NEWSLETTER

No. 89

October 2020

Family Solidarity

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EDITORIAL

Much of this edition is taken up by the discussion presented by our Board member Angelo Bottone of the Iona Institute, of the euphemistically called "Dying with Dignity Bill" which is essentially seeking to legalise euthanasia and assisted suicide. While we in Ireland have already made it legal to murder the unborn (many voting for the elimination of the protection of the unborn on the

grounds of compassion), the same argument is being promoted to legalise assisted suicide. We urge all our members to write to all their TDs telling that they are not representing your views and not to support the Bill. Of course, prayer will also be important, but in the secular society we now live in, and where Christian morality is actively opposed by many in the media, it is important to make your voice heard.

We have two good news stories at the back of the newsletter regard vocations to the priesthood and the beatification of a computer savvy teenager.

With the current restrictions due to the Covid-19 epidemic, fortunately most of your executive committee have been able to meet on line and we may have to have our AGM on line before the end of the year. For that purpose it would be useful to have your email addresses. If you have one please send a message to familysolidarityireland@gmail.com permitting us to use it to communicate with you.

As it is 36 years since Family Solidarity was formed, it has been suggested that we should catalogue our records. So, the following is addressed to members and particularly former members of the Family Solidarity Executive or Branch Committees.

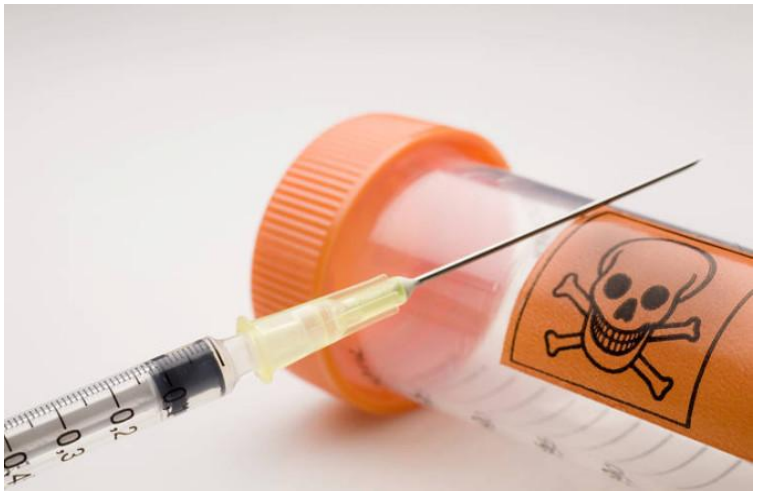
A new younger executive committee is in place and they have expressed an interest that the history and archives of the earlier days of Family Solidarity be preserved.
Some records exist in the office and indeed I have some myself but I am sure that there are other important records held by some of you! Some people have good record systems!
While I was involved at a local level quite early on, and joined the National Executive when the late Seán Bedford went to his Eternal Rest in 1989, I have only odd records.
I would be pleased to hear what you might have, and if considered sufficiently important or an only copy, permission to borrow it and copy it for return to you as you wish.
Facts of history and personal recollections of the early days are also of interest. I have a copy of the opening address at the First Annual Conference but while it is dated, it does not say who gave it! I would be pleased to be informed of who it was.
We may be advised of any materials or recollections you may have by email or by post.

Reminder: See our website for regular updates and interesting news items.

Thank you all who have paid their subscriptions and made donations to further our aims. We have put a return envelope with a subscription slip with all copies of the Newsletter as it is simpler than selecting those from whom we have not heard. If you have contributed in the last year, ignore this.

THE ASSISTED SUICIDE BILL

On October 7th the Dáil voted in favour of moving Gino Kenny's assisted suicide bill past the second stage of the legislation process, and to committee stage. Several senior Government figures voted in favour of it including Leo Varadkar, Helen McEntee, Stephen Donnelly and Simon Harris.



Some media reports say the Bill has strong safeguards and is limited in scope. This is totally false. Its definition of 'terminal illness' is incredibly broad, a person does not have to be within a few months of death to avail of the proposed law, and doctors will be forced to facilitate assisted suicide.

The proposal is obviously wrong in principle but, even allowing for that, the Bill is incredibly far-reaching. Let's go through some of the main provisions.

Terminal illness

The Bill defines 'terminal illness' as follows: "A person is terminally ill if that person has been diagnosed by a registered medical practitioner as having an incurable and

progressive illness which cannot be reversed by treatment, and the person is likely to die as a result of that illness or complications relating thereto".

This is so broad it could include heart disease, dementia, MS, Parkinson's and Motor Neurone disease in addition to many other conditions. The definition merely says, 'likely to die'. What does 'likely' mean? Does it mean a 51pc chance? It appears the condition does not have to be advanced or imminently life-threatening at all.

The Bill would permit doctors to help the suicide of anyone suffering of an incurable illness, at any stage, even if they are not at the end of their life.

No time limit set

People suffering from incurable and progressive diseases can live for many years but the Bill would permit someone diagnosed with, for instance, early stage dementia or Parkinson's, to immediately apply for assisted suicide and once two doctors agree to the request, be given a lethal drug 14 days later. (Some legislations permitting assisted suicide require that the patient is expected to die within 6 months or less. This is the case in Oregon, or in Victoria, Australia).

No proper protection for conscience rights

The Bill also obliges those health professionals (physicians, nurses, pharmacists) who have a conscientious objection

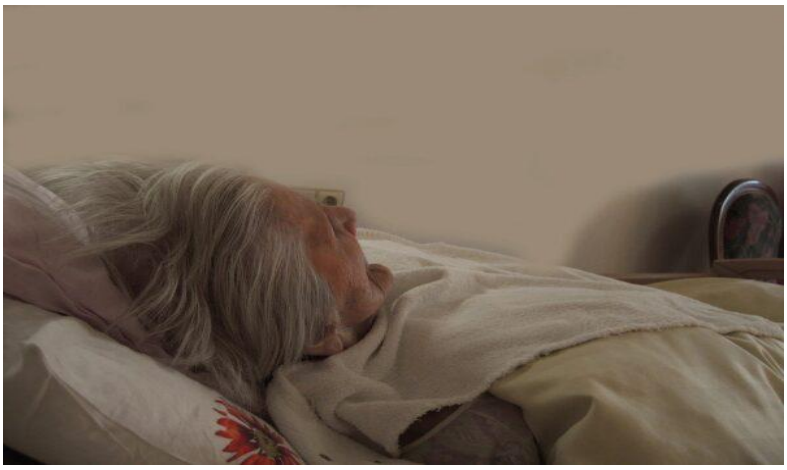
to assisted suicide, to make “arrangements for the transfer of care of the qualifying person”, which is a form of participation. This would go against conscience rights.
It amounts to a wholesale assault on the hospice movement which was set up specifically to care for people nearing the end of their lives but without the intention of ever deliberately killing a patient. Doctors working in hospices would become the very people most often forced by law to refer their patients to other doctors willing to give them a deadly poison, which can never be a part of medicine.

Few safeguards

In the Australian State of Victoria, a person must request assisted suicide three times before it is granted. Here there is only a requirement to do this once. In addition, the Victoria law requires that a person is six months from the end of their life, or 12 months in the case of a neuro-disease, before they can access assisted suicide. Of course, the Victoria law is wrong in principle, but the Gino Kenny Bill is even more permissive than it.

ASSISTED SUICIDE IS INCOMPATIBLE WITH HUMAN DIGNITY

At the core of the debate about assisted suicide is the very dangerous assumption that death by a form of suicide is compatible with human dignity.



Dignity is the intrinsic value of a person that requires respect and reverence. Suffering, physical or mental, is a terrible but there is profound dignity when someone faces the most difficult circumstances with courage and strength.

Associating this great human value with self-killing is detrimental. The more astute campaigners for assisted suicide will use more acceptable expressions such as “assisted dying” or “end of life options”, as they are well aware of the contradictions of their own perspective. But behind those euphemisms there is the dark reality that assisted suicide is a form of suicide and endorsing it, even in limited circumstances, sends the wrong message to those who struggle.

Those who are vulnerable deserve more protections, particularly protection from despair or a sense of

abandonment. They don't need a "dignified" exit option, precisely because there is no real dignity in suicide.

Among the strongest opponents of assisted suicide are health care professionals. For instance, the World Medical Association has recently reaffirmed its long-standing policy of opposition to euthanasia and physician-assisted suicide.

"The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide", they stated at their 2019 annual conference, "No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end."

Their pledge also refers to dignity twice: "… I will respect the autonomy and dignity of my patient; … I will practise my profession with conscience and dignity …"

Once we agree with the false notion that killing ourselves, with the help of others if needed, is a more dignified death than other alternatives, it becomes harder to restrict it.

It would become more difficult, for instance, to refuse a 'dignified' death to a young person who felt clinical depression (say) was making their life 'unbearable'.

Involuntary euthanasia also becomes harder to resist. If we decide deliberate killing is compatible with 'dignity',

then the way is paved to authorising the death of people suffering from severe dementia, and who are seriously ill in other ways, and cannot make a decision for themselves. There is an almost natural step from "this is *a* good option" to "this is *the* good option".

In vulnerable minds, – because this is precisely what we are discussing here – once assisted suicide becomes socially acceptable it also becomes the expected "choice".

The experience of the few countries that have introduced assisted suicide – which is still banned almost everywhere – tells us two things: with time those laws become less restrictive and the number of people who kill themselves grows, together with the number of abuses of the legislation.

It is not surprising that soon or later the initial restrictions are lifted because if "dying with dignity" is preferable to alternatives, there is no compelling reason why it should be restricted at all. Also, it is not surprising that what is initially presented as a "choice" becomes a social norm. Legalisation means normalisation.

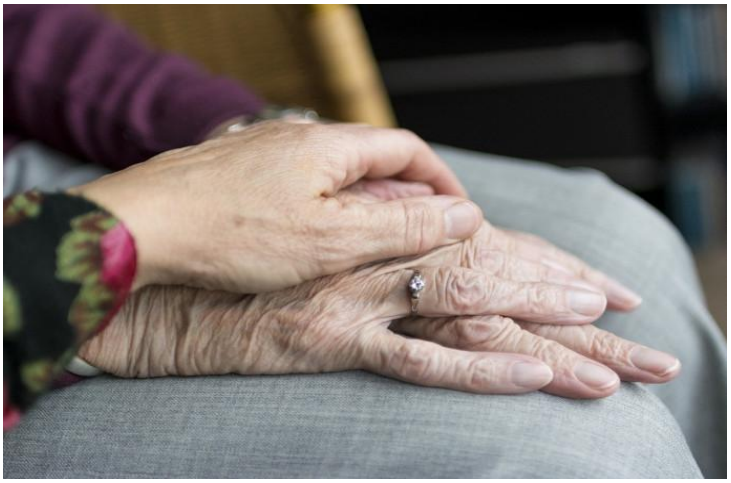
I am not saying that the proposal to allow a limited form of assisted suicide is bad because it could escalate. I am arguing that it is always wrong and it is impossible to make a distinction between bad and good suicides.

It is wrong in itself and it is much easier to see why when we consider all the necessary and logical consequences of

accepting a principle that initially is limited to restricted circumstances.
Let's be clear, there is no dignity in suicide and those who perpetuate this notion are spreading a very dangerous idea.

WHAT DO EUTHANASIA CAMPAIGNERS MEAN BY 'UNBEARABLE SUFFERING'?

The assisted suicide Bill currently before the Dail is being justified on the grounds that no-one should have to suffer 'unbearable pain'. But this concept is extremely elastic and can and has been interpreted in the most extensive manner in order jurisdictions to include even ailments absolutely commonplace in old age, as this blog will show.



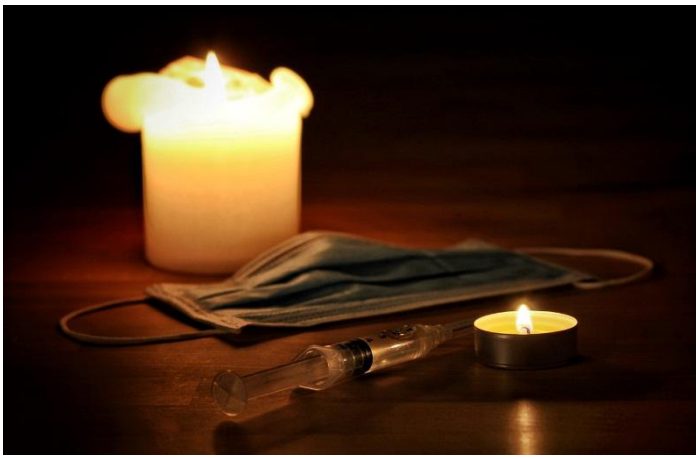
Unbearable pain is often presented as a reason to justify doctor assisted suicide but what counts as 'unbearable'? Obviously, there is no scientific demarcation. What is deemed unbearable is, by definition, highly subjective as we all have a different capacity to bear suffering. Moreover, should pain be only physical or include mental pain as well?

Let's consider the role that this notion plays in the Netherlands, a country where euthanasia has been allowed for years. The Dutch legislation requires that the doctors are "satisfied that the patient's suffering is unbearable, with no prospect of improvement."

The law does not specify the scope of "unbearable suffering", but a code of practice provides some clarification. This accompanying document, recently revised, tells us that "suffering is a broad concept. It can result from pain and shortness of breath, extreme exhaustion and fatigue, physical decline, or the fact that there is no prospect of improvement, but it can also be caused by growing dependence, or feelings of humiliation and loss of dignity". (Euthanasia Code 2018 p. 21). So, according to the code of practice, suffering does not have to be necessarily physical. The notion is so vague and broad that one might ask what form of suffering would be not included? For instance, with age many people experience a deterioration of their abilities, such as sight and hearing. Should that be a ground for euthanasia? It turns out the answer is 'yes'. The Dutch Euthanasia Code 2018 says: "As we have seen, for a patient's request for euthanasia to be considered, his suffering must have a medical dimension. However, it is not a requirement that there be a life-threatening medical condition. Multiple geriatric syndromes – such as sight impairment, hearing impairment, osteoporosis, osteoarthritis, balance

problems or cognitive deterioration – may cause unbearable suffering without prospect of improvement." To illustrate this point, the official 2019 report presents the real-life case of a man in his fifties who was gradually becoming blind and found his disability unbearable. The doctor asked the patient to contact an institute for the visually impaired and seek their advice. But "the solutions offered did not suit the patient because they were too far removed from his independent lifestyle" and he was, instead, euthanised. (2019 report, pp. 47-48).

In other words, in the Netherlands a man in his fifties killed himself with the assistance of doctors because he found losing his sight an unbearable suffering. Some people find loneliness unbearable, or the loss of a loved one, or trauma suffered by abuse and so on. Do we really want to offer suicide as a solution to those who undergo through such difficult experiences?



"Unbearable pain" is commonly mentioned by pro-assisted suicide campaigners in their argumentation, because of the emotions it triggers but those who request lethal substances do not cite it as their primary concern. Let's consider the latest reports from Canada and Oregon. In Canada, applicants are asked to describe what has

prompted the request. “Inadequate control of pain” came after “Loss of ability to engage in meaningful life activities”, “Loss of ability to perform activities of daily living”, and “Inadequate control of symptoms other than pain (or concern about it)”.

In Oregon we have similar results. “Inadequate pain control” (or fear of it) was mentioned by fewer people than other concerns such as being “Less able to engage in activities making life enjoyable”, “Losing autonomy”, “Loss of dignity”, “Burden on family, friends/caregivers”, and “Losing control of bodily functions”.

This shows that, in spite of the emotive appeal to terrible pain, people applying for assisted suicide fear more the loss of autonomy, as they see it. The signal sent to all vulnerable people by making assisted suicide available on grounds of ‘unbearable suffering or pain’ is terrible. It invites them all to devalue their lives.

There is no reference to pain in the Bill recently proposed by deputy Gino Kenny, even if he incorrectly claimed otherwise on the radio, but he used this emotive expression when he presented it in the Dáil. Other campaigners in Ireland are now claiming that this Bill does not go far enough and having a terminal illness, or even being sick at all, should not be the only grounds to apply for assisted suicide.

Tom Curran represents Exit International, a group campaigning for the “right to die” of any adult of sound

mind, for any reason. He told the Sunday Independent that assisted suicide should be extended to people with mental illnesses. “For me the test should be: are they able to think rationally? There are lots of mental illnesses that don’t affect a person’s ability to think rationally. They should be included. But this Bill is a good start”. But simply being of ‘sound mind’ means you don’t have to be mentally ill either. Similarly, journalist Fintan O’Toole told RTE radio that everybody should be given access to assisted suicide. Presenter Sarah McInerny asked him: “ … this is a conversation that perhaps started off in relation to people who are terminally ill and in a lot of pain, that wasn’t the case for your father for example, he wasn’t terminally ill so is it now people who are just ill or depressed perhaps or sad, unhappy. Where do you draw the line?”

Fintan O’Toole replied: “This is exactly why we need an open conversation about what happens in real life. As you said, my dad wasn’t terminally ill. He was chronically ill, he had a couple of different chronical illnesses, but he wasn’t clinically depressed either. I would say, what this is really about is the choice of the person, isn’t? And then it’s about what process do you have to be absolutely sure that that person is able to make the choice and is not been pressured in making the choice.“

The logic of assisted suicide is inexorable. In the Netherlands we have just seen it extended to one year old babies.

ONCE EUTHANASIA IS INTRODUCED, THE GROUNDS ALWAYS EXPAND

Supporters of the Bill claim it will be introduced with strict limits and safeguards. But the experience of other countries tells us that once the absolute prohibition of killing patients is lifted, it becomes impossible to keep the initial restrictions.

Laws allowing the direct (euthanasia) or indirect (assisted suicide) killing of a patient by doctors are rare in the world. They only exist in six countries, in one Australian state and in nine US states.

Nonetheless, in all those places we see a common pattern: legislation is initially introduced on certain limited grounds and with time those grounds continuously expand. Moreover, once a “right to die” is established, courts will find limitations discriminatory and will remove them.

Let’s see some examples.

In the Netherlands euthanasia was introduced for terminally ill adults who were mentally competent. Then, step by step, it was extended to those with chronic condition, with disabilities, mental health problems and even to non-mentally competent children. This happened not through a modification of the legislation but with changing the interpretation of the law in courts or by medical professionals.

Last April, the Dutch Supreme Court cleared a doctor who administered euthanasia to a woman in the advanced stages of dementia who resisted death when the time came to give her a legal substance. Her family helped to hold her down. She had previously said she wished to be killed when she was no longer mentally competent. The Dutch parliament currently has before it a private members bill that proposes to offer euthanasia to anyone over 75, even healthy people. If this passes, the next step will be to lower the age limit or to remove it completely.

In Colombia, the Constitutional Court decriminalised euthanasia in 1997. In 2014, it established the “right to die with dignity” as a fundamental right and therefore subject to special legal protection. In 2017, this ‘right’ was extended to minors, who can avail of euthanasia even without consent from their parents. While parents can request euthanasia for their children if they are not able to express themselves.

In Canada, assisted suicide was introduced in 2016 for those who are in pain and for whom death is “reasonably foreseeable”, even if the condition is not terminal. But in 2019 the Supreme Court in Quebec deemed this requirement unconstitutional and ruled in favour of two people for whom death was not foreseeable but, nonetheless, they desired to die. The court decided it was discrimination not to extend the same right to the chronically ill who might be suffering.

In Oregon, in the US, the limits were expanded without even changing the law. With time, the Oregon Health Authority took an expansive interpretation of what constitutes a terminal illness, including conditions that if treated would be not terminal. Moreover, in 2019 they removed the 15-day waiting period.

In Belgium, euthanasia was legalized in 2002 for those with incurable conditions (not necessarily terminal) and in 2014 they allowed minors to access it.

Other examples of this “slippery slope” could be mentioned.

There is a logic in all those developments. If choosing when and how to die is a right, why should it be limited and restricted? If killing is a solution to ‘unbearable suffering’, there is no compelling reason to limit its availability to one category of patients. Why only those with terminal illness? Why only to those experiencing

physical pain? Why only adults? Why only mentally competent?

Medicine is based on the principle of doing no harm. The introduction of the direct or indirect killing of a patient transforms and betrays profoundly the purpose of the health system and the role of doctors. Lifting the absolute prohibition of killing is not a small step, it is a fundamental cultural shift. Everything else follows from such move and this is why it has to be rejected without compromise.

Once the threshold is passed, it is only a matter of time before the next restriction is removed and it becomes hard, if not impossible, to go back.

WHY LEADING DOCTORS OPPOSE ASSISTED SUICIDE

The last time when assisted suicide was discussed in Leinster House, three years ago, some of the strongest opposition came from the members of the medical profession and disability advocacy groups. It's worth recalling what they said because it is still completely relevant.

The Joint Committee on Justice and Equality heard from two doctors, Regina Mc Quillan, speaking on behalf of the Irish Association of Palliative Care, and Des O'Neill,

professor of Medical Gerontology at Trinity College Dublin.

Dr Mc Quillan made five main points: “1. A change in the law would put vulnerable people at risk. 2. It is not possible to put adequate safeguards in place. 3. The drive to improve the care of people with life-limiting illnesses by education, service development and research may be compromised. 4. Personal autonomy is not absolute and we are part of a society. 5. Allowing assisted suicide or euthanasia for some populations for example the terminally ill or the disabled, devalues the lives of those compared to those targeted in suicide prevention campaigns.”

Dr Mc Quillan cited research by *The National Safeguarding Committee* revealing that half of the population has witnessed abuse of an adult, and so she maintained that it is “not prudent to assume vulnerable people can be protected in the context of assisted suicide and euthanasia.“

People are already at risk, even with laws and regulations, and “changing the law to allow assisted suicide and euthanasia will endanger the lives of many”, despite suggestions that abuses of this type of legislation can be prevented.

She referred to research showing failures in the countries where medically assisted killing has been introduced. Even where restrictions were in places, there is evidence that

euthanasia was offered to those who were not terminally ill or were suffering from psychiatric problems.

Dr Mc Quillan explained which areas within palliative care need development. She said: “the acceptance of assisted suicide and euthanasia could lead to an underinvestment in palliative care research and service delivery, as assisted suicide and euthanasia may be promoted as cheaper options than appropriate health care provision.”

Doctors who everyday deal with suffering and end of life decisions are rarely heard in public debates on these issues, which tend to concentrate on dramatic, high-profile cases. The experience and the concerns of those who offer palliative care are particularly meaningful as they offer a view that is an alternative to common emotional appeals.

“We do not currently have equitable access to palliative care, disability services, psychiatric or psychological support services and my concern and that of many working in health care is that to move in the direction of euthanasia would be to move away from investment in the appropriate services.”, Dr Mc Quillan said.

She also highlighted that, as women are more likely to live longer with greater disability and more likely to have less social support, they will suffer more if euthanasia or assisted suicide is introduced. Women, she claimed, “are more likely to be a victim of ‘mercy killing’ by a male

family member in cases which have come to the criminal courts in different countries."

Professor Des O'Neill was another firm opponent of medically assisted killing. He told the Oireachtas Committee: "That there might be two forms of suicide – one which is clearly upsetting and worthy of strenuous societal efforts to prevent, and one which might be tolerated and given the support and protection of law – is a deeply challenging and contradictory premise. … The decriminalisation of suicide was a humane initiative, aimed at avoiding stigma and further hurt in terms of both completed suicide and attempted suicide, and emphasising the need for help and support for people in this situation, an impulse that holds true for those seeking assisted suicide as well. It was certainly never seen to be an expression of a societal desire to extend access to suicide as a human right, or to position suicide as an act that equality legislation might facilitate".

Prof. O'Neill criticised the idea of unlimited choice, based on the assumption "that all patients are independent and autonomous, even at moments of high vulnerability". Instead, we should remember that decisions are often led by the "potency of prejudice against ageing and disability."

He said that all the major UK advocacy groups for disability have rejected assisted suicide.

To those proposing 'death with dignity' he replied: "Human dignity is not a thing that can be lost through disability, disease, dependency, or suffering, although insensitive treatment or attitudes to those so affected can constitute undignified care."

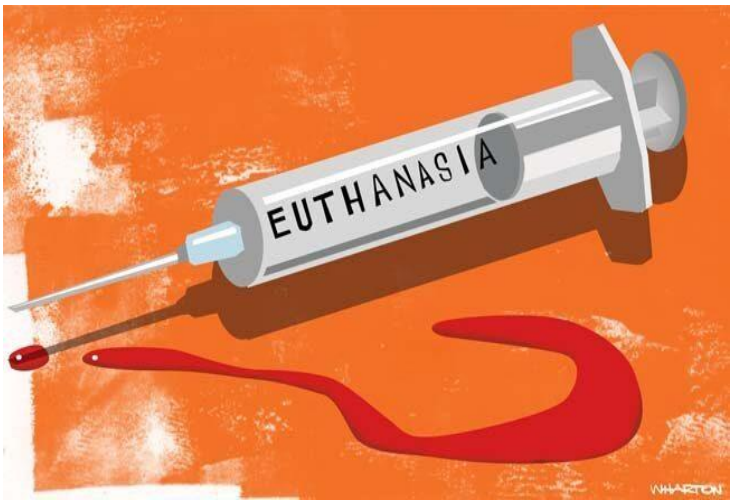
The promotion of dignified care, instead, is the best way to contrast assisted suicide. In this respect, health care professionals play a pivotal role. Their opposition to deliberately killing, or facilitating self-killing, is something rarely appreciated and highlighted in the current public debates about the end of life decisions.

Prof. O'Neill expresses this perspective clearly: "Public and private discussion with regard to assisted suicide should be seen to represent concerns over adequacy of treatment and support as well as existential concerns relating to the future: these need to be proactively addressed.

"To ask doctors to run counter to this by killing patients short-circuits and undermines our impetus to care, comfort and support and damages our framework of care. Current and future patients need to be reassured that the response of the healthcare professions to distress and pain is one of compassion and care, addressing the needs at a range of levels – biological, psychological, social and spiritual – while respecting wishes to the greatest extent possible."

NEW VATICAN DOCUMENT SETS OUT CLEARLY THE CASE AGAINST ASSISTED SUICIDE

In September, the Congregation for the Doctrine of Faith, published 'The Good Samaritan', a letter approved by the Pope decrying euthanasia. It is very timely from the point of view of the assisted suicide bill currently before the Dáil. Some form of it could be passed within the next 12-18 months.



The document describes euthanasia as "an intrinsically evil act, in every situation or circumstance", as it directly causes the death of an innocent human being.

It says assisted suicide makes the act of suicide even worse by involving another person in it, namely the health workers and anyone else involved in the decision. This could include family members.

The document refers to legislators as well. It states: "Those who approve laws of euthanasia and assisted suicide … become accomplices of a grave sin that others will execute". It reminds Catholic hospitals that they must never cooperate with assisted suicide or euthanasia.

It reaffirms that life is a fundamental good, necessary of every other good. “Just as we cannot make another person our slave, even if they ask to be, so we cannot directly choose to take the life of another, even if they request it.”

But the Church also makes clear that while you must never directly kill a patient, it is morally lawful to suspend futile treatments when death is imminent and those treatments would only extend the pain with no real benefit for the patient. But, even when futile treatments are suspended, the therapeutic care continues and the essential physiological functions have to be maintained.

Similarly, deep sedation in the terminal stage is morally licit, when the direct purpose is not kill the patient but to mitigate unbearable pain.

The Vatican letter presents three cultural obstacles that obscure the sacred value of every human life. First, the use of the misleading term “dignified death” as measured by a person’s “quality of life”. Second, a false understanding of compassion. Third, a growing individualism within personal relationships.

In contemporary culture, human life is no longer recognised as a value in itself but, instead, it is considered worthwhile only when it has an acceptable degree of quality. The presence of physical or psychological discomfort, according to this point of view, impoverishes the quality of life and makes it not worthy of continuation.

A false sense of compassion claims that it is better to die than to suffer but, the document states, “human compassion consists not in causing death, but in embracing the sick, in supporting them in their difficulties, in offering them affection, attention, and the means to alleviate the suffering”.

The third obstacle to appreciate the value of human life is individualism. Those who become dependent on others are not able to exercise perfect autonomy, so choosing one’s own death becomes the ultimate act of self-affirmation.

The document reminds readers that the doctor “is never a mere executor of the will of patients, but retains the right and obligation to withdraw from any course of action contrary to the moral good discerned by conscience”.

A significant portion of the letter is devoted to conscientious objection. “Laws exist, not to cause death, but to protect life. … It is therefore never morally lawful to collaborate with such immoral actions or to imply collusion in word, action or omission”. This is the case for individuals and also for institutions, such as hospitals or nursing homes. When conscientious objection is not legally recognized, “one may be confronted with the obligation to disobey human law”.

Catholic healthcare institutions cannot cooperate with gravely immoral laws. This also means “Institutional collaboration with other hospital systems is not morally

permissible when it involves referrals for persons who request euthanasia", as this would be a form of participation.

Episcopal conferences, local churches and Catholic institutions should "adopt a clear and unified position to safeguard the right of conscientious objection in regulatory contexts where euthanasia and suicide are sanctioned".

The Vatican document also says that while chaplains are allowed to assist spiritually those who expressly wish to legally end their lives, they should avoid doing anything that could be interpreted as approval of such an act. If the patients are determined in their intent, they cannot be given absolution during Confession. This is intended not to condemn but to the lead the sinner to conversion.

This document deserves careful reading and urgent dissemination by the Irish Church.

Family Solidarity hosted an on line ZOOM webinar on "assisted suicide, euthanasia and dying with dignity" on Thursday 15th October. Dr Noreen O'Carroll presented a paper, which was followed by a discussion with a panel that included David Quinn of the *Iona Institute*.

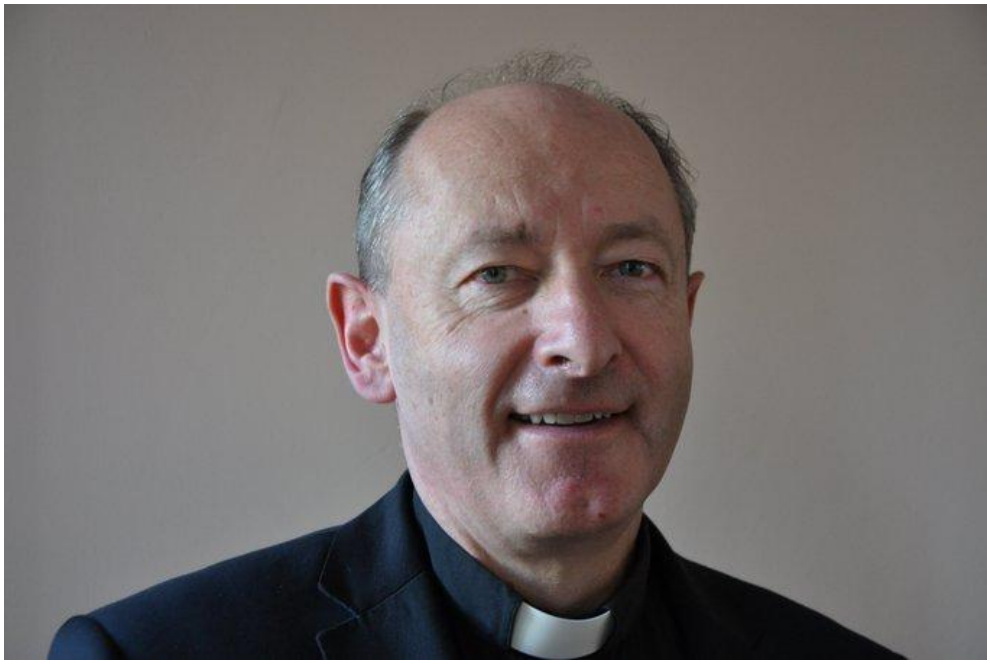
When making or updating your will please remember Family Solidarity . We are grateful to those who have already done so, and as well as providing us with funds for family related causes we will include you specially in our masses said for deceased members and in our annual Mass.

THIRTEEN STUDENTS BEGIN STUDIES FOR PRIESTHOOD FOR IRISH DIOCESES

Thirteen seminarians have begun their formation and academic program for 2020 – 2021. The new students are currently in formation in Saint Patrick's College, Maynooth; the Pontifical Beda College, Rome; the Redemptoris Mater Seminary, Dundalk; and the Venerable English College, Rome; with a number beginning their propaedeutic program in other locations in Ireland and abroad. This brings to 72 the total number studying for the priesthood for Irish dioceses.

Commenting on the 2020 – 2021 intake of seminarians,

Bishop Alphonsus Cullinan, chair of the Bishops' Council for Vocations, said, "While we are all aware of the great challenges facing the Church and society at this time, we know also that God the all-powerful is always with us. These formation figures released today offer us a sign of hope.



Bishop Cullinan continued, "In his message for Vocations/Good Shepherd Sunday on 3 May last, Pope Francis asked us to find courage to say 'yes' to God, to overcome all weariness through faith in Christ. My prayer is that all who are being called to diocesan priesthood will have that courage to say 'yes' to God`s call!"

Father Willie Purcell, National Diocesan Vocations Coordinator for the Bishops' Conference said, "The role we have as Vocations Directors is to help young people realize that each one of them has a unique calling from Christ, and we aim to support them in answering that call, particularly in the case of those who are discerning vocations to the priesthood or religious life. I take this opportunity to thank all the vocations directors across the country for their work in accompanying those who are discerning a vocation to the priesthood."

BEATIFICATION OF CARLO ACUTIS: "TO HEAVEN WITHOUT A NET"

The Beatification of Carlo Acutis, a young Italian who died in 2006 offering all his sufferings for the Church and for the Pope, took place in Assisi on October 10, 2020. Here is a translation of an article by Isabel Orellana on the Church's new Blessed. Carlo Acutis, a contemporary of ours, was 15 when he gave his soul to God, having left to the world a backpack full of blessings obtained by his daily surrender. Prayer, the Eucharist, love of the Virgin . . . and profound eagerness to take the faith through the Internet — the instrument he had at hand, working with it intelligently and ably. He achieved his objective, moving

innumerable people, who no doubt were unaware of the existence of Eucharistic miracles, as well as many who knew about them. For good reason, he is called the "first *influencer* of God" and "cyber-apostle of the Eucharist." He, who put the simile of the balloon that to ascend must let go of all burdens, just as we must do with "our venial sins," went up to Heaven without a net. He had thrown himself into the bottomless void of divine love as a child and now nothing and no one could stop him. Of Milanese parents, well-positioned professionally, he was born in London on the day of the Holy Cross, May 3, 1991. A few months later, his parents took him to Milan where he would spend the rest of his short life. He was handsome, diligent in his studies, an alert boy and, in appearance, like all others, although his acts of generosity to the weak and homeless already gave away that something great was beating in him.

Although his parents were non-practicing Catholics, they had him baptized and did not object to his receiving his First Communion and Confirmation. He studied in religious schools and was initiated in the truth of the faith through his Polish nanny. Later, a domestic employee in his home

converted due to his witness. To his habit of entering any church that was at hand, he added the pious practices common to those of a holy life. His companions, his friends appreciated his worth, and his dear ones, including his mother, were affected by his example and got used to seeing Carlo's singularity as something natural. Perceived in his gestures and words was the exceptionality of someone who, though being in the world, lived with his eyes fixed on Heaven. They are those "next door saints" that appear shining when they go to the bosom of our Heavenly Father. He had been adorned with divine wisdom. He regarded the Eucharist as his "Highway to Heaven" and, the Rosary, as the shortest ladder to ascent to it, and the "most powerful weapon" after the Eucharist, to fight against the devil. He believed that "our aim should be the infinite, not the finite because the former is "our homeland. Heaven is always waiting for us." He loved the Church profoundly, which he defended without hesitation. With great lucidity, he was aware of the uniqueness of a person. "We are all born as originals, but many die as photocopies." He knew that an ordinary life can become extraordinary if we put God at the center. The sole

"program" of his life was to be united to Jesus; hence he counseled: "Find God and you will find the meaning of your life." In his life, there was no woman other than the Virgin Mary. And he was very sure that the "only thing we must really fear is sin." These and other thoughts, which are being revealed these days, reflect a whole theology. On October 11, 2005, an aggressive leukemia was extinguishing his life. He knew that he would not come out of it alive, and showed it in a video, in all its crudeness, with serene joy. He offered himself in libation for the Pope and the Church, in order to avoid Purgatory and "be able to go straight to Heaven." On October 12, the day of the Virgin of Pilar, his eyes closed to this world only to open in the Heaven he had dreamed about. All the good he had sowed began to germinate. On opening his tomb, his body was found to be incorrupt. He was beatified on October 10, 2020.