The Heart of Medicine

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The Heart of Medicine is for good health outcomes. To maintain health, to restore health, to heal. To cure sometimes, to comfort always[i], to ease the way, to relieve distress until the final breath. To practice in conscience with compassion[ii].

Working in cooperation with the patient to inform and teach. Informing of treatment options and risks; sometimes informing of better ways; sometimes gently challenging; rarely confronting.

Always conscious of the privilege of the doctor-patient relationship; gently probing, analysing to find contributing factors[iii] and causes.

Seeking to develop empathic awareness.[iv] To listen. To be there[v].

To *ease the way*, but *never* to intentionally kill[vi].

To heal on request even if government forbids[vii] it.

To refuse "treatments" and procedures even when government compels[viii] it.

Collegiality and loyalty – but not at the expense of truth[ix].

To seek, and to speak for, the future of medicine especially in ethical standards[x] and the doctor-patient relationship, being aware of the lessons of history[xi], with active engagement depending on the opportunity. Understanding that it is not enough to evaluate medical or surgical options while ignoring the merits of the purpose for which those techniques are being discussed[xii]. Understanding also that there will be ethical divides when it becomes essential for medicine, not activists and not governments, to be decisive and authoritative, when there is no neutral[xiii].

To promote physical and mental health in community, helping the disadvantaged, and promoting a global consciousness with respect to all who are at risk. It is also to warn of risk to health of family and community and to engage in such action as is necessary to counter those risks both within Medicine and in Government.

The heart of Medicine demands of its practitioner skill, knowledge, sensitivity, respect for people and their backgrounds to ensure good health outcomes. It involves understanding, assessing what is happening and what is needed, education and explanation, and working respectfully with the patient to ensure the best possible good health outcome.

Footnotes:

[i] Cited as a 15th century folk saying but also attributed to Hippocrates, Ambroise Pare, and Sir William Osler

[ii] **Where do we stop in response to the call for compassion?**
When the threat is made to suicide because of distress?
When the threat is that the baby might be a dwarf? Ending the pregnancy is an extreme option but deliberately killing the baby in utero is even more extreme when the baby could have been delivered alive and, if desired, not ever seen by the mother and adopted.
"Terminating" the pregnancy by simple induction of labour is one thing but terminating the life of the baby is another.
When the threat is that the baby has Down Syndrome? That it might have talipes (a surgically correctable foot deformity)? That it has a cleft palate? Even when there are waiting lists to adopt such babies?
There is the underlying assumption that such babies do not deserve to be alive, they are not fit to live, that they will be a drain on the public purse as was evident at a Senate Committee hearing in 2008. There may be a perverted economic logic to this but why does the *mother* want the baby killed?
Because it is somehow her fault? That she is responsible? Is it a matter of turning back the clock as if it had never happened? Like the logic that a partial birth abortion (see below) will ensure a relatively easy vaginal delivery and a flat tummy.

Is this the end of guilt for the mother? That if she knows the baby is alive somewhere, someplace, being cared for by someone else, she will be plagued by a constant reminder that somehow she is responsible and one way or another has failed – either in actually conceiving such a baby or failing then to care for it? If the baby is born dead then her dilemma is resolved by the doctor's "compassion" in killing it. Is it right, is it just, to kill in the name of compassion?
Is it compassion to kill the invalided child? The Down Syndrome baby now born? To abort the baby conceived by rape? To abort/kill the female baby because it is female?
Is it right, is it just, to refuse to refer to another doctor who will kill that baby and for the doctor to then be "cautioned" by the medical "authorities" because of that refusal? And yet the doctor who performs the execution is left alone?
Is it right, is it just, to tear off the baby's limbs in utero – with no anaesthesia – in the name of compassion for the mother who didn't want to be a mother?
Is it right, is it just, for the baby to be partially delivered as a breech and then to feel the puncture wound in the upper neck for the sucker to penetrate into the Foramen Magnum and suck the brain out so the skull can be "collapsed" to aid a vaginal delivery with the "advantage of a dead baby"? (Partial Birth Abortion – NHMRC report of 1995). Is this compassion?
Is it compassion for the sake of the relatives watching their loved one die to prematurely kill their loved one and "put them – the relatives – out of *their* misery"?

[iii] pain syndromes, self-cutting, possible "false" memories in *False Memory Syndrome*, dysphorias including gender dysphoria, repetitive strain injury – particularly in epidemics. Re transgenders, if we have not even queried whether there are possible contributing factors or stressors in children wishing to transgender – such querying itself labelled as abuse by those who insist on affirming the wish – then we have failed our ethical and professional responsibilities as doctors, and our duty as community leaders and parents. We have failed the child and we have failed the community. We have failed medicine.

[iv] Empathy and intuition add to the doctor/patient connection in a way that cannot be known unless it is experienced or observed closely. *Intuition is a sacred gift; rationality its faithful servant* (Einstein). When the doctor has met the patient's point of need as the patient perceives it, intuition helps a doctor to move beyond that to meeting the unexpressed and often unrealised point of need. The ideal doctor/patient relationship enables the doctor to add something to the patient's life – to leave the surgery richer than before, not only with more knowledge and understanding and responsibility in their part of the relationship but also strengthened to face another day. The rapport that is established with this kind of personal relationship also gives strength in the patient's last illness particularly if the treating doctor is able to keep the dying patient at home. Health bureaucrats concerned with economic rationalism may not understand this kind of professional relationship unless they have experienced it for themselves. Medicine's primary concern must always be with *patient health* and not just be providers of Government-defined *medical services* on demand. See http://www.medicinewithoutmorality.info/wp-content/uploads/downloads/2011/09/Notre-Dame-Law-and-Ethics.pdf

[v] *Which was it? the thrill of the chase of the elusive diagnosis? the triumph of solving the puzzle? the entrée into people's lives? the adventure of saving life? the awe, excitement and responsibility of the birth? the presence during the last illness?*
The passion was the privilege of being there… The Passion of Medicine 1998.

[vi] Killing by doctors, or assisting in killing, is never to be seen as a solution. Medicine would be the poorer. Society would be the poorer. And, yes, there are other consequences too but paling into insignificance in light of such a catastrophic shift in the heart of Medicine.
Killing must never be endorsed as "good medicine". Killing must never be a part of *Good Medical Practice.*

[vii] For example, so-called "conversion" therapy.

[viii] For example, Section 8 of the Abortion Law Reform Victoria; transgender surgery in Texas.

[ix] Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion. *The obligation to practice conscientiously is the obligation on which all other medical ethics are built* (Dr Farr Curlin).

[x] Rubicons that must not be crossed: destructive embryo research; abortion: sex-selective abortion, Down Syndrome genocide; abortion specimen research and selling of parts for this purpose; babies born alive and left to die; euthanasia; cloning with or without destructive research or transfer of mature organs; mixing of animal and human genetic material, never to sacrifice one human life for another including organ transfer from prisoners or people condemned to death.

[xi] Medical Ethics and Human Rights: Legacies of Nuremberg (the "Doctors Trials")
https://quadrant.org.au/magazine/2010/05/the-return-of-eugenics-in-australia/
Abstract: In 1996, on the fiftieth anniversary of the Nuremberg medical trials, German doctors gathered together in conference. They commemorated this anniversary under the title 'Medicine and Conscience' and reminded their medical peers throughout the world that the separation of biological power from a moral sense would always be a danger to the profession. 'This history,' they said, 'should not be viewed as just happenstance in Germany at a certain period in time.' The removal of conscience from medicine creates an amoral medical force, but worse still, a force that can be sent in any direction. 'Medicine can be distorted by state; physicians must be above state-decreed strategies,' they warned.

[xii] http://medicinewithmorality.org.au/what-we-do/ Medicine with Morality was formed in early 2006 to unite doctors across Australia in response to an increasing drift of medical ethics away from moral absolutes. The actual trigger was the argument in the RU-486 debate that *evidence-based medicine* alone should govern the use of such drugs. But this line of reasoning ignored

consideration of intent and outcome morality. The application of evidence-based medicine in an ethical vacuum reduces human life to its biological function. It is not enough, for instance, to simply discuss the `best´ technique for euthanasia without consideration of its significance for the individual, the doctor-patient relationship, and the community.

[xiii] For example, the mutually exclusive "affirming" pathways for children wishing to transgender and which pathway constitutes child abuse.
Which side of the polarity regarding child abuse will Medical Defence Organisations defend? If they defend surgeons who do transgender mastectomy for a 25 yr-old on the grounds that fully informed consent was given, will they also defend surgeons who have done the same procedure for a 13 yr-old who decides to sue when an adult?
Further, will MDOs defend the surgeon who *refuses* to do a mastectomy for a 13 yr-old?
And how will MDOs decide? Will different MDOs have different approaches to these matters because their boards have been taken over by people with set ideologies? Because ethical doctors have been quietly going about their ethical work and have failed to recognise the need to be involved at these higher levels. Will MDOs simply side with that which is legal – if governments declare that affirmation of birth sex or reversal counselling is child abuse and punishable by law?

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