.

The study assessed the association between exposure to suicide and suicidal thoughts and suicide attempts among young people based on a cross-sectional and prospective two year follow-up study done between 1998 and 2007. The study examined the responses from 8766 children aged 12 - 17 years.

1. The respondents were asked whether anyone in their school had died by suicide (schoolmate's suicide) and they were also asked if they personally knew someone who died by suicide (personally known suicide)?

2. Respondents were asked if they had seriously considered attempting suicide in the past year? If they answered yes, they were asked to report the number of suicide attempts in the past year?

The study assessed whether personally knowing a peer decedent increased the risk of suicidality outcomes relative to a lesser-known peer decedent.

Exposure to suicide:

The study found that aged 16-17, 24.1% of the respondents reported a schoolmate's suicide and 20.1% reported personally knowing someone who died by suicide.

Cross-sectional analysis:

(a) **Risk of suicidal ideation and attempted suicide if the person was exposed to a suicide.**

Ages 12-13: 15.3% of those exposed to suicide in the past year had suicidal ideation and 7.5% had attempted suicide, while 3.4% of those unexposed to suicide had suicidal ideation and 1.7% attempted it.

Ages 14-15: 14.2% of those exposed to suicide in the past year had suicidal ideation and 8.6% had attempted suicide, while 5.3% of those unexposed to suicide had suicidal ideation and 2.3% attempted it.

Ages 16-17: 15.1% of those exposed to suicide in the past year had suicidal ideation and 8.1% had attempted suicide, while 7.4% of those unexposed to suicide had suicidal ideation and 2.7% attempted it

(b) **Risk of suicidal ideation and attempted suicide if the person personally know the person who died by suicide.**

Ages 12-13: 13.7% had suicidal ideation and 5.6% had attempted suicide, if they personally knew a person who died by suicide, while 4.6% had suicidal ideation and 2.3% had attempted suicide if they did not personally know a person who died by suicide.

Ages 14-15: 18.4% had suicidal ideation and 12.5% had attempted suicide, if they personally knew a person who died by suicide, while 7.6% had suicidal ideation and 3.6% had attempted suicide if they did not personally know a person who died by suicide.

Ages 16-17: 14% had suicidal ideation and 8.4% had attempted suicide, if they personally knew a person who died by suicide, while 8.1% had suicidal ideation and 3.2% had attempted suicide if they did not personally know a person who died by suicide.

The study found that personally knowing someone who died by suicide presented a marginally greater risk of suicidal ideation or attempted suicide in relation to exposure to suicide alone.

The study stated:

"We found that exposure to suicide predicts suicidality. This is true for all age groups, although exposure to suicide increased the risk most dramatically in the youngest age group, when the baseline suicidality was relatively low. ... Exposure was consistently associated with attempts and to a lesser degree ideation; some of these associations were still significant 2 years later."

Exposure to suicide is not uncommon. The study indicated that 9% of the 16-17 age group reported that a schoolmate had died by suicide in the past year and 15% reported that a schoolmate had died

by suicide more than a year earlier.

Since the study found that personally knowing a schoolmate who died by suicide was only of marginal greater risk for suicidal ideation or attempted suicide as compared to exposure to suicide alone therefore the study emphasized the importance of suicide prevention strategies being implemented within a whole school rather than focus on the friends of the person who died by suicide.



The Globe and Mail newspaper quoted study author Ian Coleman as saying:

"2009 Statistics Canada figures show 227 Canadians aged 10 to 19 died by their own hands, with 202 of those cases were among 15 to 19-years-olds. But as the second leading cause of death after accidental injury among Canadian youth, it's an issue that needs to be taken seriously."

The Canadian Medical Association stated:

Exposure to suicide within the last 2 years was associated with suicidal thoughts and suicide attempts among Canadian youths. This finding is based on responses from 8766 children aged 12–17 years in a national survey carried out between 1998 and 2007. The findings support school-wide or community-wide interventions over targeted strategies following a suicide, say the authors.

The Euthanasia Prevention Coalition (EPC) is concerned with the connection between suicide and assisted suicide.

This study did not examine the effect of access to suicide devices or weapons related to suicide attempts.

This study also did not examine the effect of suicide exposure related to how the media reports a suicide death. Considering the fact that exposure to a suicide death when the person is a similar age and part of the same community is related to a significant increased risk for suicidal ideation and suicide attempts it is likely that how the media

reports suicide deaths also increases the risk for suicidal ideation and suicide attempts especially when the person who dies by suicide is a similar age.



reports suicide deaths also increases the risk for suicidal ideation and suicide attempts especially when the person who dies by suicide is a similar age.

The World Health Organization published a set of guidelines to prevent suicide. One of the best practices include the media, when reporting about suicide, should at offer a links to suicide prevention resources.

A great suicide prevention resource is the group Your Life Counts.

The EPC urges researchers to do a study on the relationship between suicide, assisted suicide and the promotion or normalizing of assisted suicide upon the rate of suicide.

In the state of Oregon, where assisted suicide has been legal since 1998, the suicide rate has been steadily climbing. The suicide rate in Oregon is now 49% higher than the national average.

This article was first published on May 22nd 2025 by the Euthanasia Prevention Coalition Euthanasia Prevention Coalition in Canada, at <https://alexschadenberg.blogspot.com/2013/05/canadian-study-proves-that-suicide.html>

Alex Schadenberg is International Chair of the Euthanasia Prevention Coalition in Canada.

Was the Break- Up of the Catholic Church in England in the 16th Century caused by Syphilis

Dr Michael Straiton



This essay focuses on the medical background of the Tudors, presenting a strong argument that the English Reformation and the break-up of the Catholic Church in England from Rome was a direct consequence of King Henry VIII suffering from syphilis.

In 1492 Christopher Columbus set out Westwards from Spain in the hope of finding a new trade route with Asia. The exploration included three ships and a good company of sailors, landing in the islands that we now call the Bahamas. The generally accepted hypothesis is that many of these sailors cohabited with local, indigenous women and picked up a new disease - syphilis - which was endemic in the Americas and brought it back to Europe. The first documented outbreak in Europe took place in 1495 when troops serving Charles VIII of France invaded Italy. The story is that the Spanish mercenaries fighting for Charles had a retinue of prostitutes and it could be that from this epicentre, the disease swept across the continent.

Henry VII, King England and Lord of Ireland died in April 1509. His heir, Henry VIII was only 17 but his youthful vigour and his dual Yorkist and Lancastrian blood made him the perfect emblem for the Tudor dynasty. He was dashing, a keen sportsman, well educated, and a supporter of the arts. He was also a loyal Catholic. Henry, with his secretary Thomas More, wrote a traditional defense of the Seven Sacraments of the Catholic Church, dedicating it to Pope Leo XI in 1521. The

King's reward from the Pope was the title 'Fidei Defensor' - Defender of the Faith.

By the late 1530s however, Henry VIII was no longer an athletic 'Renaissance Prince' but an obese, tyrannical monarch. The most common argument for this change of personality focuses on an infamous jousting accident in 1536 when he fell from his horse and injured his leg. The resulting painful and ongoing ulcer was blamed for his irritability, which was set against the context of his developing conflict with the Pope as a result of his decision to marry Anne Boleyn without the Pope's consent.

I believe that there is significant evidence to suggest that Henry VIII had contracted syphilis and that this disease was a strong influence on his change in personality and on his actions, which determined the break up of the Catholic Church in England and Wales, with a significant effect in Ireland as well.

Syphilis is a highly infectious bacterium, *Treponema pallidum*, and it spread like wildfire, far and wide. By the mid-16th Century syphilis lurked everywhere in Europe. In 1497 Aberdeen Council had been the first civic body in the British Isles to implement regulations to tackle the 'Great Pox' (commonly understood to be syphilis), which indicates that there was a high level of infection in the city at this time.

By 1547 a quarter of the patients in St. Bartholomew's Hospital in London were syphilitic. In his book 'Syphilis in Shakespeare's England', Johann es Fabricius states that an estimated 20% of the population of London were infected with syphilis in the 16th Century and that literary and dramatic fraternities were particularly high risk groups, possibly connected to the proximity of theatres and bordellos. As a young man Henry VIII is believed to have encouraged an artistic environment at his court, becoming a patron to visual artists and writers alike. Given that this was a time in which the promiscuity of Kings was condoned, it is not inconceivable that his court was vulnerable to the disease.

What are the indications that Henry VIII had syphilis? In his book 'Four Princes' John Julius Norwich states that by the end of 1545 the King's health had deteriorated significantly, that his

weight was obese and that he had a festering abscess on the front of his thigh, which had plagued him since 1528. This presents as a syphilitic gumma, pathognomonic of tertiary syphilis, which would explain his difficulty around fertility and in his children's pathology. We don't know how many times his first wife Catherine of Aragon became pregnant but she suffered multiple stillbirths between 1510 and 1518. A son, Prince Henry, Duke of Cornwall was born in 1511 but died only 52 days later. Catherine bore a daughter Mary in 1516, who herself developed characteristics of congenital syphilis, including a saddle nose, scanty hair and a history of multiple stillbirths.

Henry's anxiety to produce a healthy, male heir with Catherine led him to a liaison with Anne Boleyn which precipitated the devastating

conflict with the Pope, who refused to grant an annulment for his marriage to Catherine. Anne Boleyn, in turn, produced another daughter, Elizabeth. Anne's seeming inability to secure a male child led Henry to have her executed, enabling him to move to a third wife, Jane Seymour. Jane did give Henry the boy he had been longing for and Edward succeeded to the throne, after the death of his father, aged 9 but died aged 15. The general conjecture is that his death was either due to tuberculosis, arsenic poisoning or syphilis.

In his midlife, Henry VIII showed significant changes to his personality, becoming voracious in his appetite for wealth and in his murderous zeal, which could be indicative again of the tertiary stage of syphilis. In 1534, the act of Supremacy broke the 900 year attachment to the Pope in Rome and made Henry VIII the head of the Church in England. Despite him remaining a Catholic and continuing to attend Mass in his private life, this public declaration made the Catholic church illegal in his realm.

From 1536-40 he ordered the Dissolution of the Monasteries in England and Wales, with some 800 abbeys, priors and monasteries closed and land surrendered to the Crown. The shattered remains of monasteries such as Binham Priory, Buildwas Abbey, Gloucester Greyfriars, White Ladies nunnery and Shap Abbey are testament to a process where the lead on the roofs, the silver



and gold plate and other fine goods were removed. The residents were expelled and the lands sold, with some buildings adapted for private use and others left to the elements. For centuries the Pope had received annates - funds for the upkeep of the Holy See - and these funds were now acquired directly by the King.

There is little evidence to suggest that Henry's Dissolution of the Monasteries was fuelled by a zeal for the ideas of the Reformation coming from Luther in Germany. They were decisions fuelled by his personality and political insecurity. Furthermore, his actions went beyond the pragmatic, to become cruel. People who frustrated his authority met vicious retribution and death. These included two of his wives - Anne Boleyn and Katherine Howard, his political advisers including Sir Thomas More and Bishop John Fisher who both opposed Henry's attack on the Catholic Church and paid the consequences and Carthusian Monks who refused the Oath of Supremacy and were tortured, burned at the stake and left to starve to death in cells.

To my mind, Henry VIII's vicious and determined actions against the Catholic Church indicate the tertiary stage of syphilis, while the evidence of his physical condition and long term problems around fertility both strengthen the case. If the King was syphilitic, it is hard to avoid the direct connection between the disease and the fate of the Catholic Church in the British Isles.

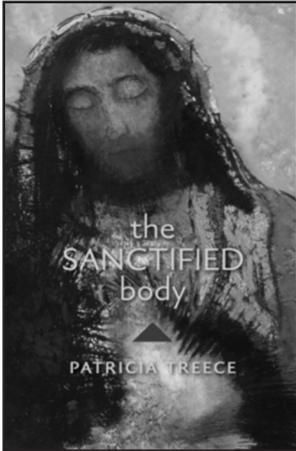
The difficult fact in my hypothesis is that Elizabeth I, Henry's second daughter, did not suffer from syphilis and reigned for a full term of 40 years, proving that she was free of 'The Great Pox'. Full of spite against Anne Boleyn, Henry fostered rumours that Elizabeth was the child of one of Anne's lovers, Mark Smeaton, a musician and groom in the chamber of the Royal Household, who was executed with Anne Boleyn. Mary Tudor stated that her half-sister resembled Mark Smeaton. Could it be that Elizabeth was not a legitimate daughter of the King? Henry certainly ignored Elizabeth. He gave her a comfortable household, but denied her his company. When Elizabeth I died on 24th March 1603, there were no male Tudor heirs and the Tudor Dynasty came to an end, to be replaced by that of the Stuarts.

Alas, The Great Pox is still with us —8,692 cases of syphilis were reported in the U.K. in -2022 according to the UK Health Security Agency.

Dr Michael Straiton. June 2024

BOOK REVIEWS

The Sanctified Body



by Patricia Treece.

Angelico Press
Reviewed by
Dr Pravin
Thevathasan

I have read plenty of psychiatric textbooks that claim St Joan of Arc was insane, St Catherine of Siena had an eating disorder, St Teresa of Avila had sexual hangups and St Bernadette had neurosis. The late Professor Andrew Sims responded that psychiatrists and psychologists have no expertise in this area except to diagnose mental illness, if it exists. And, of course, there have always been frauds and those controlled by evil spirits.

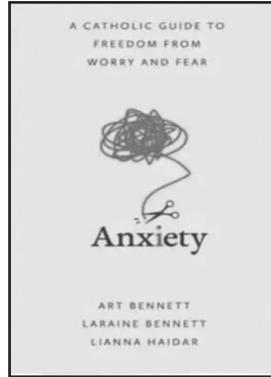
This beautiful book shows us that genuine mystics are firstly and foremost souls who do the ordinary things extraordinarily well. Above all they love God and neighbour. Everything else flows from this. Some of them possessed extraordinary manifestations, reminding us that holiness affects both body and soul.

Some of these manifestations include levitation, bilocation, the odour of sanctity and the ability to live without food or drink. Among the holy people discussed are Padre Pio, St John Vianney, St Titus Brandsma, St Gaspar del Bufalo, St John Bosco, Blessed Miguel Pro, Blessed Anna Marie Taigi, and Blessed Marie of Jesus Crucified.

Some caution is needed as the author discusses some controversial cases including that of Gino Buresi. The author also mentions some non-Catholics, including Agnes Sandford, and even some non-Christians.

That said, this book is a wonderful source of inspiration for the discerning reader.

Anxiety- A Catholic Guide To Freedom from Worry and Fear



by Art Bennett,
Laraine Bennett,
and
Lianna Bennett
Haidar

Sophia Institute Press
Reviewed by
Dr Pravin
Thevathasan

Anxiety is on the rise. I was speaking to a priest who said that he was dealing with more and more people who are anxious and who don't know how to manage it. The authors of this very helpful and practical book argue that there are good ways and bad ways of managing anxiety.

One option is avoiding all occasions that cause us more anxiety. But this may be impractical or more lead to more anxiety in the long term. The strategy known as "Reframing" leads us to reframe the anxiety-provoking situation. Rather than running away, we need to look at it in a different way. All this sounds like living the spiritual life according to the Catholic faith: accepting the cross in such a way that it ceases to be a burden.

It is therefore not surprising to see so many scriptural quotes and stories from the saints in this book. St Therese of Lisieux, for example, suffered from anxiety until she reframed her circumstances. Of course, grace is needed.

Anxiety may also damage our interior life. We may become so preoccupied with our worries that we no longer focus on God. Reframing changes the way we manage anxious thoughts. We move from negative to positive thinking. By examining the evidence for and against negative thoughts, we learn to develop a more realistic understanding of them. Reframing our thought patterns lead to less anxiety.

Reframing appears to be in harmony with Catholic spirituality. The Way of the Cross is the way to happiness.

Transgenderism A Question of Identity



by Francis
Etheredge.

En Route Books
and Media
Reviewed by
Dr Pravin
Thevathasan

The Supreme Court of the United Kingdom has unanimously concluded that there is a real difference between a biological woman and a "transgender woman." This is big news; many individuals have been persecuted for saying just that. It is a vital issue because it is a question of identity.

Our identity matters, says the author of this superb and timely book. God has made us male and female and that complementarity is essential to our nature and vocation. Ultimately, it is our enemy who seeks our destruction by means of attacking the biological family.

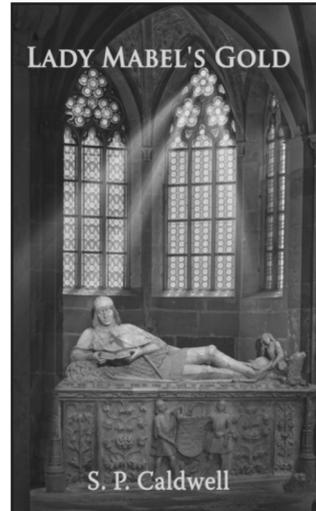
The author notes that while we are called to show charity towards the transgendered person, chemical and surgical means have been applied for that person to appear what he or she is not in essence. Why has there been such a rapid escalation in so-called gender affirming care? The breakdown in the family and peer and social pressure are surely things to be taken into account. But the author also notes that doctors are making a great deal of money from this.

But, surely, is it not good to improve the psychological wellbeing of those who suffer from gender dysphoria? The author cites research that indicate that far from improving mental health, transition may lead to higher rates of depression and suicidal ideation and behaviour.

As a lot of people have pointed out recently, common sense has prevailed. It makes no sense for a biological male to take part in a sporting event when the rest of those participating are biological women.

The author has noted that transgenderism affects and afflicts persons and society. It is also a profoundly spiritual affliction.

Lady Mabel's Gold



by
Simon Caldwell

Gracewing
Reviewed by
Dr Pravin
Thevathasan

According to a Wigan legend, the ghost of Lady Mabel appears in the forest in atonement for the bigamy she committed while her husband was away fighting in the Crusades. The author of this highly readable book has intertwined this story with a contemporary crime thriller. Journalist Jenny Bradshaigh (the surname has links with the legend) feels she is a failure. Her story about a raid on a Crusader's grave has been rejected. But then there is a murder and burglary at a second vault leading her to investigate a criminal gang which is exploiting trafficked children to find treasure. This is her biggest scoop. The criminals are looking for treasure they believe Sir William, Lady Mabel's husband, brought back from the Crusades for her.

Is there such a thing as a Catholic novel? I believe there is. Even someone as un-Catholic in his personal life as Grahame Greene wrote some splendid Catholic novels. That is because he was interested in objective truth. Caldwell shares a similar interest in truth. In his first novel, he examined the topic of euthanasia, a topic he has an in-depth knowledge of. In this his second book, he shows an equal degree of knowledge about human trafficking.

Antony Porter

“Is there a Christian attitude towards the internal combustion engine and the way of life that it makes possible?” This question is often asked but rarely gets much of a response, perhaps because so often we get distracted and end up talking about our own personal use of cars.

Yet we are all aware of the negative themes concerning motorisation such as the ruthlessness of motorway planning, the horrid deaths of animals, the widening gap between rich and poor and the manipulation of road death statistics to make our highways seem safer than they are.

Motorisation remains the largest area of modern life to be ignored by the Christian Churches, with people’s road deaths and injuries considered less important than their genders and sexualities. No wonder that to me, a non-driver, the whole culture of motorisation seems so adolescent and immature, despite its many benefits.

The Pedestrians Association, now known as Living Streets, was founded in 1929 by Tom Foley, a London journalist who had become concerned about road deaths and injuries at a time when motorised vehicles were considered the best thing since sliced bread! Several other road safety groups now exist such as Brake and Roadpeace.

Nevertheless in 1933 and again in 1955 the Pedestrians Association had organised conferences in London to which senior religious were invited, although sadly after that these connections seem to have ended. Both conferences were entitled “The Churches and Road Safety”.

The 1933 conference was attended by various notables such as Miss Rose Macaulay, Viscount Cecil, Lord Riddell and the Master of Balliol.

Meanwhile, striking messages of support were received from the Archbishop of Canterbury, the Bishop of Carlisle and the Master of Balliol.

There were also representatives of several interesting groups such as the Anti-Noise League, the Federation of Rambling Clubs, the National Horse Association and the Road Walking Association. Some claimed that “the underlying cause of accidents was speed” and that this was leading

to “spiritual and moral loss”.

The 1955 conference featured contributions from the Archbishops of Westminster and York, another Bishop of Carlisle, Canons from Westminster Abbey and Cathedral and the Chief Rabbi. There was talk of “Road Safety Sundays” as well as the need for elderly people to pray and ask for help before crossing roads.

It is indeed an irony that all these years later things have scarcely changed! Notably, drunk driving was scarcely mentioned and of course it is now doubly worse with the growth of drugged driving. More recent problems include “ramming” whereby an individual, usually a young man, drives into a crowd and kills many people.

The two conferences evidently marked the last time that British clergy specifically focused upon the tragedies of our highways. In 2023 there were 1,624 deaths on Britain’s roads, some 31 per week, yet these figures refer only those who died within one month of their accident.

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