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It may be okay in practice but will it work in theory? Dignity therapy in palliative care

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Some years ago, Dr Harry Chochinov came to speak at a palliative care conference here in Sydney.[i] A colleague who works in palliative medicine advised me to go along. 'He invented 'dignity therapy': you'd really like what he says.' I had not heard of dignity therapy, and as someone trained in philosophy I was intrigued as to what such a therapy could be. I trusted my colleague's judgment. I went along to hear Dr Chochinov. I was most impressed by both the manner of the man (as doctor, as human being) and by what he had to say about how best to respond to the 'psycho-therapeutical' needs of people who are approaching the end of their lives.[ii]

But I wondered about the label 'dignity therapy'. Dr Chochinov does marvellous work with people who have lost a sense of meaning and worth as they near the end of their lives. His approach certainly seems to work in practice: it was the label which puzzled me. I have something of the same puzzlement about the increasingly-frequent advice to health care professionals in palliative care that they need to develop strategies for maintaining dignity, advice which is both informed by, and informs, Chochinov's work.[iii] For there is so much confusion about the idea of human dignity in bioethics. So I could not resist using the famous reply of the French diplomat to a proposed UN solution to the crisis in Algeria, 'That's all very well in practice, but will it work in theory?'[iv]

As an idea, 'dignity' can be puzzling. How come both the *proponents* and the *opponents* of the legalization of euthanasia do so in the name of dignity? On the one hand, the proponents insist that

legalizing the deliberate bringing-about of death in order to relieve suffering or in order to meet the autonomous wishes of a person who wants to be helped to die, is necessary if everyone is to be able to 'die with dignity'. On the other, the opponents argue that deliberately bringing about a person's death, even for humane motivations and even in order to respect that person's wishes, violates the person's intrinsic dignity'.

Or again. How come both the *proponents* and the *opponents* of treating a profoundly intellectually disabled young girl so that she would remain below normal height and weight do so in the name of her 'dignity'? In an op-ed piece in *The New York Times*, Peter Singer discussed the so-called 'Ashley' treatment, and considered the strength of some objections by its opponents. He says:

'Finally, there is the issue of treating Ashley with dignity. A Lost Angeles Times report on Ashley's treatment began. "This is about Ashley's dignity. Everybody examining her case seems to agree at least with that." Her parents write in their blog that Ashley will have more dignity in a body that is healthier and more suited to her state of development, while their critics see her treatment as a violation of her dignity. But we should reject the premise of this debate. As a parent and grandparent, I find 3 month old babies adorable, but not dignified. Nor do I believe that getting bigger and older, while remaining at the same mental level, would do anything to change that. Here's where things get philosophically interesting. We are always ready to find dignity in human beings, including those whose mental age will never exceed that of an infant, but we don't attribute dignity to dogs or cats, though they clearly operate at a more advanced mental level than human infants. Just making that comparison provokes outrage in some quarters. But why should dignity always go together with species membership, no matter what the characteristics of the individual may be?" [v]

Singer seems to think dignity is no more than something we - arbitrarily? - choose to attribute to some (babies) but not to others (cats and dogs).

So clarity about the meaning of dignity matters, and no more so than when, as now, there is a move within palliative care to speak of pain relief as a human right.[vi] The concept of human rights is internally connected with the concept of human dignity: we are obliged to respect a person's rights because not to do so would be a violation of the person's dignity. As Ronald Dworkin points out:

'Anyone who professes to take rights seriously... must accept ...the vague but powerful idea of human dignity. This idea, associated with Kant but defended by philosophers of different schools, supposes that there are ways of treating a man that are inconsistent with recognizing him as a full member of the human community, and holds that such treatment is profoundly unjust'. [vii]

Of course, some people are deeply suspicious of how the idea of dignity is used. Responding to the claim that that eating in public – in particular, the 'cat-like licking of ice-creams'- is undignified, Stephen Pinker once remarked that the noble idea that human beings have a distinctive and intrinsic dignity, simply because they are human, is sometimes used to condemn something that 'just gives you the creeps'![viii]

So perhaps it is worthwhile to identify and to clarify the conception, *or conceptions*, of human dignity found in bioethics. Perhaps it is worthwhile to work out whether dignity is something we *find* in human beings or something we (choose to) *attribute* to them. Perhaps it is worthwhile to work out why it is that some *assert* and others *deny* that all human beings have intrinsic dignity. Perhaps the controversies about human dignity are themselves informed by other controversies. All this with a view to seeing whether we think it is a good idea to call an approach to care at the end of life 'dignity therapy'.

From the start, I must say that what I have to say on this matter draws directly on the writing of Daniel Sulmasy, Professor of Medicine and Ethics at the University of Chicago. No one, in my judgment, better clarifies the concept of human dignity as it informs contemporary bioethics. I warmly recommend his work on the idea of

dignity. In what follows I shall make extensive use of his work on the way 'dignity' works in the bioethical and the wider medical literature.[ix]

Sulmasy points out that two conceptions of dignity are critically important in bioethics and ethics: 'attributed dignity' and 'intrinsic dignity'. By attributed dignity, Sulmasy means the worth or value that human beings *confer* upon others by acts of *attribution*. (The act of conferring this worth or value may be accomplished individually or communally, but it always involves a choice.) By intrinsic dignity, Sulmasy means the worth or value that people have simply because they are people, not by virtue of any social standing they may happen to have, not by their ability to evoke our admiration, not in virtue of any particular set of talents, skills or powers. Intrinsic dignity is the value that human beings have by virtue of the fact that they are human beings. The great Prussian philosopher of the 18th century, Immanuel Kant, expressed the idea of human dignity in this way: 'Humanity itself is a dignity.' Intrinsic dignity is not conferred or created by human choices, individual or collective. Indeed, intrinsic dignity is prior to human attribution. Nor can it be assigned in degrees. The radical equality of human beings is a matter of their intrinsic human dignity.

To elaborate. Attributed dignity is created dignity. It constitutes a conventional form of value. Thus we attribute dignity in this sense to people we highly esteem: dignitaries (the Governor-General, the Chief Judge of the High Court, etc), those we admire (Nelson Mandela is an uncontroversial international example, Noel Pearson an uncontroversial Australian example), those who carry themselves in a 'dignified' way (I think of the Head of the Australian Army when he attends the funerals of soldiers killed in Afghanistan), those who possess certain talents, skills or powers (a favourite of mine is Professor Fred Watson, the Astronomer-in-Chief of the Anglo-Australian Observatory in Coonabarabran, who can encourage even the most unscientific of us to have a go at appreciating the majesty of the cosmos!).

We can even attribute worth or value to ourselves using this word. I use the word 'dignity' in this sense when I say that I felt so undignified when I fell down the stairs in front of so many people. People use the word 'dignity' in this sense when they say it would severely diminish their dignity to have to wear a nappy in order to avoid the even deeper embarrassment of incontinence. People use the word in this way when they say that being intoxicated is undignified. Peter Singer refers to this use of the word when he remarks that we do not attribute dignity to cats and dogs. People use the word in this sense when they say they want to die 'with dignity'. A few years ago some people used the idea (if not the word itself) when they said that they wanted euthanasia legalized so that, when they died, they would not be an ugly ('undignified') corpse.

All these examples of the idea of dignity (or its loss) as something we choose to attribute to others, or to ourselves, are perfectly familiar. When I say to my friend that I felt undignified falling down the stairs in front of others, she understands perfectly: for she too would feel ashamed of herself in those circumstances. That is to say, she (sympathetically) recognizes my loss of attributed dignity and would fear experiencing such a loss herself, even as she tries to encourages me not to make too much of this loss of dignity. And illness, grief, loss of employment, can all make us doubt our own dignity. They can threaten the dignity we attribute to ourselves.

On the other hand, intrinsic dignity demands respect. Sulmasy says that his favourite artistic depiction of intrinsic human dignity is the famous photo of Martin Luther King, Jr in his Birmingham, Alabama, prison cell. King had been denied freedom. He had been denied control. He had been denied 'dignity by attribution'. Yet the photo revealed his intrinsic dignity. Sulmasy says: King's intrinsic dignity cried out for recognition. We Australians, I submit, often see intrinsic human dignity depicted in the faces of Afghani refugees at their most 'undignified': sitting cheek by jowl in a leaky Indonesian boat utterly vulnerable to the manner in which they will be now treated by members of the Australian navy.

Intrinsic human dignity is the true foundation for all our moral duties to each other. When societies institutionalize these duties, they correspond to what we now call human rights. Certain acts are inconsistent

with intrinsic human dignity and others contribute to, build up, intrinsic human dignity. Call the former negative rights and the latter positive rights. Negative rights include a right not to be killed, a right not to be experimented on without consent. Positive rights include a right to basic education and basic health care and, it is now argued, a right to the relief of one's pain. So, putting the negative and the positive rights together, we can say that respect for intrinsic human dignity means never acting in a way which violates human rights. And, we can add, respect for intrinsic human dignity means taking concrete steps to build up the attributed dignity of our fellow human beings, to help them to flourish and to regain and maintain their sense of their own dignity. Of course, building up a person's attributed dignity, the dignity that others (or they themselves) choose to attribute to them(selves), is a moral demand on us that competes with other moral demands on us, and for which our resources – of time, imagination, energy - will always be imperfect.

One last point about these two conceptions of human dignity. Respect for intrinsic human dignity is prior – ethically prior - to concern for attributed dignity. Two ambulances with critically ill passengers arrive at the same time at Emergency. In one is the critically ill Prime Minister, in the other is the critically ill Joe Citizen. We certainly attribute greater status (or dignity) to the prime minister than we do to the ordinary citizen. Both, however, possess intrinsic human dignity; in that regard they make radically *equal* demands on us. So who gets attention first, or should get attention first, depends on their relative health care needs (whose need is more urgent, who is more likely to benefit therapeutically from the available treatment, who is likely to suffer the greater harm without treatment, etc[x]) and *not* on who is the more important dignitary.

Some people, however, think that not all human beings have intrinsic dignity. Peter Singer certainly seems to think that 3 month old babies lack intrinsic dignity! This remarkable view, one which seems to fly in the face of so much international agreement, in law, in philosophy, in politics, since the adoption of the *Universal Declaration of Human Rights* over 60 years ago, is, however, a widely shared. In fact it is the 'dominant' view of intrinsic dignity in contemporary moral philosophy. Most contemporary moral philosophers would reject the idea that intrinsic dignity is possessed by all human beings.

In order to understand the debate between those who think that all human beings have intrinsic dignity and those who think that only some human beings have intrinsic dignity, it is helpful to understand what lies behind each of these views. For there are two, competing, views of the basis of intrinsic dignity. On one view, the basis for intrinsic dignity is the idea of a 'natural kind'. On the other view, the basis for intrinsic dignity is the idea of a 'logical set or class'. Let me explain, again drawing directly from the writing of Daniel Sulmasy on this subject:

'Although it is in many ways an ancient idea, [a natural kind] is a relatively new concept in analytic philosophy, designating a category of entities, all the members of which, by virtue of being brought under the extension of the kind, can be necessarily known to be that sort of thing. This theory argues that nature fixes certain 'sortal predicates', so that it is not open to human beings to decide to classify natural kinds as anything other than what they are, for example, oxygen or a lemon or a human being.'[xi]

A natural kind is not an artefact. A natural kind is not a classification of objects created by human beings for human purposes. Sulmasy quotes the contemporary philosopher David Wiggins:

'The determination of a natural kind stands or falls with the existence of law-like principles that will collect together the actual extension of the kind around an arbitrary good specimen of it; and these law-like principles will also determine the characteristic development and typical history of members of this extension.'[xii]

The philosopher Lisska calls these law-like principles 'dispositional properties'.[xiii] They serve to describe both typical members of the kind and the way typical members develop and behave. The dispositional properties serve as standards for judging when a particular member of a kind is a defective member of

the kind. A defective member is just that: a member of the kind and defective. I go to make a gin and tonic. I find I have both a fresh juicy lemon and an old and wizened one. But whether fresh and juicy or old and dry, both are lemons.

Membership of a natural kind determines a thing's intrinsic value. This is what word 'intrinsic' means: the value of the thing in question is the value it has by virtue of its being *the kind of thing that it is*. Lemons, whales, stars, etc, each have a distinctive value that we recognize and do not merely confer. Recall how central to contemporary environmental ethics is the recognition of the intrinsic value of non-human species of animals.

A thing's intrinsic value is the value a thing has by virtue of being the *kind* of thing it is. That value is not created or conferred by people. Rather it commands recognition. That is to say, recognition of this value makes demands on us. It commands that we act in a manner consistent with the value we recognize. For instance, we ought never to inflict pain on animals without some very serious reason. The ethical prohibition on causing unnecessary pain has long been a part of traditional ethics (even if it has sometimes been under-acknowledged in the case of non-human animals).

How does the idea of a natural kind form the basis of the idea of intrinsic dignity? 'Intrinsic dignity' is the intrinsic value proper to the highest order of natural kinds. Intrinsic dignity comes by way of membership in a natural kind that has, as a natural kind, the dispositional properties of intelligence, reason, love, free choice, moral agency, sociability, creativity, etc. Any member of this kind, the kind that has these dispositional properties has intrinsic dignity. On this view, then, the intrinsic value of human beings, called 'intrinsic dignity', is universal, inalienable, and does not admit of degrees. It is respect for this value, this 'intrinsic dignity', that is the basis of universal rights.

Is this 'speciesism' as Peter Singer implies it is in the quote above? Does it involve making an arbitrary distinction in favour of human beings just because of their membership in a biological species? No, the idea of a natural kind is not reducible to the idea of a biological species. If there were other beings (angels, Martians, beings from another planet, etc) who manifested these same dispositional properties (intelligence, reason, love, free choice, moral agency, sociability, creativity, etc), then all the members of these natural kinds would have intrinsic dignity too. That is to say, we would be obliged to act in a manner consistent with recognizing their dignity as radically the same as the dignity of all human beings. So the charge of 'speciesism' fails.

This, then, is one view of the basis of intrinsic dignity: it relies on the idea of human beings belonging to a natural kind. All human being, no matter how rich or poor, educated or uneducated, abled or disabled, cognitively advanced or cognitively impaired, etc, belong to a natural kind, the worth or value of which we call 'intrinsic dignity'. All human beings, whether their capacities for intelligence, reason, love, free choice, moral agency, sociability, creativity, etc, are relatively un-developed or impaired or only-beginning-to-be-realized or fully-developed, that is to say, whether they are *'potentialities'* or *'actualities'*, belong to a natural kind the worth or value of which we call 'intrinsic dignity'.

So the other, competing, view of the basis for intrinsic dignity is the idea of a 'logical set or class', the class of beings we describe as 'person'. The idea of 'personhood' has a long history[xiv], during most of which time the concept of being a person and being a member of a natural kind capable of reason and moral agency were conceptually interchangeable. But something happened in 17th and 18th century philosophy which changed all that: John Locke re-opened the philosophical discussion of what it is that makes the diamond (or the oak tree or the animal or the person) you see on Monday the same diamond (or oak tree or animal or person) you see on Friday. He separated 'personhood' from the being who possesses 'personhood', and he cashed out 'personhood' in terms of (self-) consciousness. Someone is a 'person' only in so far as he or she has consciousness and memory.

Influenced by this part of Locke's philosophy, the dominant school of thought in contemporary Anglo-American philosophy now divorces the idea of a 'person' from the idea of being a member of the human natural kind. According to contemporary view, 'person' refers to an individual member of a humanly-devised class or 'logical set', not an individual member of a natural kind. The concept 'person' picks out only those individuals who *actively* express, as individuals, the particular characteristics that define the class. For some philosophers of this school of thought, these characteristics are consciousness and memory. For others, they are intelligence, reason, love, free choice, moral agency, sociability, creativity, and other properties. All agree, however, that the word 'person' means *not* a kind of thing who has certain properties whether as potentialities or actualities but rather *an individual of which these properties can actually be predicated.* Thus, some members of the human natural kind (eg embryos, foetuses, the permanently comatose,) turn out not to be 'persons' (because these characteristics cannot be actually predicated of them). And some members of certain highly advanced non-human natural kinds (eg porpoises, higher apes) may turn out to be 'persons'! On this view, not all human beings have intrinsic dignity. Only those who fall into the logical class 'person' do: that is to say, only those who *actually* possess intelligence, reason, love, free choice, moral agency, sociability, creativity, etc. Only those who fall into the class 'person' have inalienable rights.

This, then, is the other view of the basis of intrinsic dignity. This view relies on the idea that only some human beings are persons because only some human beings *actually* have intelligence, reason, moral agency, etc. Some human beings are too young to have those things *actually* said or predicated of them: certainly embryos, and foetuses, perhaps even new born babies. Some are too old, or too cognitively impaired, to have those things *actually* said or predicated of them: those in post-coma unresponsive state, those in prolonged coma, those who suffer dementia or even brain cancer, etc. And since they are not persons, they do not have intrinsic dignity.

Which of these views of intrinsic dignity, or more accurately which view of the basis of intrinsic dignity, is the preferable view? Which is the more reasonable? On this, as on any genuinely philosophical matter, there is no such thing as absolute proof, no knockdown argument. But, as Sulmasy argues, the second view, the 'personhood' view, is much less reasonable. For the following reasons.

Firstly, basing morality on this contemporary conception of personhood would mean that there is no such thing as intrinsic human value, the value that a human being has by virtue of being the kind of thing that a human being is. But do we *not* think that comatose human beings and professors of palliative medicine are equal with respect to their intrinsic dignity because they are all the same kind of thing: human beings? Of course, some are more imperfect or deficient than others in their expression of the dispositional predicates of the natural human kind. But do we not think of them as *beings of the same kind*?

Secondly, basing morality on this contemporary conception of personhood would mean that the dignity associated with personhood would, as attributive, necessarily be stipulative.(Sulmasy reminds us that, in 1857, the US Supreme Court stipulated that black human beings were property, and thus that they did not have human rights!) But the *Universal Declaration of Human Rights* does not *stipulate* that all human beings have rights: it *recognizes* that they do. The radical equality of human beings, the fact of their having inalienable human rights, may only have been spelt out 60 years ago, but it did not just come to be sixty years ago. What happened sixty years ago was not that these rights came into existence – by someone or some group deciding to stipulate them - but that they were then officially recognized for the first time.

Thirdly, if all values existed only by attribution, and rights could only be conferred by membership in the class of person, stipulatively-defined, one would need to justify, morally, one's stipulation of the particular characteristics by attribution that define the class. But this would quickly lead to an infinite regress of reasons. If all values were only by attribution, then the value one

attributed to members of the class of persons could only be justified by giving good reasons for one's stipulative definition. But these reasons could only be good if one had some criterion for judging a reason to be good, and this would, in turn, need to be attributed to the process of giving good reasons... *ad infinitum*. By contrast, the intrinsic value of membership of the human natural kind stops this infinite regress of reasons by positing something other than human attribution of value as a justification for morality.

Fourthly, basing morality on the contemporary conception of 'personhood' would fail to account for the moral meaning of much of medicine. Medicine implicitly depends on the concept of natural kinds. 'Health' is the 'well functioning' of the organism as a whole. Roughly-speaking it is deviation from the biological dispositional properties of the human natural kind that *constitutes* illness. As Pellegrino says, medicine treats 'wounded humanity'. The personhood approach thus narrows the range not only of *what* counts as an illness but also of *who* counts as a patient.

I conclude that, of the two competing views of who has intrinsic dignity, all human beings (all members of the natural kind 'human') or only some human beings (only those members of the human species who *actually* possess consciousness, memory, etc), the former is the more reasonable view.

Kant was right to say that once we understand dignity we understand how we should act. On the view expressed in this paper, illness does not and cannot undermine our intrinsic human dignity. But it surely can and does threaten the dignity that sick people attribute to themselves. Think of how ashamed some people feel of being ill. Think of how fearful they are of being a burden on others. Think of how 'control' seems to matter so much even though no amount of psychological adjustment or practical success can free us from what Mark Johnston calls the 'large scale structural defects' in human life.[xv] I welcome dignity therapy, both its practice and in name. For it prompts us to confront the challenges of helping to restore, maintain and deepen the sense of their own intrinsic dignity which sick people often lose. And, properly understood, it helps us to get beyond the superficialities of merely *attributed* dignity.

References

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[i] Talk given at 19th Annual Symposium of the Sydney Institute of Palliative Medicine (in association with the New South Wales Society of Palliative Medicine), Royal Prince Alfred Hospital, Sydney, 24th – 25th June 2010.

[ii] See, for example: H. M. Chochinov et al. Dignity Therapy: a novel psychotherapeutic intervention for patients near the end of life, *Journal of Clinical Oncology*, 23.24, 2005: 5520-5525

[iii] See, for instance, National Health and Medical Research Council: *Guidelines for a Palliative Care Approach in Residential Aged Care, 2006: http://www.palliativecare.org.au/Portals/46/APRAC%20guidelines.pdf (accessed 6th September 2010)*

[iv] I first came across this amusing remark in Mark Johnston's book *Surviving Death*, Princeton University Press, 2010

[v] Peter Singer: A convenient truth, *The New York Times* , 26th January 2007

[vi] Frank Brennan et al; Pain management: A fundamental human right, *Pain Medicine,* 105,1,2007

[vii] Ronald Dworkin, *Taking Rights Seriously,* Harvard University Press, 1977, pp 198-9, as quoted by Daniel P. Sulmasy: Dignity and the Human as a Natural Kind, in *Health and Human Flourishing* edited by Carol Taylor and Robert Dell-Oro, Georgetown University Press, 2006, pp 71-87

[viii] Steven Pinker: Science and the eternal struggle with dignity, *The New Republic*, republished in *The Higher Education Supplement, The Australian,* 28th May 2008, p 33

[ix] Daniel P. Sulmasy: Dignity and the Human as a Natural Kind, in *Health and Human Flourishing* edited by Carol Taylor and Robert Dell-Oro, Georgetown University Press, 2006, pp 71-87

[x] *Healthcare Allocation: an ethical framework for public policy,* edited by Anthony Fisher op and Luke Gormally, The Linacre Centre, London, 2001, p 129

[xi] Sulmasy, op cit, pp 76-77

[xii] David Wiggins, *Sameness and Substance,* Harvard University Press, 1980, pp 77-101, as quoted in Sulmasy, Dignity and the Human as a Natural Kind, op cit, pp 77

[xiii] Anthony J Lisska, *Aquinas' Moral Theory: An Analytic Reconstruction,* Clarendon Press, 1996, pp 96-100, as quoted in Sulmasy, Dignity and the Human as a Natural Kind, op cit, p 77

[xiv] '*Persona*' was the word for the mask used in ancient Roman theatre, and Christians will remember that it is the concept used to describe the relationships between 'The Father', 'The Son' and 'The Holy Ghost'.

[xv] He has in mind: arbitrary suffering, ageing (once it has reached the corrosive stage); our profound ignorance of our condition; the isolation of ordinary self-involvement; the vulnerability of everything we cherish to time and chance, and finally, to untimely death. Mark Johnston, *Saving God*, Princeton University Press, 2009

Considerations for Policy Guidelines Regarding the Performance of Bariatric Surgery

Introduction

The prevalence of harmful (or 'morbid') obesity, including among children, has increased dramatically in the last twenty five years. Harmful obesity is associated with burdensome diseases, loss of work productivity, early disability, premature death, and of course with social prejudice and unfair discrimination. So measures which address obesity are greatly to be welcomed. These fall into three broad categories: behavioural therapies, drug therapies, and surgery.

For many years there has been debate in the medical literature about the efficacy, and the safety, of drug therapies which are recommended for the purpose of inducing and maintaining weight loss. Increasingly, now, there is debate about the efficacy, and the safety, of surgical means to bring about the same end: so-called 'bariatric' surgery. The term 'bariatric' (which means 'pertaining to weight') refers to surgery which is aimed at the treatment of obesity and its consequences.

Clinical and ethical issues abound. What are the relative benefits and harms of surgery compared with drug treatment and behavioural therapy? Who should be offered surgery as treatment for obesity? Which surgical procedure is best (safest and most effective) for a particular person? Who should offer to conduct such surgery? With what kind of clinical centre should the surgeon be associated? What are the responsibilities of surgeons with respect to the pre-operative and post-operative care of potential patients? How should surgeons respond to patients who plead for surgery, or 'demand' surgery, particularly in circumstances in which the popular press talks up the benefits of surgery? And what are the responsibilities of the profession in circumstances in which bariatric surgery is not available, practically-speaking, to those who cannot afford private health insurance?

These questions deserve careful thought, by individual doctors, by professional groups, by hospitals and other healthcare institutions, by the public. Prompted by the request for informed ethical comment, Dr Helen McCabe, who was then Research Associate at the Plunkett Centre for Ethics, prepared such advice, in the form 'considerations for policy guidelines regarding the performance of bariatric surgery'. Dr McCabe consulted widely amongst relevant professional groups, received assistance from many people, in particular from Dr Craig Taylor of the Mater Hospital in Sydney and the Bioethics Committee of St Vincents & Mater Health Sydney.

The result of this work - below – would be a useful starting point for the revision, or development, of international or Australian 'guidelines'. We publish it in the hope that it will be useful to others.

Context and Purpose

These recommendations resulted from a request for advice, particularly on ethical issues, from within St Vincents & Mater Health, Sydney. They are consistent with the requirements and standards as set out in the *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia.* The recommendations address the practice of bariatric surgery as a measure for both preventing illness and for restoring and promoting health in patients afflicted by obesity.

The recommendations are intended to guide the practice of bariatric surgery towards the proper goals of health care which include: the provision of diagnostic or prognostic information; deepening of the community's understanding of the causes of disease and the development of new forms of treatment; saving human life; improving and/or maintaining the patient's health by curing an illness or slowing the course of an illness or stabilising the patient in a reasonably satisfactory condition; relieving pain, suffering and disability; nourishing and sustaining the patient; and caring for people when they are sick, disabled, frail or elderly.

Outcome

The patient undergoing bariatric surgery will be adequately prepared for the procedure and receive optimal care during and following the procedure.

Definitions

Bariatric surgery refers to the surgical treatment of obesity by procedures which modify the stomach or gastrointestinal tract to achieve reduced nutrient intake or absorption. There is now abundant evidence for the efficacy of bariatric surgery in obese people in reducing weight over the short and long term with considerable benefit for comorbid conditions and future health. On the other hand there are significant potential adverse effects which may vary according to the chosen procedure. Such surgery can be done in a number of different ways:

Laparoscopic adjustable gastric banding refers to the placing of a band, laparoscopically, around the stomach so as to both induce a feeling of satiety and to restrict the amount of food ingested at any one time. Following surgery, both these effects can be adjusted and controlled by an injection of saline into a subcutaneous access port. These post-operative adjustments are attended on an outpatient basis. This procedure is reversible as no organs or other tissue have been removed, redirected or stapled.[1]

Laparoscopic sleeve gastrectomy refers to the surgical division (and part removal) of the stomach vertically to reduce its size to about 15-20% of its pre-operative volume. Because the gastric fundus, which produces the hormone Grehlin, is also removed patients feel increased satiety. The pyloric valve at the bottom of the stomach remains intact to allow normal

function and digestion. The sleeve gastrectomy is not reversible.[ii]

Laparoscopic Roux-en-Y gastric bypass refers to the transection of the stomach, resulting in a very small gastric pouch. Intestinal continuity is then restored by anastomosing the pouch to the small bowel. This results in the food stream bypassing the majority of the stomach and duodenum. This procedure is popular in the United States, South America, and Europe, and is the most widely studied bariatric procedure. It consistently results in a greater proportion of patients achieving at least 50% excess weight loss than LAGB, and may be particularly effective in the remission of diabetes. However it carries significant short and long term risks. It is potentially reversible albeit with difficulty.

Biliopancreatic diversion refers to the surgical diversion of bile and pancreatic enzymes away from the food stream until the end of the small bowel is reached. This results in weight loss from the malabsorption of calories. The Duodenal Switch is a variant of biliopancreatic diversion in which the gastric pylorus is preserved. This is frequently performed as a second stage following the sleeve gastrectomy procedure. It is a very effective weight loss procedure, however it does carry significant risks including nutritional and vitamin deficiencies and reversal is difficult. For this reason it is questionable if it should be performed and, if so, should generally be reserved for highly selected patients on a case by case basis [eg as a second-line procedure], where close patient follow-up can be guaranteed.

Admitting Medical Officer (AMO) refers to the doctor who has ultimate responsibility for the care of a particular patient. In the private hospital and private outpatient sector, the AMO may be a visiting medical officer or medical consultant.

Dedicated service refers to a health care service instituted specifically for the care and medical management of patients with a specific need, such as for the management of obesity-related co-morbid conditions.

Scope of Policy

This policy is intended as (a) a guide to approaching the suitability of persons for undergoing bariatric surgery as a means of both treating existing obesity-related illness and preventing further deterioration in that person's health; and as (b) a guide for ensuring that the safest possible measures are employed in the management of surgery for obesity. This policy is not intended to replace clinical decision-making, or to specify details of optimum clinical management for individual patients.

This policy addresses the responsibilities of the Attending Medical Officers, their medical team, consultant physicians, nursing staff, psychologists, dieticians, and relevant others in attending to the following matters: identifying and assessing patients eligible for bariatric surgery; caring for patients considering, undergoing or recovering from bariatric surgery; and monitoring and caring for patients

living with surgical modification of gastrointestinal function for the purpose of limiting dietary intake.

Policy Statement

Patients who are a) considering, b) undergoing and c) recovering from bariatric surgery will be treated with respect, care and encouragement.

Bariatric surgery is considered an appropriate means of preventing and/or reversing the ill effects of morbid obesity where less invasive measures have been ineffective in this respect. In particular, laparoscopic gastric banding is considered a relatively safe, 'minimally invasive' procedure which is readily reversible. Nonetheless, some adverse events have accompanied this procedure, including death.[iii] In order to reduce the possibility of iatrogenic harm, bariatric surgery should be offered only when:

a) a patient has suffered morbid obesity (unrelated to reversible medical conditions such as hypothyroidism) for more than 5 years;

b) a patient's response to non-invasive measures (including dietary and weight loss programs) has not resulted in either effective weight control or significant improvement in obesity related co-morbidity

c) a patient's body mass index (BMI) measure is at a level considered to justify extreme or unusual measures for weight control. Recent international recommendations would suggest a BMI of at least 40kg/m^2 in the absence of obesity related co-morbidities, or 35kg/m^2 if co-morbid conditions are already established such as diabetes, dyslipidaemia, sleep apnoea, infertility and/or hypertension. However some experts now feel that the levels of 35kg/m^2, or 30kg/m^2 with co-morbidity, are appropriate

d) a patient is older than 18 years of age or, subject to a comprehensive assessment by a child psychologist, older than 14 years of age; and

e) a patient is assessed by a physician with appropriate expertise, such as an endocrinologist, to be a suitable candidate for bariatric surgery in accordance with the stipulations in points a) – e).

Each patient considered for bariatric surgery needs consideration of psychological issues in regard to the suitability of this procedure as a treatment measure. As well, should a patient otherwise eligible for bariatric surgery also suffer from a psychiatric disorder or illness, the patient should receive psychiatric assessment and recommendation and, if necessary, treatment and care.

All patients considered eligible for bariatric surgery will receive adequate explanation as to the nature of the procedure, the nature of the (long-term) commitment involved on the part of the patient, and expected outcomes of surgery. If the patient is from a non-English speaking background, interpreters must be used in accordance with the Department of Health's policy on the use of interpreters (Cir 94/10).

All patients considered eligible for bariatric surgery will receive extensive pre-operative care from health care professionals in possession of the requisite knowledge and expertise, possibly including physicians,

surgeons, dieticians, nurses and psychologists [ideally a dedicated obesity service].[iv]

All forms of bariatric surgery should be performed in facilities where patients have access to intensive care services and appropriate precautions are taken to minimise perioperative risk.

The care of patients undergoing bariatric surgery should be informed by policies on safe handling to avoid staff injury associated with caring for very heavy patients.

Given the nature of the procedure (modification to the patient's digestive function) and, in some cases, subsequent concerns over nutritional deficiencies and other complications related to surgery, patients will require long-term monitoring and support. This follow-up service will be provided by specialist staff in conjunction with the patient's general practitioner and relevant community services.[v]

Clinical practice is properly guided by reference to the goals of health care. Accordingly, bariatric surgery will not be offered for purely cosmetic reasons.

If a person who is ineligible for bariatric surgery (in that the person has a BMI below eligibility criteria, does not suffer from obesity-related co-morbidities, and/or is unable to comply with ongoing effective dietary restrictions), then a person's request for bariatric surgery would be considered unreasonable and the surgeon ought not to act in accordance with the request. Instead, the surgeon ought to explain why the request is unreasonable and offer medically and ethically sound alternatives, including a second opinion.[vi],[vii]

References

[i] O'Brien, P., Brown, W. & Dixon, B., 'Obesity, weight loss and bariatric surgery' (2005), *Medical Journal of Australia*, vol. 183 (6): 310-14.

** In the American literature, bariatric surgery is recommended for people whose BMI is > 40kg/m^2 – titrated to height.

[ii] Colquitt, J.L, Picot, J., Loeman, E., & Clegg, A.J., 'Surgery for Obesity (Review)'. *The Cochrane* Collaboration. Available at: http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD00364N/frame.html Accessed on: 6th July, 2009.

[iii] O'Brien et al, op. cit.

[iv] Snow, V., Barry, P., Fitterman, N., Qaseem, A, & Weiss, K. (2005), 'Pharmacologic and Surgical Management of Obesity in Primary Care: a clinical practice guideline from the American College of Physicians'. *Annals of Internal Medicine*, 142 (7): 525-531.

[v] Nguyen, N.T., Paya, M.M., Stevens, M.C., Maandadi, S., Zainabadi, K. and Wilson, E. (2004), 'The relationship between hospital volume and outcome in bariatric surgery at Academic Medical Centres', *Annals of Surgery*, 240:4.

[vi] See sec 1.17 in *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, (2001), Red Hill, ACT: 16.

[vii] Bariatric surgery is not generally available in public hospitals in Australia. This is a matter that has important financial, ethical, administrative and political aspects. Though these matters are not dealt with in this document, they require serious review in the planning of public hospital services.

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