Bioethics Outlook

Plunkett Centre for Ethics

Australian Catholic University, St Vincent's Health Australia (Sydney) and Calvary Healthcare

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Excellence in end-of-life care: a restatement of core principles

1 Medicine's longstanding Hippocratic ethic informs the care we provide to all our patients and residents. That is, we put into practice the ancient commitment of the medical profession to cure where possible, to care always and never intentionally to inflict death.

2 Our clinicians are trained to provide effective pain management and to respect patients' decisions (or, if they are not competent, their substitute decision-maker's decisions) to forgo treatments that are too burdensome or medically futile: in doing so, our clinicians act in accordance with the needs and preferences of the patients.

3 Our clinicians do not and will not intentionally inflict death on patients (that is, provide euthanasia), nor intentionally assist patients or residents to take their own lives (that is, provide physician-assisted suicide). We accept and act according to the Hippocratic commitment that these interventions are not medical treatments. In addition, they contravene our *Code of Ethical Standards*. In this context, it is important to be aware of the fact that the terminology used to describe these interventions varies from place to place. In the *Voluntary Assisted Dying Act 2017 (Vic)* they are collectively referred to as 'voluntary assisted dying'.

In this issue

- **In June 2019, Victoria's *Voluntary Assisted Dying Act 2017* will be implemented. Catholic hospitals do not assist their patients to commit suicide. Nor do they perform euthanasia. In 'Excellence in end-of-life care', *Catholic Health Australia* restates its core ethical principles with regard to these 'services'. We set out this statement, and add some notes of explanation.**

- **Next, an address given by Dr Aaron Kheriaty to the incoming medical students at the University of California, Irvine, School of Medicine in August called 'The doctor's vocation'.**

4 We will honour our long-standing practice of having open and sensitive discussions with those within our care and their families about their treatment and their care, including where they disclose that they are considering requesting physician-assisted suicide or euthanasia. If a patient, resident or their family initiates such a discussion, we will respond to it openly and sensitively while making clear we will not participate in, provide or refer for these interventions. We will ensure that trained staff are available to engage in such discussions and that processes are in place to respond to the results of these discussions.

5 We will not facilitate or participate in assessments undertaken for the purpose of a patient or resident having access to or making use of the interventions allowed under the *Voluntary Assisted Dying Act 2017 (Vic),* nor will we provide (or facilitate the provision of) a substance for the same purpose.

6 We recognise our duty to people in our care is based on trust and will continue to commit to and implement our ethic of care. We believe this to be the best way to respond to the needs of people who have a life-limiting illness and/or are nearing the end of their lives. We will continue confidently to welcome all people into our care.

Excellence in end-of-life care in the context of Catholic services

Catholic health and aged care services are committed to the ethic of healing, the ethic which is found in both the Hippocratic tradition of medical practice and the long Christian tradition of providing care, especially for poor and vulnerable people. The main features of this ethic as it pertains to people who have a life-limiting illness and/or are nearing the end of their lives are set out in the *Code of Ethics for Catholic Health and Aged Care Services in Australia*.[1]

These features include commitments: to heal and never to harm; to relieve pain and other physical and psycho-social symptoms of illness and frailty; to withdraw life-prolonging treatments when they are futile or overly burdensome or when a person wants them withdrawn and gives informed refusal of these treatments; and to never abandon patients.[2] We are always committed to improving care at the end of life. In addition, we do whatever we can to ensure that such care is available to all people who need and want it.

Though we always strive to ensure that those in our care die in comfort and with dignity, we do not assist them to end their own lives or provide euthanasia.[3] We will continue to promote and provide healthcare that is consistent with our Hippocratic commitment and ethic of care and which avoids harm, especially to those most vulnerable.

[1] Catholic Health Australia, *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia* (Deakin West: Catholic Health Australia, 2001), Part 2, no. 1.13; 1.14; 1.15; 1.16; 5.21. https://www.cha.org.au/code-of-ethical-standards

[2] *Code of Ethical Standards*, Part 2, no. 1.13; 1.14; 1.15; 1.16; 5.21;

[3] *Code of Ethical Standards*, Part 2, no. 5.20

Answers to three frequently asked questions

- **What is the 'Hippocratic Ethic'?**
- **Why is PAS not a medical treatment?**
- **What is the difference between pain relief that carries the risk of shortening life and euthanasia?**

Governments sometimes ask doctors to use their medical knowledge and techniques for non-medical purposes. For instance, when states in the US changed the method by which they performed capital punishment - from hanging or electrocution to lethal injection - they sought the assistance of doctors trained to give injections. Indeed, individuals sometimes ask doctors to use their medical knowledge and skills for non-medical purposes. For instance, the 'Parrotman', described in these pages last year[1], seeks the assistance of doctors to provide him with procedures that help him to resemble more and more closely a parrot: tattoos, remodelling his face so that his nose looks more like a beak, building bone horns into his skull, etc. His doctors use the techniques they learned at medical school!

The moral is: Just because a doctor will do it does *not* mean it's a medical treatment!

To distinguish genuinely medical treatments from any number of procedures that doctors may provide, we need to understand what philosophers call the 'internal ethic of medicine'.

The key features of the internal ethic of medicine include informing patients truthfully and sensitively about their diagnosis and prognosis, giving them reliable advice, respecting their right to decide the healthcare that best suits their needs, being prepared to share the burden of decision-making with their patients, keeping up to date with the most effective treatments. And, most important, a commitment to providing *genuine therapy.*

The Hippocratic Code is the oldest and best known code which articulates the internal ethic of medicine. It is an oath which for centuries informed the attitudes and practices of doctors. Its authorship is unknown as indeed is its precise age. It sets out, in the form of a public promise, what doctors should and shouldn't do.

[1] Anthony Fisher, OP. Drive-Thru Healthcare: is there more to medicine than supply and demand? *Bioethics Outlook*, Special Edition, 2017.

A key promise goes as follows: *'I will apply dietetic measures for the benefit of the sick, according to my ability and judgment: I will keep them from harm and injustice. I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.'*

The Hippocratic Oath thus makes explicit what is implicit in the reason young students typically give when they apply to be admitted to medical school: they invariably say that they want to help sick people. And the Oath makes explicit the reason why the community can be relied upon to trust the medical profession.

Of course, a Hippocratic doctor will not shy away from any *discussion.* He or she will encourage patients to express their fears about, and hopes for, the last part of their lives. He or she will ensure that the patient has fully-adequate pain relief.

But, as the Oath says, a doctor true to the ethics of the profession will not inflict death on the patient (nor, for that matter, refer patients to other doctors so that they can provide this 'service'). As Sulmasy *et al* say,

'*Medicine's central task is to heal. Although healing is a much broader concept than curing, it makes no sense to claim that patients have been healed by having assisted them in ending their lives. Symptom relief heals, and forgoing treatment acknowledges the limits of healing, but physician-assisted suicide undermines the very meaning of medicine.*'[2]

Giving necessary pain relief is neither euthanasia nor physician-assisted suicide. Pain management that carries a risk of shortening life is neither euthanasia nor physician-assisted suicide. Withdrawing or withholding life-prolonging treatment (either because it is futile/ overly-burdensome or because it is refused) is neither euthanasia nor physician-assisted suicide.

Confusions abound with respect to all these critical distinctions, confusions which have been fostered *inadvertently* (by inaccurate journalism) or *deliberately* (by some advocates for physician-assisted suicide and euthanasia).

The management of pain can have two effects, one intended (the relief of pain), the other not (the shortening of life). Pain management that carries a risk of shortening life is an authentic medical treatment, perfectly in accord with medicine's central task (to heal) and perfectly permissible so long as it includes no intention to kill. The same goes for the management of any other symptom such as breathlessness: the relief of symptoms that carries a risk of shortening life is an authentic medical treatment, perfectly in accord with medicine's central task (to heal) and perfectly permissible so long as it includes no intention to kill.

Bernadette Tobin

[2] Daniel P. Sulmasy, MD, PhD1, Ilora Finlay, FRCP, FRCGP, FMedSci2, Faith Fitzgerald, MD3, Kathleen Foley, MD4, Richard Payne, MD5, and Mark Siegler, MD. Physician-Assisted Suicide: Why Neutrality by Organized Medicine Is Neither Neutral Nor Appropriate. *J Gen Intern Med* DOI: 10.1007/s11606-018-4424-8 © Society of General Internal Medicine 2018

The doctor's vocation

Aaron Kheriaty, MD.

The following is an address given to the incoming medical students at the University of California, Irvine, School of Medicine White Coat Ceremony on 3rd August, 2018

A student once asked the famous anthropologist Margaret Mead a fascinating question: "What is the earliest sign of human civilization we have discovered?" The student expected her to say something like a piece of pottery or perhaps a fragment of a handheld tool. But Mead replied that the first sign of human civilization was a healed femur—a 15,000-year-old human thigh bone. [1]

In a primitive society, a person with a broken leg would have nothing to contribute to the functioning of the community; he was a drain on the collective resources. After the bone was set and while it healed, the injured person would have to be carried from place to place, fed, sheltered, and tended to for months.

And yet… this person *did* live long enough for the broken leg to heal. And this means that he *was* cared for by the community, at considerable cost and at some risk to the welfare of the others. It's encouraging to consider that the compassionate practice of medicine—this ancient profession dedicated to healing the sick—signals the dawn of human civilization. This is a great enterprise that you are embarking upon today.

The challenge

Full disclosure right up front—and I doubt this will surprise any of you: medical school is a challenging path. Few careers require as much schooling. When you receive your medical degree you will graduate from at least the 20th grade, and then there's residency and perhaps fellowship training. While you are here, you will digest an enormous amount of information in the first two years. Then you'll experience a steep learning curve as you acclimate to life on the wards in the second two years. Some days will be difficult.

[1] Recounted in Byock, I. (2012). *The best care possible: a physician's quest to transform care through the end of life.* New York, Avery.

To be honest, there were times as a medical student when I contemplated finding another career path. But, like me, you'll navigate the challenges; and when you finish, you'll look back with no regrets.

I promise also that medical school will be a thrilling ride. Your hands will tremble as you perform your first lumbar puncture. You heart will skip a beat as you wait with a woman in labour to deliver your first baby. You will make some rookie mistakes on the wards and hope that the residents and attendings—not to mention the patients—don't notice. But in the end, you will thrive.

Practicing medicine will change you, as it changes all physicians. Becoming a physician is kind of like becoming a new parent: it alters you permanently.

The practice of medicine shapes your identity mostly for this simple reason: your patients become a part of who you are. Your own happiness and success will no longer be a separate project, somehow standing apart from your patients' wellbeing. Their lives become intertwined with yours.

Physicians deal with tremendous suffering every day. You will soon be thrown into the charged, complicated, and often anguished centre of your patients' lives. More than any textbook, more than your professors in medical school, more than your mentors in residency, your patients will be your best teachers. They'll teach you lessons about suffering, about resilience, and about hope. And if you let them, they will change you for the better.

Medicine is about the patients

As medical students, you'll be granted many extraordinary privileges. You'll be allowed to do things that in any other context would be considered a felony—like dissecting a dead body. You'll be permitted to practice unperfected procedural skills on patients. Later, as a physician, society will grant you a monopoly on other privileges, like prescribing, ordering diagnostic tests, and performing procedures.

You'll be granted these privileges not because of your personal merit. These are not primarily for us. Likewise, none of the great apparatus of modern medicine—the hospitals, the MRI scanners, the surgical robots, the powerful medications, the vast sums of money spent on the whole enterprise—none of this exists for the sake of med students or physicians. At the end of the day, medicine is always and only about the patients—that woman lying there in the hospital bed, that child nervously walking into the clinic, that man anxiously waiting his test results. That's why we're here.

These patients will tell you things in confidence they have never revealed to another soul. They will entrust their lives to you. To become worthy of this trust, and to remain always loyal to this trust, should be the aspiration of every medical student who dons the doctor's white coat.

Remember that this trust must be earned. Doctors are held to higher ethical standards than any other profession. As a cautionary tale, consider the neurology resident from Miami who was recently caught on film yelling at an Uber driver while drunk. The video went viral, and she lost her position. Our professional standards do not dissipate when we leave the hospital. Society expects that physicians will be men and women of integrity. Our patients deserve nothing less.

The heart of a profession

While I am grateful for all of modern medicine's amazing technological advances, technology is not at the heart of medicine. At the heart of medicine is a human relationship. Our profession is grounded in the relationship between a patient who suffers from illness, and a physician who pledges to use his or her powers to heal. The patient is vulnerable because of illness, and he or she enters only reluctantly into this relationship. We must remain aware of our considerable power and our immense responsibility.

In modern usage we have become accustomed to calling just about any occupation a "profession," but in the Ancient and Medieval world this was not so. The term *profession* was originally used to designate only three occupations: medicine, law, and the priesthood. What all three of these had in common was a particular kind of relationship: the doctor-patient relationship, the lawyer-client relationship, the priest-penitent relationship. In each of these relationships, one member was vulnerable and in need of assistance, and the other member promised to provide just such help: healing, or legal counsel, or spiritual care. Great harm could come to individuals if these professionals abused their power and privilege.

To help gain the public's trust, these professionals developed the ancient tradition of taking a public oath. Prior to engaging in their work, they made a solemn and binding promise. They were *professionals* precisely because they *professed* this oath.[2] What physicians professed was, of course, the Hippocratic Oath. We maintain this tradition of a solemn oath. With this promise, we pledge to use our learning and our abilities always and only to heal the sick patient: we likewise promise to minimise harm, to maintain confidentiality, and to stringently avoid exploiting the patient or abusing our position. By this promise we also become members of a moral community of physicians, responsible for holding one another accountable to the high ideals that we profess.

Life as a patient

For the last year and a half of my life, I've been not only a doctor, but also a patient. A lumbar disk rupture led to incapacitating pain, followed by a spine surgery a year ago, followed by a second spine surgery a few months ago.

[2] Kass, L. (1985). *Toward a more natural science: biology and human affairs.* New York, Free Press. (Kindle Locations 4125-4126). "To profess" comes from the Latin, *pro* + *fateor*, "to declare publicly; to own freely; to announce, affirm, avow."

Despite these interventions, the daily debilitating pain continues. I can only sit or stand for an hour or so before I need to lie down to relieve the pain. I don't know whether this will ever be fixed, and I doubt my life will ever go back to the way it was before the injury. I wouldn't wish this kind of injury on my worst enemy. But I will say that it's not a bad thing for physicians, from time to time, to also be on the receiving end of medical care. You see things differently when you're lying on the examination table.

I've seen rehab docs, pain docs, four spine surgeons—all of them excellent, though none of them entirely successful with my case. I know that the next doctor may not be able to fix my problem. But I hope that he or she will relentlessly pursue answers with me. And even before we embark on the project of trying to find a solution, I need the physician to acknowledge the implications of the disease.

One of the most consoling physician encounters I've had during this time took only a moment. It was so subtle most people wouldn't have noticed. I was seeing a top-flight spine surgeon here at UCI. After looking at the MRI of my original injury and nerve compression, he paused for a few seconds before launching into his assessment and recommendations. He took a moment just to acknowledge the severity of my pain, to sit with it, without immediately trying to jump in and fix it. As it turned out he couldn't fix the problem; but that was okay. In that moment of acknowledgment and recognition his humanity shined through.

A physician's knowledge and technical competence are necessary but never sufficient. In the words of Sir Francis Peabody, "The secret of the care of the patient is in *caring* for the patient"[3]. It is disarmingly simple, yet often challenging, especially when you are overworked, or stressed, or fatigued: to forget about yourself and give yourself generously to the patient in front of you.

"Where ignorance is bliss..."

I recall surgery rounds with Dr. Katz as a fourth-year medical student. She had been grilling us all morning with questions, virtually none of which anyone answered correctly. In a pleasant mood that day, she decided to poke fun at us rather than berate us. "Where ignorance is bliss…" she said, waiting for us to finish the line. "Where ignorance is bliss…" she repeated. We stood by dumbly. "What's the rest of the line?" she asked, annoyed at our ignorance not only of surgery but also of poetry.

Now, if you don't know the answer to an attending's question, you should look it up. So that night I dutifully did an online search for "where ignorance bliss," and found the poem. The next day during rounds, I triumphantly announced, "'Where ignorance is bliss, 'tis folly to be wise.' Matt Gray, Eighteenth Century American poet."

[3] Peabody, F. W. (1984). "Landmark article March 19, 1927: The care of the patient. By Francis W. Peabody." *JAMA* 252(6): 813-818.

Dr. Katz smiled at me for the first time. With my confidence bolstered by this small victory, I continued, “I thought of a better line of poetry to describe this rotation. It comes from Robert Frost.” She asked me what it was. “And miles to go before I sleep, and miles to go before I sleep”, I said, thinking myself quite witty. It was true, the long hours on this rotation were gruelling for the whole team.

But then Dr. Katz became more serious. “Just remember”, she said, “no matter how long you stay here at the hospital, you eventually get to go home. But the patients do not get to go home. They are still stuck here.”

“Yes”, the resident said, nodding her head, “it’s no fun being sick.” Thinking only of my own discomfort, I had forgotten the most obvious fact. I had lost sight of the patients. Yes, I was tired, yes, I was feeling overworked—we all were. But by comparison, this was trivial. It is no fun being sick.

Uncertain outcomes

Our society still views the physician as an authority figure, as someone who can confidently administer the right solutions for serious problems. But through hard experience the physician knows that this is often an idealised fantasy. We don’t always have the answers.

We must learn to live with uncertainty and with our limitations. Like every medical student, every physician struggles from time to time with doubts. What if I’m not up to the task? What if the patient doesn’t respond? What if I make a mistake that harms my patient?

We naturally want to help people. But we also need to live with the cases that do not turn out as we hope. You will experience the joy of healing the sick, and this is tremendously rewarding. But you will also experience the sorrow of watching someone you have cared for grow worse and die, in spite of your best efforts. Indeed, the fact of death is inescapable in our work: despite all our amazing medical advances, the human mortality rate continues to hold steady at 100 percent.

In medicine, specific outcomes are never guaranteed. It’s the courage to continue our work, day in and day out—even without the promise of success—that characterises good physicians. In all this, we need to remember that “there are incurable conditions, but never untreatable patients.”[4] We continue to care for the sick even when cure is no longer possible.

Not the path of least resistance

I recall my transplant surgery rotation as a third-year medical student. During this rotation, I witnessed incredible medical triumphs — true miracles of healing. But those were the easy cases.

[4] Kass, L. (1985). *Toward a more natural science: biology and human affairs.* New York, Free Press. (Kindle Location 4302).

One day on transplant rounds with Dr. Smith, we entered the room of a dying patient. She had, among other medical problems, severe liver disease. The family was begging Dr. Smith to do a liver transplant. He politely but firmly refused, explaining that the patient's heart would not be able to handle the operation; surgery would likely kill her. The family replied that she would die anyway, without the transplant. They had a point.

The family insisted that he explain her odds of surviving the surgery. Dr. Smith told them it was less than 10 percent. "Well", they replied, "that's better than her odds without the operation, which are zero. We're willing to take the chance." Again, they had a point.

What Dr. Smith knew but did not want to say was that the transplant team could *not* use a precious liver on a patient who would most likely not survive. A transplantable liver is a rare resource, so the recipient is carefully selected. This patient's family, understandably, cared nothing about this problem of distributing a rare resource. They saw only that they were losing a loved one.

The conversation continued around in circles for several more minutes. Finally, unable to make headway, Dr. Smith left the room. I can still remember his face as he turned to me and said with a sigh, "No one ever said this job was easy."

My friends, nobody ever said this job was easy. But that's why you are here, isn't it? You have not chosen a cushy or comfortable career. You have not chosen the path of least resistance. But you have chosen something very worthwhile.

Lifelong education

If you'll permit me, a few parting words of advice. From now until you retire, do not stop cultivating and reviewing your medical knowledge. We make progress through a continual critique of what we have learned. At the same time, keep in mind that knowledge alone is not enough. It's not science, but love and devotion, that transforms the world. You will alleviate pain and distress not only with a well-chosen prescription, but also with a word of encouragement and compassion.

Cultivate and maintain a breadth of interests, even while in medical school. All of your human passions and pursuits can be relevant to your professional work. After all, physicians are not robots who treat diseases; we are people who treat other people. In your clinical practice, attend with particular devotion to the abandoned patient, the lonely patient, the patient who suffers not only physical deprivations but human deprivations as well. In your work, always, always follow the light of your conscience, even when your decisions are unpopular. Guard against professional envy. Instead, focus your energies on serving your patients and assisting your colleagues. This will be success enough.

Medicine as a vocation

I have great hope for our profession. All of you bring exceptional personal gifts to this work. The students I teach continue to inspire me. The future of the medical profession is bright, not because we have a perfect healthcare system—which we don't, and not because we have amazing advances in medical technology—which we do. The future is bright because every year we have exceptional men and women who come to medical school and take the plunge. Always remember to thank those who are here with you—your family and friends—the people without whom you would not have made it to medical school. And be absolutely convinced that you are here for a great and noble purpose. Not one of you landed here by accident.

Being a physician is a way of life, not just a livelihood. Medicine is a *vocation*; it's not just a *career*. What is the difference, you might ask? Here's the best that I can explain it. Four years from now, when the dean hands you your medical degree, consider this: You are a physician not because you went to medical school; rather, you went to medical school because you are a physician.

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Annual Plunkett Lecture

Thursday 15th August 2019
5.30 – 7.30 pm

Dementia and nature of the mind: Implications for disclosure, depression and shared decision-making

Professor Julian Hughes
Professor of Old Age Psychiatry
University of Bristol
Deputy Chair, Nuffield Council on Bioethics
Advisor, National Institute for Health & Care Excellence

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