

Address to Council of Christians and Jews, Western Australia Inc.

Sunday 26 February 2023

Mary Lockett Hall, Claremont

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| BIOETHICS IN THE CONTEMPORARY ENVIRONMENT |
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Thank you for inviting me to speak with you today. May I begin by acknowledging and paying respect to our ancestors:

- To the elders, past, present and emerging of the Wadjuk Noongar people, traditional custodians of the land on which we gather; and
- To the teachers, the holy men and women, the leaders past and present of our faith traditions, which today share in responsibility for this land.

I am delighted to be with you to share my reflections on 'Bioethics in the Contemporary Environment'. I have always believed that everyone has a right to my opinion.

By the word 'bioethics' I mean ethical reflection on matters affecting human health and wellbeing, including issues in medicine and health care

- in all of its forms: care for people with illness, or who are ageing, or who have disabilities, or are in hospitals, or otherwise are reliant on others for their health and wellbeing; and
- health and wellbeing in all its human dimensions: from politics to technology to clinical care to research and beyond.

In this definition, bioethics is not limited to medical matters: it considers any issues that have a bearing on human wellbeing, whether of individuals or of whole societies. The issues I want to raise today include the medical, but also human wellbeing in this wider sense.

I began my journey in bioethics when I undertook postgraduate studies in Italy nearly 40 years ago, in order to resource the Catholic health and aged care sector here in WA. Twenty-one years ago, I took up my current role as Director of what is now known as Bioethics Perth, in which role I have been able to engage long-term with public and private health care providers in WA, a number of committees and boards advising WA Health, and all five of WA's universities, as well as several national bodies in both the Catholic and public health sectors.

The kinds of bioethical issues I have engaged with over the last twenty years include the following (in more or less chronological order) beginning in 2003:

- Stem cell research, and especially the derivation and therapeutic use of embryonic stem cells

- Voluntary assisted dying – not once but three times! (first in 2004, again in 2010, and finally from 2017 onward)
- Assisted reproductive technology: issues in IVF and its variations
- Genomics and the ethics of building and maintaining genetic databases
- Surrogacy, a legally and ethically loaded arrangement for other individuals or couples to carry a baby for an infertile woman or couple
- Proposed changes to organ donation laws and to the medical determination of death
- The advent of advance health directives and powers of enduring guardianship
- Ethics in dementia care, and of informed consent more generally
- Human cloning, and research using human embryos
- And the posthumous collection and use of gametes – creating babies using the sperm or ova of a person who has already died – a complex question which a few legal judgments made even more complex well before any ethical reflection or legislative remedies were possible

In recent years I have also been working on two current social issues in education, namely

- Care for secondary students who are same-sex attracted
- And since 2016, the care of school students with gender incongruence – the so-called ‘transgender’ question.

Finally, I am involved in a collaborative project to rewrite the *Code of Ethical Standards* that guides Catholic health and aged care services in Australia, a sector representing 85 hospitals and many more aged care facilities and services across the country, providing about 10% of the national total of acute and aged care. This has been a three-year project that is in its ultimate stages.

As the title of this presentation suggests, I believe that some kinds of questions in ‘bioethics’ are intimately linked to and even generated by ‘the contemporary environment’ in which they arise – as distinct from issues that arise because of changes in medical practice or the technology that empowers so much of medicine today.

And I say ‘changes’ rather than ‘evolution’ in the social environment, because ‘evolution’ implies a process of gradual improvement but I would argue that many contemporary issues in bioethics seem to arise very suddenly from social changes that many of us would struggle to define as improvements.

I also note that ‘contemporary issues in bioethics’ are only sometimes about serious ethical problems: sometimes those changes represent a welcome move in the right direction.

So what kinds of ‘changes in the social environment’ am I thinking about? Let me name just four – although there are many others we could name. With each of these four changes, I’ll try to illustrate one of their effects in the world of health care ethics.

The changes I have in mind are

- 1 The rise of populism and loss of objectivity in news media and politics
- 2 The advent of a cancel culture at the hands of social pressure groups
- 3 Shifts in social attitudes toward medicine as a ‘supply-and-demand’ transaction
- 4 Within medicine, increasing emphasis on the need for a solid evidence-base

Some brief comments on each will suffice, I hope.

1 *The rise of populism and loss of objectivity in news media and politics*

Politicians seem today to be enslaved to a vague notion of ‘the will of the people’ that is shaped by opinion polls which are conducted almost every day by media companies.

The outcomes of these polls are often heavily influenced by the polling questions themselves, which every trained researcher knows is ethically fraught but the media don’t seem to appreciate that.

This is just one dimension of the complex interrelationship between public policy and the media: witness the interesting revelations recently about Fox News’ willingness to support Donald Trump’s claims about the last US presidential election – claims Fox knew to be untrue but which it served its ratings to perpetuate.

Politics itself has become less about principled, well-argued proposals for long-term social improvement and much more about fast-food snapshots of ‘the will of the people’ here, today – a will often shaped, as I say, by the polling itself. A vicious circle emerges: media polls produce results giving the impression of public support for a position, which the government adopts because it has public support, which the media proves by further polling, and so it goes on.

And Joe Public goes along with this because ‘*it is in the paper so it must be true.*’ The symbiotic relationship between media and political power is nothing new, but today there is no real effort made by either side to even simulate objectivity or to engage the substantial issues: debating an issue on its merits has become virtually impossible.

A case in point: the 2017–19 process of legislating voluntary assisted dying in this State. In the face of saturation exposure of a few very tragic and highly emotive stories, there was never any chance that VAD would not succeed – yet the government felt it had to run a process of public enquiry to inform a Parliament for whom the final result was already a foregone conclusion.

In the end the Government paid lip-service to balancing competing claims, promising to improve palliative and end-of-life care throughout the State, but since that was all rolled into VAD anyway, the net outcome has been no significant improvement of access to palliative care in rural and remote regions – witness the higher per capita rate of access to VAD in country WA.

Whether one supports or opposes VAD in substance, it is still reasonable to ask the Socratic question: is VAD right because a majority of people support it, or do a majority of people support it because it is right? In the face of overwhelming media and political support for an ethically contentious option, bioethics is obliged to ask the complex questions and seek complex answers – even if doing so makes some of us unpopular. How else can we as a society be assured that we have done ‘due diligence’ on such important issues? But what we saw, and continue to see, is a different logic in play: science (or in this case, populism) sets the question, politics answers the question, and ethics is left to run along behind asking not ‘*what should we do?*’ but ‘*should we have done it?*’

2 *Cancel culture enforced by social pressure groups*

Along the same lines of suppressing rather than encouraging an open and effective exchange of diverse views, today we see the power of single-issue interest groups intent on pursuing only one line of thinking by demonizing and silencing alternative views. Somewhat perversely, groups which outwardly champion the value of diversity seem intent on suppressing any possibility of real diversity of opinion. ‘Cancel culture’ has claimed many scalps: witness J K Rowling, Jordan Peterson, and numerous others.

Behind this is a loss of the idea of ‘truth’. Today there is no one ‘truth’, there is only ‘my truth’ against ‘your truth’. Those who set the terms of a question also determine the measures of truth, and no other measures will be countenanced. To disagree with the established view is to disqualify oneself from holding any view at all, and so again the outcome is implicit in the opening proposition. Hardly a logical process.

As an example, and with due respect for we who have personal experience, one way or another, of gender variance among family members or friends, consider the current standing of the medical treatment pathway for adolescent gender incongruence. Notice I’m not commenting on gender incongruence *per se*, but on the ‘received wisdom’ of the medical treatment of it.

A ‘transgender clinic industry’ has grown up around treating childhood and adolescent gender incongruence by invasive medical means – essentially, puberty suppression hormones, +/- cross sex hormones, +/- transgender surgery – often without due attention being paid to co-occurring psychological pathologies such as anxiety, depression, self-harming, internalizing and externalizing disorders, autism and ADHD, which co-occur in as many as 80% of cases. As long ago as 2016, on the basis of having read dozens of research reports, I joined the ranks of those pointing to the lack of robust research into the medical pathway.

Imagine medical professionals promoting such radical and invasive treatment for any condition, much of it having irreversible effects, in the absence of any serious research into its nature, limitations or long-term outcomes! My belief is, it is essentially a problem of the medical professions being held hostage to the risk of being called out and publicly cancelled by those promoting these treatment pathways for reasons of their own. A very good paper from the Westmead Childrens' Hospital in Sydney made this point very clearly in 2021.¹ (*I prefer to think of medical professionals being held hostage, but I suspect a few have been actively complicit in this travesty of a noble profession.*)

What we see here is a struggle between mere assumptions and assertions on one hand, and robust, peer-reviewed epidemiology on the other. The strength of the cancel culture strategy is such that only formal legislation can withstand it: thankfully in respect of medical treatment for childhood and adolescent gender incongruence, the transgender industry is coming under greater scientific and legislative scrutiny in several European countries² and I hope Australia will follow very soon. We should never be afraid to follow the science, as long as the science is sound.

3 *Shift in social attitudes toward medicine as a 'supply-and-demand' transaction*

When did doctors stop being called doctors and begin being called '*health care providers*'? And when did patients stop being patients and become '*clients*' or worse, '*health consumers*'? Words are powerful, and the new words we use to describe the doctor-patient relationship reflect worrying social shifts in the status of medicine as a socially valued profession built on personal and professional relationship and trust: it has become, for many, just another transactional, supply-and-demand situation in which, often, the consumer shops around to find a compliant supplier.

The signs are all around us:

- The emergence of large group GP practices, sometimes owned and serviced by private or listed companies, may deliver healthcare more efficiently but they have also hurried the demise of the old-style single GP surgery built upon a trusting long-term 'therapeutic relationship' in which many of us place greater trust and confidence.
- Fewer medical graduates want to train as GPs, preferring instead to specialize in other areas that promise better lifestyle options. I agree with those who say that just fiddling with Medicare rebates won't fix this problem, because it is systemic and cultural at heart. Better remuneration of GPs will help, but what is needed seems to be a restructure of the whole 'supply chain' (to use a consumerist term).

¹ Kozłowska, Kasia et al. (2021). Australian children and adolescents with gender dysphoria: presentations and challenges experienced by a multidisciplinary team and gender service. *Human Systems: Therapy, Culture, and Attachments* Vol 0(0) 1-26. Online at <https://journals.sagepub.com/doi/full/10.1177/26344041211010777>

² [Cass Review – Independent Review of Gender Identity Services for Children and Young People](#)

- We have seen recent examples of consumer-driven medical practice in the field of cosmetic surgery: outside genuinely medically indicated cosmetic procedures there is a huge industry in all kinds of nips and tucks and sculpting – I see the most recent trend is buccal lipectomy, surgical reduction of the fat pads inside the cheek, leaving one's face more finely sculpted. It costs in the realm of \$2000–\$5000 per procedure. It is not marketed for medical indications, but as a purely discretionary cosmetic procedure. For me this raises a major ethical issue of responsible use of scarce medical resources.
- Perhaps the most worrying trend in my experience – referencing here my 20 years working in the governance of reproductive technology – is the emergence of IVF clinics owned and run by publicly-listed companies who, naturally, are expected to make annual financial returns to their shareholders. I know enough about finance to know that the only ways to make money in business are to control costs, to increase margins, and to grow volumes – preferably all at the same time. Taken together, these are not directed to meet the best interests of the patient seeking treatment: the business model is structured to optimise profits which flow out of the company in any case.

This model of medical practice simply embeds the view that medicine is a service, not a profession; small wonder if the patient (or the consumer) prefers to chase the best deal. Again, in my view, this is a major ethical issue for medicine.

4 *Within medicine, increasing emphasis on the need for a solid evidence-base*

I have already made some comments on expectations of a solid evidence base in respect of medical treatment pathways for childhood and adolescent gender incongruence. What I have come to understand over the years is that, contrary to general assumptions, quite a few clinical medical practices lack an objective evidence base. I'm thinking of situations in which there are several different 'standard treatments' for common conditions, but no-one has ever established on the basis of evidence which treatment is better for given cases: they all seem to work, so they all remain in use.

Now in many ways this has not been problematic until recently, when the idea of 'evidence-based medicine' has become the catchcry of the profession. It certainly fits better with the notion of medicine as a science rather than an art – although the ancient Greeks were on to something important when many of them classed medicine as '*ars*' rather than '*techne*'. The best doctors combine rigorous empirical methods with an intuition that borders on the artistic.

This admirable drive to establish sound evidence bases for various treatments runs into difficulty however when, on the one hand, you need to obtain prior informed consent to include a person as a participant in a medical research project and yet, on the other hand, you want to research best treatments for people who are unconscious – as they typically are

in an Emergency Department. An unconscious person, being unable to give prior informed consent, cannot be a participant in medical research unless there are other ways of gaining legally valid proxy consent from someone acting on their behalf (I won't comment on the obvious conflation here of legal and ethical questions).

So after some serious prodding by doctors and lawyers alike, the WA Parliament just a few years ago created a legal solution to this problem, meaning that finally we can establish – according to empirical standards – solid evidence for the best treatment options. This is a development identified, driven and welcomed by medical professions themselves, but equally to be welcomed by us all. Typically the proxy consent process is cumbersome and very involved, and it will need to be improved, but that is the price we need to be prepared to pay if we wish to balance an individual person's right to autonomy with the common good of improving everyone's health and wellbeing.

Now before we open the floor for questions and discussion, I want to offer some hopefully constructive observations of my own.

Our faith traditions, the Jewish and the Christian, have been mainstays of good medicine in this State for many generations – and long may it remain so. I think of the close relationship between the Sisters of St John of God in Subiaco and the Jewish doctors and surgeons who have served that hospital so faithfully for so many years. I am reminded that the Christian faith tradition emerged from the Jewish tradition – we hold a great deal in common, including shared ancestry in the line of Abraham – and in medical ethics we are very close together indeed. If our faith communities can remain active in this space, we may yet have the possibility of preserving and recovering the best human qualities and virtues of medical practice.

For me, awareness of the common history of our religious traditions enriches the bond between my religious faith and my work as an ethicist. As a Catholic priest I draw great strength every morning from the words of Zechariah, father of John the Baptist, whose canticle begins, "*Blessed be the Lord the God of Israel,*" a saying with many echoes in the First Testament. I try to say those words as reverently as I can every morning.

I think too of Moses ben Maimon (Moses Maimonides), the great Twelfth Century Jewish philosopher, scientist, doctor and teacher based initially in Cordoba and then in North Africa and finally Palestine, one of history's greatest luminaries in the field of medical ethics and practice. So great is his wisdom that we can still rely on Maimonides to light our way through changing social environments and ethical issues today:

- On the issue of populism, when politics is driven by the electoral cycle rather than sound principles, and ethics runs a solid last, Maimonides might remind us: ³

We each decide whether to make ourselves learned or ignorant, compassionate or cruel, generous or miserly. No one forces us. No one decides for us, no one drags us along one path or the other. We are responsible for what we are.

- On cancel culture, which would silence all dissenting views, he might remind us:

Truth does not become more true by virtue of the fact that the entire world agrees with it, nor less so even if the whole world disagrees with it

- On the shift toward supply-and-demand medicine and away from the personal professional relationships of old, Maimonides in his *Treatise on Asthma*:

The physician should not treat the disease but the patient who is suffering from it

- And on evidence-based medicine:

You must accept the truth from whatever source it comes.

But my all-time favourite advice from Moses ben Maimon proves that really sound medical and ethical wisdom is truly timeless. It remains as applicable today as it was 800 years ago when Maimonides wrote:

A small amount of wine such as three or four glasses is of benefit for the preservation of the health of human beings and an excellent remedy for most illnesses.

This is good medical advice, which I follow to the letter.

Thank you for your attention.

³ Maimonides quotations from [TOP 25 QUOTES BY MAIMONIDES \(of 149\) | A-Z Quotes \(azquotes.com\)](https://azquotes.com/quotes/maimonides/)