Symposium in Rome to seek ways to enhance the relationship between Religion and Medical Ethics

The Pontifical Academy for Life (Vatican City) and the World Innovation Summit for Health (WISH), an initiative of Qatar Foundation, have announced a joint symposium titled ‘Religion and Medical Ethics: Palliative Care and the Mental Health of the Elderly’, to be held in Rome on 11-12 December, 2019.

The first day of the symposium will focus on palliative care and will provide an overview of current practices in Qatar and the Arabian Gulf region in comparison to Western practices.

Discussions and presentations on the second day will focus on the mental health of the elderly. Speakers and delegates will examine the great potential benefits of religion and spirituality in improving the well-being and quality of life of elderly patients. service provision from an interfaith perspective.

The academic partners for the symposium will be The BMJ, who will be represented at the event by editors of the BMJ’s Journal of Medical Ethics.

Archbishop Vincenzo Paglia, President of the Pontifical Academy for Life (R in the picture), states: “Palliative care and the health of the elderly are two specific themes of great interest to our Academy; Pope Francis has asked us to articulate an anthropology that sets out the practical and theoretical premises for conduct consistent with the dignity of the human person, and ensure that the tools are made available for critically examining the theory and practice of science and technology, as they interact with life, its meaning and its value”.

Ms. Sultana Afdhal, CEO of WISH (L in the picture), adds: “WISH was founded to help build a healthier world through global collaboration. We greatly appreciate this opportunity to work closely with the Pontifical Academy for Life to bring experts together in Rome who can help shine a spotlight on important issues at the intersection of religious and medical ethics and that deeply affect people of faith at critical times in their lives.”

The Message of Cardinal Pietro Parolin

The day opened with the Archbishop Paglia' speech.
on Twitter: @PagliaAbp: #palliativecare is our key-word to connect #Religions for a better humanity. #HumanaCommunitas is our goal. No #eutanasia No #suicidioassistito #Si alla #cultura del #prendersi #cura.
Then dr. Sultana Afdhal' speech. "Our mission has been to build a healthier world through global collaboration. It is therefore a natural progression for us to be here in Vatican City to actively promote dialogue between people of faith and medical experts around issues that have such a profound affect on individuals, their families, their communities, and healthcare workers.
The message of Cardinal Pietro Parolin, Vatican Secretary of State.
Pubblichiamo di seguito il Messaggio che il Segretario di Stato, l’Em.mo Card. Pietro Parolin, ha inviato questa mattina, per l’apertura dei lavori, al Presidente della Pontificia Accademia per la Vita, S.E. Mons. Vincenzo Paglia, e ai partecipanti al Simposio Internazionale “Religione ed Etica Medica: Cure Palliative e la Salute Mentale durante

l'invecchiamento" (Religion and Medical Ethics: Palliative Care and the Mental Health of the Elderly), organizzato dalla Pontificia Accademia per la Vita e dalla World Innovation Summit for Health (WISH) (Augustinianum, 11-12 dicembre 2019):
Messaggio del Segretario di Stato
Your Excellency, I offer cordial greetings to you and to the scholars and experts from different religious traditions assembled in Rome in these days for the International Symposium on Religion and Medical Ethics. Palliative Care and Elderly Mental Health, as you explore this complex issue of pressing concern.
The theme of this event, co-sponsored by the Pontifical Academy for Life and the World Innovation Summit for Health, seeks to place the elderly - especially those suffering from mental health issues and those in the final stages of life -at the very centre of our consideration. The frailty and vulnerability of people in need of palliative and other types of care should never permit a merely utilitarian attitude to take hold. Tragically, they are all too often overlooked, rejected or even "discarded with an attitude of abandonment, which is actually real and hidden euthanasia" (Address of His Holiness Pope Francis to the Elderly, Saint Peter's Square, 28 September 2014). Hence the urgent need that they should find a solid support for their God-given dignity and worth in the ethical and spiritual vision shared by the various religions.
May the ecumenical and interreligious cooperation, evident in this Symposium, continue to be fruitful in defending the care to which the elderly are entitled and in building a culture of encounter and acceptance in which they are esteemed and loved.
In expressing these sentiments, I have the honour to convey the Holy Father's prayerful good wishes for the Symposium and its important deliberations.
Yours sincerely in Christ,
Pietro. Card. Parolin - Secretary of State

POST EVENT PRESS RELEASE

Final Day. Elderly Mental Health

The key-question for Elderly people: not do you live alone but: do you feel alone? Final Q&A

Some speeches:

Mental Health and the Wellbeing of Older People (Most Reverend Noel Simard, Bishop of Valleyfield, Québec, Canada)

I- FUNDAMENTAL ETHICAL VALUES AND PRINCIPLES

- The Inherent Dignity of the Elderly Person
- i) The elderly person remains a person
  ii) Must continue to becoming a person
  iii) As social being, needs the community

• It is essential to include spirituality and religion in the healing process in order to improve the well-being and the quality of life of the elderly with a mental problem or disorder,

• « What is good for the soul may also be good for the body,

• A holistic approach for health presupposes a holistic concept of the person, an integration of care, a Covenant of care, compassion and love,

• An ethics of frailty is necessary to learn about the meaning of dependency and vulnerability, and to develop human relationship based on solidarity, reciprocity and compassion.

Mental Health of the Elderly from an Islamic Perspective (Professor Mohammed Ghali)

•Cannot be separated from the larger Islamic moral framework; •Individual dimension (in case of competence); •Theological; •Juristic; •Moral/ spiritual; •Actualization of beautiful names and attributes of God; •Role models and examples in the scriptural sources; •Continuous moral/ spiritual development/cultivation; •Social dimension (particularly with lack of competence); •Collective and participatory framework; •Family relationships; •Medical team; •Broader social connections/implications/ stakeholders.

•Importance of underlying conceptualization of oneself and one's place in the universe; •Role of religion and culture; •Paying special attention to the role of mental health in elderly care; •Individual and collective responsibilities; •Incorporation of the elderly perspective; •Role of family members; •Role of specialized medical staff; •Involvement of various stakeholders; •Development of and continuous revision of special/specific protocols; •Should be based on collective reflections and deliberations; •Should cover various physical, social, religious, and financial needs; •The sick; •The elderly; •The dying.

Christians and Muslims agree about the social importance of Elderly people. They are a living memory. Take care of their economic, social, spiritual, health situations.

Safeguarding the Mental Health of Elderly patients receiving Palliative Care (dr. Ferdinando Cancelli)

•Ensure that patients and their families are offered regular opportunities to talk to staff about their changing situation and concerns. •Use the patient's name as they like to be addressed; •Make time for the patient; •Create the opportunity to talk about spirituality; •Always seek to enable a patient to express their preferences; •Offer a private room for the patient; •Be clear about the relative benefit and need for sedative medication; •Ask the patients/family if they have any particular religious beliefs; • Consider offering the sacrament of communion and involve the chaplaincy team as soon as possible.

•Depression remains underdiagnosed even in institution: too often we forget that depression is in no way a consequence of normal aging; •Suicide remains an important cause of death for the elderly person (2010: 2873 people older than 65 yrs, 30% of total suicide); •In the older than 85 years group, the prevalence of suicide is twice as high as that of the 25-44 age group; •Men older than 95 yrs of age kill themselves on average 10 times more than the general population; •Safeguarding the mental health of elderly patients receiving palliative care is the better way to avoid euthanasia and assisted suicide.

•«I like this place because death, when it comes, still finds us alive!»

The bridge of Love: dementia (Prof. Marco Trabucchi)

We must improve our ability to care both at the personal and social levels, considering that a dementia cure is far away.

In the world there are 4 kinds of persons: Those who cared 4 someone Those who are caring 4 someone Those who will care 4 someone Those who needed care or will need it.

Other subjects: "I think we need to talk WITH elderly people not just ABOUT them". Dr. Mohammed Ghaly from @HBK
Prof. Paulina Taboada: "Treating spiritual issues as part of a checklist in the same way as physical symptoms does not allow one to adequately tackle them, as they are more encompassing. Spirituality can contribute in it's own right to healthcare".
Abp. Paglia closing remarks: "We are speaking about all believers on all religions, not just leaders. Otherwise we would take away from the people most in need in love and place everything in the hand of experts". Make palliative care a required part of all medical training, and 4. prioritize the development of pediatric palliative care. We have a long way to go and we are just at the beginning. "We are speaking about all believers on all religions, not just leaders. Otherwise we would take away from the people most in need in love and place everything in the hand of experts".
“Suicide is a request for love that hasn’t been answered”. What a powerful closing statement
"Faith needs to be integral to holistic care" - Final remarks from Archbishop Vincenzo Paglia and Sultana Afdhal at the conclusion of the meeting.

Day 1. The role of different Religions

1. Muslim Approach to Bioethics Questions:
A. Life-Sustaining Treatments (LSTs). Cardiopulmonary resuscitation (CPR) & Mechanical Ventilation

•Brain death: IOMS, IIFA, IFA; •Medical futility: ECFR (2003), IFA (2015), Fatwa no. 12086 (1989); •Arguments; •Forgoing optional treatment; •LSTs harms usually override possible benefits; •DNR policies: Fatwa no. 12086; •HMC; •North West Armed Forces Hospital (NWAFH); •King Faisal Specialist Hospital and Research Center.

B. Artificial nutrition and hydration (ANH)

•IIFA 2015 (vague); •Muslim physicians: euthanasia in disguise (qatl al-sabr); •WISH Report: "Do not force your patients to [consume] food or drinks. Truly, God feeds and waters them"; •Benefit-harm assessment: Alleviating the symptom of hunger? Most dying patients are no longer experiencing hunger because the organ systems are shutting down; •Accumulating fluids in unwanted places because of the dysfunctional GI tract (taking in food, digesting it to extract and absorb energy and nutrients, and then expelling the remaining waste as feces).

C. Conflicting Values.

• Dying without pain or with a clear mind; •Benefit (reducing pain) Vs. harm (suppressing consciousness); •Good balance: religious rituals; •Main problem: full and permanent sedation; •Harm: Foreseen BUT unintended effect of shortening a patient's life; •ECFR 2003: Indirect euthanasia; •IOMS 2004: Permissible; •"The intensified administration of a strong medication to stop a severe pain, although it is known that this medication might ultimately end the patient's life, is not forbidden".

•Communicating bad news: truth or compassion; •Classical works on the etiquettes of the physician (adab al-tabib); •Contemporary works on medical ethics; •Communicating such news by using gentle words (lutf min al-qawl), e.g.; •"Make your will (awsi)"; •"Eat whatever you want"; • Sensitive, compassionate delivery of bad news; •To who? The patient and/ or family.

2. Christian Approach: Dignity following the compassionate Jesus Christ

•We are in favour of the death with dignity (too); •Dignity is to choose the moment?; •For Christians is to accept the natural moment; •For Christians the dignity is in the person; •is intrinsic, can not be taken…; •But, there are indignity modes to die; •Alone, in pain, without relief, in breathlessness, without to know, …; •Don't care, or don't care well, provokes perception of indignity in the dying person; •Without care some one could perceive himself as miserable; •With care: or the more dignius!: I am worth to be cared, I want to life to be cared.

3. A Jewish approach.

Con le Cure Palliative ci prendiamo cura del sofferente e curiamo i sintomi del disagio causato dal dolore, il vero dolore. Non rimaniamo impassibili

di fronte alla sofferenza. Nella Bibbia la persona che soffre grida e il suo grido sale fino al cielo. Noi abbiamo il compito di raccogliere quel grido. E' imperativo occuparci delle Cure palliative perchè forniscono un'alternativa sistemica alla cultura della morte.

4. Role of Religione / Medical aspects

A shared decision-making? That is the problem. Pope John Paul II, Evangelium vitae. Libreria Editrice Vaticana, Vatican City:

•§65 'Euthanasia must be distinguished from the decision to forego so-called 'aggressive medical treatment', in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. … Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances…'

England and Wales: Mental Capacity Act (2005), Code of Practice:

5.31 All reasonable steps which are in the person's best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death.

'Notwithstanding its promise, SDM [supported decision-making] has its limits. Undeniably, there are situations where despite the decision-support offered, a patient remains unable to make an informed treatment decision. The comatose patient provides a pertinent example, but similar considerations hold for a range of persons with other conditions, such as late stage dementia or psychosis. Accordingly, SDM does not make competence assessment and substitute decision-making superfluous. That said, reasonable accommodation requires health professionals to exhaust the available resources of SDM before they take recourse to substitute decision-making.'Scholten M, Gather J. (2018) Adverse consequences of article 12 of the UN Convention on the Rights of Persons with Disabilities for persons with mental disabilities and an alternative way forward. Journal of Medical Ethics, 44, 226–233.

The questions are opened, but in any case we need to be persons in communion with the others.

On Tuesday 10 December at 11.30, in the Holy See Press Office, Via della Conciliazione 54, a press conference presented the International Symposium on “Religion and Medical Ethics: Palliative Care and the Mental Health of the Elderly”. The speakers at the press conference were:
- Archbishop Vincenzo Paglia, President of the Pontifical Academy for Life;
- Dr. Sultana Afdhal, Chief Executive Officer – WISH, Qatar;
- Dr. Kamran Abbasi, Executive Editor of the BMJ (British Medical Journal).

Background Paper: OLD AGE AND MENTAL HEALTH AT THE END OF LIFE: THE ETHICAL FOUNDATIONS OF DECIDING FOR OTHERS