FEBRUARY 2019 Vol 69 No 1

catholic medical QUARTERLY

cmq

www.cmq.org.uk
Price £5.25 (free to CMA members)

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JOURNAL OF THE CATHOLIC MEDICAL ASSOCIATION (UK)

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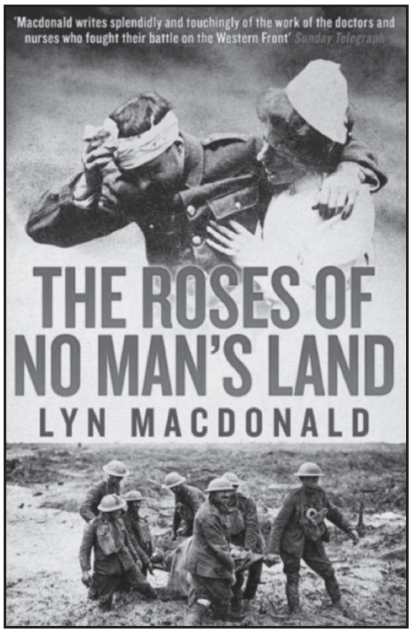
FIRST WORLD WAR MEDICS

DR STEPHEN BRENNAN FRCP



I came across a book review in the BMJ 1980[1], as you do when retired; it set off some thoughts about how things have changed. It was written by Ronald Gibson, a colleague of my father, Edward Bernard Brennan, both in the RAMC in the WW2 and who both became radiologists after that war. The book was "The Roses of No Man's Land" by Lyn MacDonald[2] about medical services in WW1. It spoke of the initial enthusiasm and hopes, gradually moving to anxiety and weariness at the endless mutilation and destruction. I have yet to obtain a copy of this extraordinary book, but it is thoroughly researched and full of letters from doctors, sisters, and members of the Voluntary Aid Detachment at the front-line. They didn't have time to be novices, quickly getting used to improvisation, inadequate equipment and accommodation, as they dealt with thousands of casualties, many of whom who had only left the safety of home days before. Wards were soon in chaos with "mud and cold, hunger and fatigue". Casualties of gas attacks, gunshot wounds, shrapnel, gas gangrene, blindness, suffocation, pneumonia, enteric fever and shell shock. Sometimes two surgeons would be working six operating tables "with only a Padre to give the anaesthetics". "Filthy dressings had to be torn off screaming soldiers by gentle girls who had never seen suffering before, let alone chronic agony and death".

Without antibiotics, the complications of wounds were unimaginable; lives depended on antiseptics like Eusol, Dakin's Solution and more surgery. Later in the war, blood transfusion became useful in cases of chronic infection as well as blood loss. Loading casualties on to lorries and trains to move them back from the front after the battles to varied accommodation, maybe open-air muddy shelters, local homes, hotels, or even stately homes, must have been the final straw; everyone cold, wet, hungry, dirty and lice-ridden, but trying not to let it all rub off on the patients. "If you couldn't laugh you were finished".

Could we health workers of today cope like that now, "spoilt" as we are by our splendid NHS? I think the computer says "no"! However, we of faith have other resources, and could, as always, rely on God's help to keep us going from day to day, provided we asked for it. We must pray that our NHS can keep going.

REFERENCES

[1] BMJ 1980. Vol.281. p.1464.
[2] "The Roses of No Man's Land" by Lyn Macdonald. 1980. Michael Joseph.

CARE OF DYING CHILDREN WITHDRAWAL OF TREATMENT IN CHILDREN.

DR ANTHONY COLE J P, F R C P (EDIN). F R C P C H,

I write as a paediatrician with forty years experience in general paediatrics and neonatology in the N H S. Here are two m points that I think important

1 The insights of parents

It is not uncommon for disagreements to arise between parents and healthcare professionals over small signs of consciousness or other responses in very sick children. Parents have a natural empathy with their child and are often in nearly continuous contact . Professional, on the other hand, may attach great importance to relatively small X-ray findings or other investigations which parents may not appreciate. Communication is of the essence to maintain confidence with the clinical team. Images as such, may not be synonymous with a diagnosis. The observations of parents should be treated with the utmost seriousness and documented. The comment that is sometimes made that "the response is just reflex " may be unhelpful or even mistaken.

2 The withdrawal of life supporting treatment

This is a very sensitive matter and a good relationship between clinical decision makers and the parents is of paramount importance. This will take time and the issue is not only the survival of the child, but the long term emotional and spiritual well being of the parents and the wider family. As Dame Cicely Saunders reminds us, the manner of death lives on with the survivors. I have been humbled and great full to parents that I have known and, in particular, a willingness to accept the inevitable, but clinicians must be prepared to wait for the right moment.

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