Bioethics Outlook

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The right and good healing act

A patient is in Intensive Care after a serious car accident. After strenuous attempts to save his life, the doctors have come to the view that this is no longer possible. They talk to the family about how they think they can best care for him now. The shocked and grieving family ask them to continue with life-prolonging treatments.

A patient is brought into hospital after an overdose. After surviving the initial emergency, she now wishes to leave the hospital. The medical staff urge her to stay, so that she can receive specialist care for what might be a serious addiction.

What is the right thing to do for the patient in difficult circumstances? More generally, what is a reliable ethical framework for guiding healthcare practitioners in resolving complex questions? Medical students are taught to answer these questions by referring to four principles: autonomy, beneficence, non-maleficence and justice. These so-called 'Georgetown principles' were introduced into medical education, and into the education of other healthcare practitioners such as nurses and social workers, shortly after the publication by Beauchamp and Childress of *The Principles of Biomedical Ethics* in 1979.

In this issue

- **Report of a webinar on *Moral distress, healing and hope.***
- **Advance Notice of the Annual Plunkett Lecture: 5.15pm Wed 20 Nov 2024 at St Vincent's Clinic, Darlinghurst: Prof David Kissane: *Demoralisation: its influence on the will to live.***
- **Advance Notice of the Inaugural Nicholas Tonti-Filippini Memorial Mass & Oration: Fri 29th Nov 2024 in Melbourne: Prof Tracey Rowland: *Christian Ethics and the Imago Dei.***

The book is now in its eighth edition, and though many of those who know these four words may not have read it, the approach set out there has dominated bioethics for nearly fifty years. Indeed, some would be inclined to think that the 'Georgetown Mantra' provides the *only* approach to ethical thinking about the practice of healthcare. Or at least the only *vocabulary* to use in bioethics.

Not so, says Dr Myles Sheehan, SJ, the director of the Ethics Consultation Service at the Pellegrino Center at Georgetown University. According to him, the

> *'famous four principles are very important, but the most important elements are the recognition of the patient's vulnerability, the doctor's commitment to help, and then the process where you try to understand what is the most important healing decision for the patient's good.'* [1]

Dr Sheehan's approach derives from the work of Dr Edmund Pellegrino after whom the Pellegrino Center is named. Pellegrino had been director of the Kennedy Institute of Ethics at Georgetown and before that served as President of Catholic University in Washington DC - all the while maintaining an active medical practice.

A good introduction to Dr Pellegrino's thinking is found in a short article entitled 'Edmund Pellegrino's Philosophy and Ethics of Medicine: an overview' written by the current director of the Kennedy Institute, Dr Daniel Sulmasy.[2] In what follows I draw on that article to set out the main features of Pellegrino's approach, beginning with an explanation of why Pellegrino thought we need to understand both a *philosophy* and an *ethics* of medicine. That said, I warmly recommend a reading of Sulmasy article itself – in its entirety.

A *philosophy* of medicine as foundation for an *ethics* of medicine

Pellegrino argued that in order to know *how* healthcare practitioners should act, one must know '*what* medicine is'. He helped to establish what can be called a study of the *philosophy* of medicine. He worked on diagnostic and therapeutic reasoning and on the nature and definition of illness, and in all this he focused on the patient's *experience* of illness.

Pellegrino assumed, and sometimes argued, that medicine is a distinct human practice with its own intrinsic or '*internal*' purposes. He insisted that *before* one can derive a set of moral expectations for practitioners and *before* one can establish norms for the relationship between healthcare and society at large one needs to understand what medicine *is*.

[1] Sara Piccini. *Finding the 'right and good healing acts'.* https://today.advancement.georgetown.edu/health-magazine/summer-2023/2023/finding-the-right-and-good-healing-acts/

[2] D P Sulmasy. Edmund Pellegrino's Philosophy and Ethics of Medicine: an overview, *KIEJ,* 24, 2 June 2014, pp 105-112

And so, instead of reflecting on the *rest of life* to find ethical principles to bring to 'apply to' medicine, he reflected on medicine *itself* to discover its own 'internal' ethical principles. He searched for a rich, objective, 'universal across times and cultures' view of medicine, what Sulmasy calls a 'phenomenology' of illness and of the doctor-patient relationship, arguing that this core of medicine could be captured in three things: the 'fact of illness', the 'act of profession', and the 'act of medicine'.

The 'fact of illness', the 'act of profession', the 'act of medicine'

By the 'fact of illness', he meant the experience of illness, that universal human experience of vulnerability, restrictedness, dependence, loss of selfhood: in summary, 'wounded humanity'.

By the 'act of profession', he drew attention to the fact that medicine and allied professions such as nursing are socially established institutions by which individuals receive special training and publicly swear to use that training for the service of the patient.

By the 'act of medicine', he meant a 'shared intentionality' between sick person and the doctor to improve the patient's biomedical state. Medicine is thus first and foremost a relationship, requiring trust on the part of the patient and trustworthiness on the part of the doctor.

What is wrong? What can be done? What ought to be done?

In this relationship, three questions arise: what is wrong, what can be done, what ought to be done? This last question is the moral question that pervades all of medical practice, from the momentous (Should we turn off the ventilator?) to the quotidian ('What drug should we use for this person's high blood pressure?).

In every 'act of medicine' the goal is the *good* of the patient. So, Pellegrino argued that, rather than being just one of four 'competing' principles, beneficence is *the goal* of medicine. Aspiring medical students implicitly recognise this when they that they want to study medicine in order to *help* people!

Pellegrino's notion of the good of the patient.

Pellegrino argued that the patient's good is a complex notion, consisting in a *hierarchy* of successively more inclusive goods:

1. **the biomedical good of the patient**, the restoration of physiological harmony or structural integrity of the individual;
2. **the good of the patient's choice,** in the patient's unique experience of illness and health;
3. **the good of the patient as a person,** who is to be respected not only in his or her choice but also in recognition of his or her worth as a person, and
4. **the patient's notion of the highest good,** which might be a valuing of anything, from a utilitarian maximization of good consequences for the whole of society to a religious notion of transcendent good.

Sulmasy reminds us that Pellegrino's notion of the patient's good is hierarchical: the biomedical good might be trumped by a higher good, as is evidenced by a doctor's acceptance of the refusal of blood transfusion by a Jehovah' Witness. His point was that a doctor who accepts that refusal is in fact acting *beneficently*: promoting the good of the patient in a richer sense than merely attending to his biomedical good.

Thus did Pellegrino defend the notion of a morality *internal* to medicine. Thus did he champion the need for *virtue* in medicine. For a doctor *needs* fidelity to trust, practical wisdom, compassion, justice, fortitude, temperance, integrity and self-effacement if he or she is to seek the good of the patient.[3]

The goal of medical acts was to answer the question: '*What is the right and good healing act for this patient in these circumstances?* This, summarises Sulmasy, is the shared intention of the doctor and the patient, oriented to the good of the patient, demanding virtue on the part of the clinician. Indeed, Pellegrino believed there were correct and incorrect answers to that question, an idea which *distinguishes* his view from both the 'clinical ethics is mediation view'[4] and the 'clinical ethics is consensus-finding view'[5]. Rather, he argued, clinical ethics is a collective engagement with that central question: '*What is the right and good healing act for this patient in these circumstances?'* This, I submit, is what should now be called the 'Georgetown' approach to clinical ethics.

Sulmasy's article goes on to identify trends in medicine which troubled Pellegrino and to summarise the variety of lines of criticism of Pellegrino's views which emerged in the literature. I will not go into these here. Suffice it to say that the summary of these topics provides yet another reason for encouraging a reading not only of Sulmasy's article itself but also the whole symposium on Pellegrino's philosophy and ethics of medicine in the issue of the *Kennedy Institute of Ethics Journal* to which it is a contribution.[6]

Bernadette Tobin

See also the following works of Edmund Pellegrino:
Professionalism, Profession and the Virtues of the Good Physician. Mount Sinai Journal of Medicine, 69/6 Nov2022
The ends of medicine and its virtues, in *The virtues in medical practice*, eds Pellegrino & Thomasma, OUP, 1993
The virtuous physician, and the ethics of medicine, in Shelp (ed) *Virtue and Medicine,* Reidel, 1985

[3] To these virtues, Pellegrino added the Christian virtues of faith, hope and love, virtues which would in his view enable the physician to become a truly Christian doctor.
[4] Dubler, Nancy & Carol Liberman, 2011. *Bioethics Mediation: A guide to shaping shared solutions*, Nashville, Vanderbilt University Press.
[5] American Society for Bioethics & Humanities. 2010. *Core competencies for health are ethics consultation*, Oakbrook, American society for Bioethics and Humanities.
[6] *Kennedy Institute of Ethics Journal*, Vol 24, No 2, June 2014.

The Wounded Healer

Moral Distress, Healing and Hope in Clinical Practice

Sophie is a critical care nurse in a rural hospital. No doctor is on-site out of hours: access to a doctor is via telehealth. Sophie looks after Beryl, a 78-year-old lady with early-onset dementia. Beryl was brought into the local emergency department after a fall at home and is now confused and agitated. She appears to have a urinary tract infection, and she is delirious. For the past five hours, Beryl has been waiting to be transferred to the larger hospital, where they can look after her. Sophie is concerned that Beryl is getting more confused and agitated and is at risk of self-harm. Sophie is also looking after another five patients.

John is an experienced pediatric ICU specialist who has been looking after Sammy, a 1-year-old boy with a severe neurogenerative disease. Sammy is tube-fed and not able to move or maintain any posture. Sammy's disease is progressing. He has had several bouts of pneumonia and urinary tract infections. It is becoming increasingly challenging to gain vascular access to Sammy for intravenous antibiotics, and it is apparent that each attempt distresses Sammy. John believes it is time to move towards comfort care for Sammy: he thinks that the medical interventions are becoming burdensome for the little boy. However, Sammy's parents disagree.

The Plunkett Centre's recent webinar on moral distress experienced by clinicians in healthcare brought into conversation a theologian, a medical doctor and the Centre's director to consider two things: first, whether ethics can offer insights into the factors contributing to what some believe is a crisis in the provision of healthcare, and second, whether ethics can offer insights into ways in which clinicians can grapple successfully with the challenges of constrained agency in their professional lives.[7]

Webinar: the speakers

Kate Jackson-Meyer, a John and Daria Barry postdoctoral fellow at the Human Flourishing Program at Harvard University, opened the discussion. Her research focuses on issues at the intersection of fundamental moral theology and social ethics. Dr Jackson-Meyer is currently investigating the problems of tragic dilemmas, moral distress, and moral injury not only in

[7] A recording of the webinar can be found on the Plunkett Centre's website: https://www.acu.edu.au/about-acu/institutes-academies-and-centres/plunkett-centre-for-ethics

bioethics but also in war and peacemaking in order to analyse the complexity of moral decision-making in these contexts and the prospects in each for community-based moral healing. She is the author of *Tragic Dilemmas in Christian Ethics* (Georgetown University Press, 2022). Kate earned a Ph.D. in theological ethics from Boston College, a Master of Arts in Religion, specialising in ethics, from Yale School of Divinity, and a B.A. in biology and religion from the University of Southern California. In her reflections she focussed on the context in which healthcare is delivered in the United States.

Marija Kirjanenko, a lecturer in bioethics at the Plunkett Centre and an emergency physician at Eastern Health in Melbourne and in the Victorian Virtual Emergency Department also in Melbourne, added her own firsthand knowledge of clinical cases which have caused moral distress among her colleagues. She is the coordinator of Eastern Health's Emergency Medicine Trainee Mentorship Program and a member of their Clinical Ethics Support Group. Marija reflected on matters that arise for a clinical leader in providing healthcare in emergency wards in some public hospitals in Victoria.

Xavier Symons, director of the Plunkett Centre for Ethics, initiated the discussion. Xavier has been a Fulbright Future Postdoctoral Scholar in the Pellegrino Center for Clinical Ethics at Georgetown University, a visiting Research Fellow at the Anscombe Bioethics Centre in Oxford, and recently a Postdoctoral Scholar at Harvard University's Human Flourishing Program. In the past Xavier has held research positions at both Australian Catholic University and the University of Notre Dame Australia.

Kate and Marija made a joint presentation, Kate concentrating on theory and Marija on practice. Xavier then led the Q&A session, clarifying some conclusions drawn from this discussion. In this report of the webinar, particular attention is paid to literature on the 'theory' of moral distress to which Dr Jackson-Meyer drew the audience's attention.

Three main topics were discussed: the conceptual foundations of the idea of 'moral distress', some strategies for identifying moral distress, and a range ways of healing those who experience moral distress.

1 Conceptual foundations of moral distress

The original definition of moral distress comes from Jameton[8] who said that moral distress '*arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action'.* At that time, Jameton was referring to a phenomenon experienced by nurses. The concept has since expanded so as to have application

[8] Jameton, 1984

to other healthcare professionals. According to Campbell, Ulrich and Grady, the phenomenon has the following features: an initial distress, a reactive distress (or 'moral residue'), a compromising of the individual's moral integrity or violation of that person's core values leading to 'burnout'.[9] It is to be distinguished from other forms of stress such as moral uncertainty[10], moral dilemmas[11], emotional or psychological stress[12], PTSD[13], moral fatigue[14], compassion fatigue[15] and moral injury[16].

According to Hamric et al[17], some constraints are **internal** to the person. These include perceived powerlessness, inability to identify the ethical issues, lack of understanding of the full situation, self-doubt, lack of knowledge of alternative treatment plans, increased moral sensitivity, lack of assertiveness, and socialised habit of following others. **External** constraints include inadequate communication among team members, differing perspectives, inadequate staffing or turnover, lack of administrative support, policies that conflict with care needs, the following of family wishes out of fear of litigation, tolerance of disruptive or abusive behaviour, compromising of care due to pressures to reduce costs, hierarchies within the system, lack of collegiality, exclusion from decision-making, compromises due to insurance pressures.

Hamric et al also identify **common situations** that can elicit moral distress including the provision of futile treatment, the prolongation of the dying process through aggressive treatment, inadequately informed consent, working with others who lack the necessary competence, lack of consensus about treatment plans, conflicting duties, the inappropriate use of resources, inadequate pain relief, the provision of false hope to patient and families, the hastening of the dying process, a lack of truth-telling and disregard for the wishes of the patient.

Dr Jackson-Meyer then set out some **limits** to the concept of moral distress which have been identified in the literature. These include

- the vagueness of the concept: "Is moral distress a situation? A set of beliefs or attitudes? A range of emotions? A group of symptoms?" [18], [19]);

[9] Campbell, Ulrich & Grady,2016
[10] Jameton, 1984
[11] Jameton, 1984
[12] Dudzinski, 2016
[13] Papazoglou & Chopko, 2017
[14] Timmons & Byrne, 2018
[15] Mason et al, 2014
[16] Rosen, Cahill & Dugdale, 2022
[17] Hamric et al, 2012
[18] Morley, 2016
[19] McCarthy & Gastmans 2015

- the difficulty of determining the source of one's distress and in determining its moral aspect[20],
- the view that it is "too ambiguous to be useful"[21],
- the view that the concept suffers from "fuzziness" [22]
- the view that it assumes that nurses' moral judgements are correct[23],
- the view that it perpetuates the notion that nurses are powerless[24],
- the view that it is overly individualistic,
- the view that the role of moral responsibility in moral distress is unclear[25],
- the view that it is unsettled whether the concept does or indeed should encompass conscientious objection, and
- a view that the concept should be abandoned[26].

2 Identifying moral distress

What might someone experiencing moral distress say? Ulrick et al[27] suggest: 'This doesn't make any sense: why are we continuing to do this?' 'I feel like I'm inflicting unnecessary suffering on this patient.' 'I want to tell the patient to run.' 'How can I see myself as a good nurse or doctor in the face of this situation?'

There exists a range of measures of moral distress including the Moral Distress Thermometer (MDT)[28], the Measure of Moral Distress-Health Care Professionals (MMD-HP)[29] and the Moral Distress-Appraisal Scale (MD-APPS)[30].

The *Moral Distress Thermometer* has a 10 point scale from none to worst possible.

[20] Dudzinski, 2016
[21] Morley, 2016
[22] McCarthy & Gastmans, 2015
[23] Johnstone &Hutchinson 2015
[24] Johnstone & Hutchinson, ibid
[25] Tessman 2020; Campbell, Ulrich & Grady, Dudzinski; Jameton
[26] Johnstone & Hutchinson, op cit
[27] Ulrich et al, 2010
[28] Wocial & Weaver, 2013: Dr Jackson-Meyer noted that anyone who plans to use this scale for research purposes should notify Dr Lucia Wocial at wocial@iuhealth.org
[29] Epstein et al, 2019
[30] Baele & Fontaine, 2021. English translation of original instrument in Dutch.

- The *Measure of Moral Distress-Health Care Professionals* has a list of 27 items including witnessing a healthcare provider giving 'false hope' to a patient or family, feeling pressured to carry out an order which seems to be an unnecessary or inappropriate test or treatment, continuing to provide aggressive treatment for a person who is most likely to die regardless of this treatment (when no one will make a decision to withdraw a treatment).

- The *Moral Distress-Appraisal Scale* asks respondents to assess the degree to which statements of the following kind apply to their work: 'I am prevented from carrying out my work in a way that I believe is morally right.' 'I can work in accordance with my norms and values.' 'I am helped to work in a way that I believe is morally right.' 'I am compelled to do things that I believe are morally wrong.[31]'

3 Ways of responding to moral distress

Dr Jackson-Meyer explained a variety of approaches to responding to moral distress, including:

- the approach of the American Association of Critical Care Nurses called the '4As to rise above moral distress (Ask, Affirm, Assess, Act) [32],

- Koonce & Hyrkas' work on identifying the underlying causes, and leveraging the power of spirituality to heal moral distress[33],

- Dudzinski's Moral distress map[34], and

- some evidence-based studies such as Saechao et al's comparison of the effects of a book group versus a four-hour retreat[35], Teo et al's Sip and Share Intervention [36], Vaclavik et al's mindfulness exercises[37], Jackson-Myer's own moral health rounds[38], together with some resources from the Catholic tradition on solidarity, vocation and care for the whole person.

Dr Kirjanenko added her own experience-based recommendations on the management of, and possible solutions to, moral distress. Strategies for managing moral distress could occur at the individual, team and institutional levels.

At the individual level:

[31] Baele & Fontaine 2021: English translation of original instrument in Dutch. From appendix S1
[32] American Association of Critical Care Nurses
[33] Koonce & Hyrkas, 2022
[34] Dudzinski,
[35] Saechao et al 2017
[36] Teo et al, 2022
[37] Vaclavik et al, 2018
[38] Jackson-Meyer j2020

- ***Mindfulness with a purpose.*** Mindfulness as an important safety feature. On an aeroplane, we are advised to put on our own oxygen masks before assisting others. Recognizing one's own early warning signs and "default routines" when one is stressed can be empowering.

- ***Moving away from the perfect.*** Considering what might be 'good enough' in each case that is, balancing reaching the gold standard threshold with avoiding inflicting harm threshold.

- ***Introducing pauses.*** Stopping before moving on to the next patient (on the model of the introduction of "time outs" before the start of surgery to ensure the right patient and procedure); or a spiritual pause, or just a moment of quietness, or even a quick drink of water.

At the Team level:

- ***Team-building exercises***; holding a department meeting in a different space, or over lunch or an special educational dinner, or a departmental conferences;

- ***Interdisciplinary educational sessions.***

- ***Establishing a safe space*** where team members can get to know each other, and can discuss hard cases and engage in a 'talking cure' or a 'sharing the load' cure.

- **Mentorship:** Building moral communities of practice[39]

At the organisational level:

- ***Ethics response groups:*** Establishing groups of clinicians who have expertise/interest in clinical ethics and who conduct clinical ethics consultations on demand;

- ***Ethics debriefs:*** "Hot debriefs" after complex events, with a focus on ethical questions and decision-making.

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[39] Denholm et al 2022

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Annual Plunkett Lecture

Demoralisation: Its influence on the will to live

The Plunkett Centre for Ethics, a joint centre of Australian Catholic University and participating partner hospitals, welcomes you to its annual lecture.

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5.15pm. The lecture will be followed by refreshments

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PRESENTER

Professor David Kissane is Chair of Palliative Care Research, The University of Notre Dame Australia; Emeritus Professor of Psychiatry, Monash University, Melbourne, Australia; and formerly Professor of Psychiatry at Weill Medical College of Cornell University, in conjunction with Memorial Sloan-Kettering Cancer Center, New York, NY, USA.

David Kissane will trace the arc of his groundbreaking research on demoralisation, looking at which symptoms can eventually lead to a growth of a desire to die. Professor Kissane's data in different patient cohorts shows how both "pointlessness" and "hopelessness" lead to suicidal thinking much more strongly than does clinical depression. Pointlessness – the loss of the value, purpose and meaning of life – is not a symptom taught about in medical school or psychiatry training: so it is not part of the medical lexicon. Yet it is as powerful as hopelessness in the loss of the will to live.

For more information or to register your attendance, please email:

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The participating partners of the Plunkett Centre are Sydney's St Vincent's Public Hospital, St Vincent's Private Hospital and the Mater Hospital, as well as St Vincent's Private Community Hospital, Griffith, Calvary Healthcare, the Mercy Hospital in Melbourne and Cabrini Hospital in Melbourne.