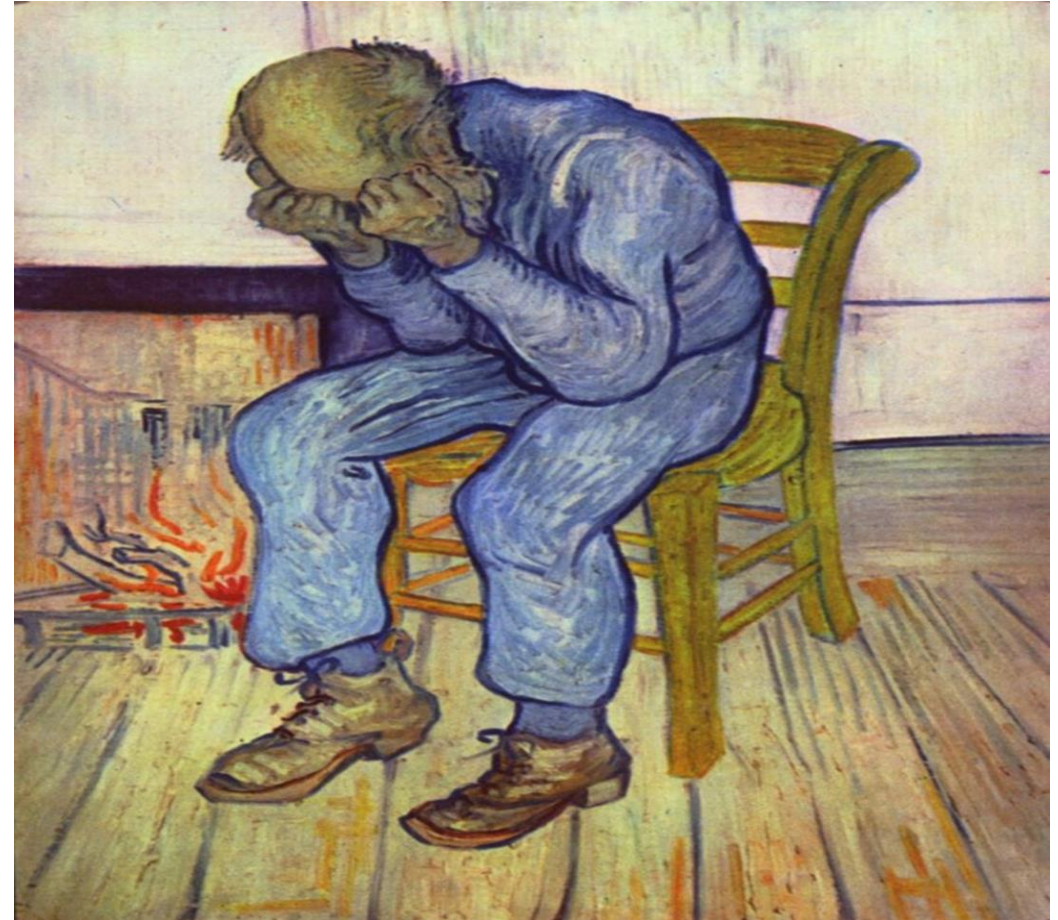


SERVING IN DYING

Personal, Professional and Communal Obligations and Cultures

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1. Expert Competence and Interactive Cooperation: a Gift from Heaven
2. Consensus and Diversity in Individual and Communal Visions of Life
3. Patient-oriented Service in Pain Treatment and Care for the Dying
4. Trusting Partners: Citizens, Care Experts, Elite Hospitals, Community
5. Pain and Death: Limits of Human Understanding and Interference



Vincent van Gogh ,At the Doorstep of Eternity' 1890

Who is a Professional Master in his/her Craft/Service

A Master

1. Knows how to produce the product/service
2. Knows why it is done this way and not otherwise
3. Knows what the product/service is good for
4. Knows the role and function of the product/service in society
5. Knows how and what to teach his/her disciples

Aristotle

Medical Art and Science: A gift from Heaven

‘The Father of Creation has given doctors the research and wisdom to take care of people with disease and sickness’.

Al Ghazali

A superior Doctor

A superior doctor takes care of the state, an average doctor takes care of the person, an inferior doctor takes care of the disease.

Confucian Doctor Sun Simiao

Diversity and Plurality: A Gift from Heaven

‘And if the Lord truly had wanted, he would have made humankind one single community (umma wahida); but they are still arguing (muhtalifun), except those in the grace of GOD (rahima); this is why he created them’.

Sura 11:111f

Differences in the congregation must be considered as a special grace of ALLAH.

Hanafi

Brethren, if you want true peacefulness in GOD, let us not lie about consensus when plurality seems to have been the plan and the goal of providence. No one among us reasons and feels precisely the same way the fellow-human does. Why do we hide from each other in masquerades in the most important issues of our lives, as GOD not without reason has given each of us his/her own image and face.

Moses Mendelsohn

Creation and Transformation of Body and Soul

Then GOD formed man of dust from the ground , and breathed into his nostrils the breath of life; and man became a living being. Genesis 2:7

Truly, the creation of each of you begins in his mother's womb within 40 days (as a drop of sperm, *nutfa*); then he is for the same time a lump of blood (*alaqa*); thereafter for the same period of time a small lump of flesh (*mudga*); then He breathes the soul into him. Hadith Tradition

Rumi uses the words 'dying' or 'being reborn in stages' to refer to the change of the human embryo from spiritless matter into vegetative form, then into animal form, and finally into the human form. He maintains that the developed man can turn into an angel or even higher than angels. S. M. Khamenei on Rumi

Personal Visions and Choices, Diverse Options, Mutual Care

‘A holistic Islamic ethics for healthcare at the end-of-life stage requires bringing together physicians, Islamic jurists and theologians, social scientists, and allied health professionals and stakeholders in a shared enterprise.’

Padela AI, Qureshi O 2017 Med Health Care Philos, 556

‘There is a believe, that human beings are created from the soil and return to the sol when they die; then they are resurrected. Even though death seems opposed to life, the Muslim who has this belief as a whole loses the fear of death.’

Sari N 2014 Concepts of Death

‘Why do you cling unto life when already the worms eat up your body and give you pain and suffering. Why don’t you follow the recommendation of the priest and ask for drink from the chalice with the poison, because doing so you confirm your belief in an afterlife in heaven’.

Thomas Morus 1516 Utopia

Medical and Cultural Definitions of Death

An individual who has sustained either (1) irreversible cessation of circulatory or respiratory functions, or (2) irreversible cessation of all function of the entire brain, including the brain stem, is dead. A determination of death has to be made in accordance with accepted medical standards. USA Uniform Determination of Death Act' 1981

When a person's heartbeat and respiration has stopped completely, his or her doctors have ruled that recovery is impossible, his or her brain functions have stopped entirely and for certain, and the brain begins to disintegrate, then the person is ruled to be dead. Islamic Jurisprudence Academy 1986

In the absence of advanced directives, the irreversible cessation of all functions of the entire brain, including brain stem, will define death. Given global cultural diversity and different legal and religious traditions, states in promoting their interest in protecting life and dignity of their citizens - in accordance with widely held values within their constituency - may as a matter of public policy define different death criteria, such as those based on cessation of functions of the entire body or the heart, but should provide a conscience clause for individual choice. A determination of death must be made in accordance with accepted medical standards. HM Sass 1989

Three Steps in Medical and Value Diagnosis and Treatment

1. Medical-Scientific Diagnosis: What is the patient's diagnosis and prognosis? What options in treatment are recommended? What benefits, risks and harms can be expected? What is unknown, is the terminology precise and correctly applied? Summary:
2. Medical-Ethical Diagnosis: What is the wish-and-value status of the patient? Is the patient well informed, does he/she can or want to share in decision-making? How to handle conflicts between patient's wishes and medical responsibility? What is unknown, is the terminology precise and correctly applied? Summary:
3. Treating the Patient as a Fellow-Person: What options are available? What are the responsibilities of doctors and medical staff? Who else can be involved in decision-making? Is an ethical and/or medical consensus required and by whom? What is unknown, is the terminology precise and correctly applied? Summary:

Three steps in Medical and Value Diagnosis and Treatment

Addendum 5: In the Care for the Dying

1. Does this patient request palliative care even at the expense of shortening or prolonging life?
2. Does this patient request medical treatment of other symptoms associated with the process of dying?
3. Is the wish of this patient clear?
4. Can the physician justify to not follow the wish of the patient?
5. What are her/his options?

Narratives supporting citizens in recognizing personal wishes

DYING OF UNCURABLE CANCER:

Mrs M, 38 years old, had had her left breast removed 5 years ago because of breast cancer. Now she has increasing pain in her lower back; her physicians have diagnosed metastatic bone cancer. They recommend chemotherapeutic treatment to reduce pain and to prevent or to slow down the development of more metastatic cancer. Mrs. M. undergoes chemotherapy with uncomfortable side-effects. Her pain increases and is not treated adequately. The physicians do not tell her the “full truth” that chemotherapy will not cure her cancer but might prolong her life. Mrs M. dies in the hospital 8 months after the bone cancer was detected; she did not die at home as she had wished. Without chemotherapy she might have died a few months earlier.

Questions: 1. How would you have wished to be treated? – 2. Would you want your physicians to fully inform you about your condition, even if it is terminal? – 3. Would you want intensive and aggressive pain treatment, even if it might reduce your mental alertness? - .4 Rewrite the story you would like it to end!

My Values and Wishes that shall govern my Treatment

On a scale of 1 to 5 evaluate your actual [1-5] and prospective [A-E] preferences regarding a long and healthy life, pain, dying process, truth-telling, health care costs, strength of self-determination

1.(a) I want to live as long as possible (b) if I am in good health, (c) if I am ill but overall recovery is expected, (d) if I am permanently unconscious, (e) if I am mentally incompetent, (f) if I am terminally ill. – 2. (a) I want to be without pain, (b) even if clear thinking is compromised, (c) even if I become drowsy or sleepy. – 3. When time has come, I prefer to die (a) at home, (b) in the hospital, (c) with loving people around, (d) being left alone. – 4. (a) I want a comfortable dying process, (b) even at the cost of heavy sedation, (c) even at the cost of shortening life, (d) even if it means active euthanasia. - 5. If my prognosis is terminal, (a) I want full disclosure, (b) my proxy must be told, (c) my family must be told, (d) my family physicians must be told, (e) ... must be told. – 6. I do not want to be a burden, (a) to my family, (b) to the financial resources of my family, (c) to health care professionals, (d) to society. – 6. I want my values to govern my treatment.

We add a footnote to statement 4a that active euthanasia is not allowed in most countries and that physician's ethics traditionally does not support it; this should be done with appropriate references, whenever this or similar questionnaires are distributed.

Four Questions in Caring for Patients in Multicultural Settings

1. Does the patient prefer paternalistic treatment, partnership or self-determination?
2. Does the patient want to include the spouse or family members in decision making?
3. Which ethical problem arise for the clinician from including other persons in decision making?
4. What can be done to guarantee that every patient is treated according to her or his personal system of belief, which may be Islamic, Christian, or secular?

Ilkilic 1993

Pain and Dying – Our Limits in Understanding and Interference

‘Lord of the Universe who has created me; who gives me guidance, food and drink; who, when I am sick, restores me, who will cause me to die and bring me back to life hereafter; who, I hope, will forgive me my sins on the Day of Judgment’
Moses, Quran 25:78ff

Good people - including good doctors and good nurses - are remembered by their community and by many grateful people, long after these doctors, nurses and other good people have passed away, because they have done good deeds during their lifetime on earth.



Giotto de Bondone ,Despair and Hope' 1304

Ferdinand Hodler 1892 Lebensmuede – Tired of Life



Three steps in Medical and Value Diagnosis and Treatment I

I. **Medical-Scientific Diagnosis of the Medical Status.** The evaluation of the medical-scientific diagnosis follows traditional patterns. –

General considerations: -What is the patient's diagnosis and prognosis? What type of treatment is recommended regarding the diagnosis and prognosis? What alternative treatments could be offered? What are the anticipated outcomes of these various treatment options? If the recommended treatment is neither offered to nor accepted by the patient, what is the prognosis? - *Special considerations:* Will the preferred medical treatment be helpful to the patient? - Will the treatment selected lead to a positive prognosis in the particular case? If so, to what degree? - Could the selected treatment harm or injure the patient? To what degree? - How can benefits, harms, and risks be evaluated? - *Medical practice:* Are any other medical treatments equally adequate? – What consideration should be given to (1) the most recent medical advances due to biomedical research as well as (2) the physician's extensive clinical experience? What relevant facts are unknown or unavailable? Are the terms employed correctly, are they precise? –

Summary: What is the optimal treatment after considering all the available scientific-medical knowledge?

Three steps in Medical and Value Diagnosis and Treatment II

2. Medical-Ethical Diagnosis of the Value-and-Wish Status: Three principles: *Health and well-being of the patient, Self-determination and the patient's autonomy, Medical responsibility.*

Health and well-being of the patient: What harm or injury may arise as a result of selecting a specific [single] method of treatment? - How might the treatment compromise the patient's well-being, cause extensive pain, or even shorten his/her life? - Might it cause physical or mental deterioration? - Might it produce fear or grave anxiety in the patient? - *Self-determination and the patient's autonomy:* What is known about the patient's [cherished] values, wishes, fears and expectations? - What is the patient's [level of] understanding of intensive or palliative treatment as well as resuscitation criteria? - Is the patient well informed about [the] diagnosis, prognosis, and the various treatment options available for him/her? - How is it possible to serve [satisfy] the patient's preferences in formulating the treatment plan? - To what degree should the physician permit this [the] patient to determine the treatment plan? - Who else, if anyone, could [should] make decisions on behalf of a patient and his/her best interests? Must the patient agree with the chosen therapy? - *Medical responsibility:* Have any conflicts surfaced between the physician, the patient, the staff, or the patient's family? - Is it possible to eliminate or resolve such conflicts by selecting a particular treatment option or plan? - How can one work to assure that the following values will be reaffirmed? - (1) establishing mutual trust between patient and physician; - (2) honouring the principle of truth-telling in all discussions; and (3) respecting the patient's privacy and protecting his/her confidentiality? - What relevant facts are unknown or unavailable? - Have the salient ethical issues been adequately formulated, clarified, and addressed within the physician-patient relationship?

Summary: What kind of treatment is optimal given thorough attention to the salient and relevant clinical [medical]-ethical issues?

Three steps in Medical and Value Diagnosis and Treatment III

III. Quality standard in medical decision making and treatment: Treating the Patient as a Person

What options (alternative possible solutions) are available in the face of potential conflict between the medical-scientific and the medical-ethical aspects? - Which of the aforementioned scientific and ethical criteria are most affected by these alternative options? - Which options are most appropriate given the particular value profile of this [the] patient? - Who, if anyone, should be consulted to serve as an advisor to the physician? Is referral of the patient necessary for either medical or ethical reasons? - What are the moral (in contrast to the legal) obligations of the physician with regard to the chosen treatment?

What are the moral obligations of the patient, staff, family, health care institution and system? - What, if any, are the arguments for rejecting the selected treatment? - How would [should] the physician respond to these arguments? - Does the treatment decision require achieving an ethical consensus? By whom and with whom? - Why? - Was/Is the treatment decision [taken with respect to treatment choice] adequately discussed with the patient? - Did he/she agree? - Should the decision process be reassessed and the decision actually revised? –

Summary: What decision was made after assessing the scientific and ethical aspects of the case? How can the physician most accurately represent the medical-ethical issues and the process of evaluating the medical and ethical benefits, risks, and harms?