

NATIONAL COMMISSION OF BIOETHICS
R E C O M M E N D A T I O N
ON ARTIFICIAL PROLONGATION OF LIFE

The National Bioethics Commission met upon invitation by the President thereof on the 1st and 22nd of April, the 10th of June, the 23rd of September, the 14th of October, the 25th of November, the 16th of December 2005 and the 27th of January 2006 in order to consider the ethical and social issues within its jurisdiction which arise from decisions related to artificial prolongation of life.

The issue is currently topical due to international reflection inspired by recent court rulings (D. Pretty, T. Schiavo), on the one hand, and in view of art. 29 of the new Medical Code of Ethics on “medical decisions at the end of life”, on the other hand.

The context in which the present Recommendation may apply will be defined by way of introduction.

A. The context

Thanks to the constant advances of modern medical technology, the potential of human intervention has progressed to an extent that would be unthinkable a few years ago. An extreme situation in this respect consists in maintaining the fundamental biological functions – among which cardiac function – of persons confirmed to be brain dead.

These interventions mean that fundamental biological functions of the human organism can be kept going artificially even for significant periods of time without expecting any curative benefits.

In-between the conventional treatments expected to yield curative benefits to patients and interventions like the above which, moreover, do not ensure an acceptable quality of life (especially in situations accompanied by non-alleviated unbearable pain and anxiety before death or in the absence of higher brain functions) lies a “grey” zone uncovered by the traditional prescriptions of medical ethics. The continuation of medical interventions in situations falling within this “grey” zone is controversial. Hence, the final decision is ultimately a matter of subjective evaluation.

In such cases, however, the continuation or interruption of medical intervention cannot be left only to the physician's judgement.

B. Decision-making

The Commission recognizes that the decision to provide medical care to patients at an irreversible stage of disease is extremely crucial since it affects both the duration and the quality of their lives.

As with any medical act, all the more so on these specific occasions, the patients themselves must make the decision provided they are capable of voicing their opinion, or by their relatives who assume the legal and moral responsibility for these decisions.

The physician's sole responsibility is to provide information and support to patients (or to their family members) so that any decision is made in accordance with the patient's interest in the best possible way.

C. The obligation to inform the patient

According to the principle of "informed consent", any decision by the patient or his/her relatives requires prior and appropriate information to be provided by the attending physician. The latter is legally and morally responsible to provide this information. This applies in both situations considered here, i.e. when the condition of the patient is definitely irreversible and either (a) the patient is at the terminal stage of disease, or, (b) it cannot be determined whether the patient is at the terminal stage of disease.

A. Patients at terminal stage of disease

In these cases, it is imperative that objective data be provided on the irreversibility of the patient's condition and the assessment that the patient undergoes the terminal stage.

The Commission holds that once this objective data has been established with certainty the curative goal of medical intervention ceases to exist and, in this sense, further treatment appertains to "medical futility". Therefore, the Commission believes that this conclusion must be stated in unequivocal terms in the context of information

provided by the attending physician depending on the patient's psychological ability to endure it and, at all events, it must be imparted to relatives.

The Commission underlines that even when all curative benefits have been excluded with certainty, the relationship between patient-physician still holds. "Medical futility" does not entail abandonment of the patient by the attending physician. This must also be stated clearly during information.

Furthermore, the Commission considers that even when no curative benefits may be expected the goal of medical intervention continues to be governed by the fundamental principle of "beneficence-not to harm". In this case, however, the only undisputable benefit to the patient is the alleviation of pain and suffering. By contrast, the artificial prolongation of biological functions with no hope of recovery can be viewed as "harm" and indeed be experienced as such by the patient.

Hence, the Commission holds that the attending physician is legally and morally obliged to suggest that all efforts be directed into relieving the patient's suffering through palliative care, accepting the prospect of impending death but aiming, to the extent possible, at peaceful departure.

B. Patients at a non-terminal stage of disease

Insofar as there is no hope of cure for the patient but deterioration is slow and artificial prolongation of life may be extended over a long period of time, the physician must make clear both the irreversibility of the patient's condition and the uncertainty of the time of death taking into account the psychological ability of the patient to take in this information. If the attending physician estimates that the patient is not in a position to receive this information, then family members must be informed accordingly.

At any rate, the Commission points out that, in this case also, artificial prolongation of life may consist "harm" if it draws out pain and anxiety before death or does not respect the patient's autonomy.

Again, the Commission considers that the attending physician is legally and morally obliged to suggest the alternative of palliative care given the irreversibility of the situation and the fact that artificial prolongation of life may consist "harm".

D. Co-ordination in order to reach a decision

By their nature decisions on artificial prolongation of life are emotionally heavily charged. At the stage preceding the decision, there may be conflict of opinion based on diverging beliefs and value-judgements or differences in the psychological management of the situation among the persons involved (attending physician, patient, family members).

For this reason, the Commission holds that it is meaningful to adopt specific procedures in order to prevent and/or resolve conflict, although the eventuality of unresolved conflict cannot be excluded.

A. Conflict between physician/patient

a. Due to different values

In this case, the physician's medical opinion is accepted as true and opposition stems from the different value systems endorsed by the two sides. The Commission considers that the opinion of the hospital's board of ethics or/and the engagement of the hospital's social workers can help the parties to approach each other. However, if this proves unattainable, the final say rests with the patient and the physician has the right to resign.

b. Due to psychological denial of the situation by the patient

Here, the patient usually wishes to try some other curative treatment which is considered as inappropriate (medically futile) by the physician. In the Commission's view such conflicts jeopardize the relationship of trust between physician and patient. Hence, a second medical opinion or/and consulting support may help to settle the issue. If, however, the conflict between physician and patient is so severe to the point of disrupting the relationship of trust, the former must withdraw after referring the patient to another physician approved by the patient.

B. Conflict between physician/patient's family members

a. Due to different values

In this case just as above family members accept medical opinion as true and the conflict springs from differences in the value systems endorsed by the two sides. In the Commission's view, the opinion of the hospital's board of ethics or/and the intervention of the hospital's social workers can help the parties to approach each other.

b. Due to psychological denial of the situation by the patient's family members

On this occasion, the patient's relatives do not accept the physician's opinion or they do accept it but are unable to decide for psychological reasons. Here, a second medical opinion and counselling represent the appropriate solution.

In either situation, if the conflict between the attending physician and the patient's relatives runs too deep, the physician must once again withdraw after referring the patient to another physician approved by his relatives.

C. Conflict between family members

If the relatives of an incapacitated patient disagree among each other either due to different values or due to diverging psychological attitudes, the attending physician must determine the source of disagreement and seek the intervention of experts as the case may require (e.g. a social worker or a psychologist).

The Commission holds that the best way to avoid such disagreement is designation by the patient of a proxy specifically for these issues in due time. Therefore, the Commission suggests that legislation be passed to sanction this option.

If the patient has not designated a proxy, as suggested above, the Commission considers that in case of unresolved conflict between the patient's relatives, the decision must be in favour of artificial prolongation of life, according to the patient's best interests.

Minority opinion – by Georgios M. Maniatis

In my view this Recommendation does not contribute meaningfully to addressing the problems arising from what the Recommendation terms "artificial prolongation of life". The situations forming the object of this Recommendation cannot be regulated

by a short and sketchy document which, moreover, is not limited to a few general guidelines but engages in casuistry, even down to arbitration details.

This Recommendation may well be based on terms used in everyday practice but these terms are, nonetheless, imprecise and prone to an interpreting framework that is too wide to provide a basis for a regulatory text. Such terms are:

- “Artificial prolongation of life” One of the main goals of Medicine is “artificial prolongation of life”. I cannot imagine, however, that, say, the administration of insulin to diabetic patients or haemodialysis or numerous other acts fall under the scope of the Recommendation. So in which situations exactly does this Recommendation apply?

- “Irreversible situation” Too many situations are “irreversible”, e.g. amputations, consumption diseases and numerous others. Which ones exactly are covered by the Recommendation?

- “Terminal stage” This is also a commonly used term but only by way of indication, not as a term that can constitute the basis for a guidance document. What is the definition of terminal stage? When does it begin?

- The text also refers to “objective data” and medical “certainty”. There is no such thing as “certainty” in medicine. There is only statistical data, but this cannot be used to make a decision about a specific individual.

- Finally, the “patient’s interest” cannot be used as basis for decision because this is precisely what the question is about, a question depending on a multitude of subjective, mostly, rather than objective factors and values.

The one point I agree upon is the recommendation to pass legislation to adopt the institution of the patient’s proxy.

To conclude, the situations the Recommendation attempts to address pertain to the wider issue of euthanasia. But, on this, the Commission has not taken a stance as of yet.