REPORT

On artificial prolongation of life

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The following report is an attempt to outline the main points of a vigorous and highly topical international reflection around certain applications of contemporary medicine.

This reflection stems from the fact that, in recent decades, technological progress in medicine has made possible not only the management and treatment of many diseases but also prolongation of life for patients. Especially after 1940, the use of mechanical ventilation appliances in intensive care wards allowed cardio-pulmonary resuscitation. Before that, respiratory or cardiac failure, i.e. apnoea and cardiac arrest respectively, were indissociable from the organism's neurological functions. As a result of the, until then, inseparable association of these functions, when one system failed the others collapsed as well causing immediate death.

The possibility of cardio-pulmonary resuscitation even after the cessation of neurological function led to the identification of some new, at the time, and special neurological syndromes. Added to the already familiar neurological conditions of coma and senility were those of brain death (1959) and persistent vegetative state (1972)[1].

The discovery of these special neurological conditions raised a series of questions around the notions of consciousness, perception of the environment and the self, voluntary interaction with the environment, pain and psychological or/and physical suffering. To the extent that these questions have remained unanswered, it is not evident which criteria should be used to determine interruption or continuation of medical treatment, particularly when decisions have to be made at the end of a patient's life.

For instance, cardio-pulmonary resuscitation was developed and is widely used to respond to unpredictable events as, for example, during a surgical operation or when the heart of an otherwise healthy person stops beating. However, the use of cardio-

[1] The diagnosis of cerebral death is based on the existence of lesions both in the cortex (hemishpheres) as well as in midbrain. By contrast, persistent vegetative state is characterized by extensive and permanent lesions located only in the cortex.

pulmonary resuscitation can be extended in order to inhibit death, even if temporarily, in persons at terminal and irreversible stages of disease such as people in a vegetative state or at the terminal cancer stage.

In such borderline situations, the question arose from patients and the medical community alike as to whether there should be limits to life prolongation, i.e. whether it makes sense to defer impending death and keep patients alive "with all means".

In these borderline situations, medical opinion on life expectancy is "infiltrated" by the value-judgments of patients or their kin on the value of life (e.g. relative or absolute) which sometimes results in the same facts giving rise to diametrically opposed wishes or/and decisions.

In part I we discuss the criteria used to determine limitations to life prolongation and in part II we examine in detail who makes the decision.

PART I

Medical Prognosis

The crucial point here is medical prognosis to the effect that the patient is at the terminal and irreversible stage of disease, i.e. that the patient's condition will gradually deteriorate whereas the effects of deterioration cannot be reversed by medical treatment and death is likely to occur soon. But how "soon" should that be for the prognosis of imminent death to be accurate?

According to the medical community itself, the possibility of error on behalf of the physician is minimal when "soon" refers to the next hours or/and days. The prognosis is fairly accurate when it refers to the next 2-3 weeks whereas the margin of error is significantly increased beyond 2-3 months. Therefore, it is not uncommon for patients to survive twice or thrice the time initially predicted if the initial prognosis gave them 6-8 months of life. The accuracy of prognosis of imminent death is also influenced by the kind of disease. For example, the margin of error decreases in terminal cancer patients whereas it may be significant in patients suffering from cardiac failure or neurodegenerative conditions (e.g. multiple sclerosis).

Curative and Palliative Medicine

A relatively recent distinction in medical practice and science is the one between curative and palliative medicine.

Aggressive treatments that cover the entire spectrum of medical acts from administration of medicines to surgical operations are characterized as curative. This category also includes treatments that support or sustain vital functions (e.g. cardio-pulmonary resuscitation, artificial feeding and hydration).

The distinction between supporting and sustaining vital functions consists precisely in that, in the first case, a fundamental function of the organism is supported in the short run and then the patient reverts to their prior condition while, in the second case, a patient at the terminal stage of an incurable disease is kept alive. As a rule, life-sustaining treatments do not offer curative benefits to patients because their clinical condition is not susceptible to improvement; what is more, these treatments can be very trying[2].

This is exactly where palliative medicine steps in, i.e. when the patient suffers from an incurable disease, is approaching the end of life and, in addition, supporting treatments are believed to offer no therapeutic benefits or the burden they place on the patient outweighs any eventual benefits. The goal of palliative medicine is to improve quality of life for patients and their families and is focused on preventing and eliminating suffering through the early diagnosis, treatment and control of pain symptoms or other physical, psychological or mental needs. In actual fact, the patient continues to receive medical support. But the goal of health care is not cure since it is considered unattainable but the elimination of all sorts of ailments that accompany people at the final stages of their lives. Palliative medicine facilitates the process of farewell to life without speeding up death (distinction between letting die and hastening death).

Hence, if it can be predicted with reasonable accuracy that impending death is also imminent (e.g. terminal cancer stages) and curative medical treatments are considered useless or burdensome rather than beneficial ("beneficence-not to harm" principle), the

[2] For instance, if the therapeutic goal is improved energy, weight and strength of patients suffering from cancer at an advanced stage of the disease, artificial fluid and nutrition is extremely unlikely to be helpful whereas it may deteriorate symptoms of dyspnea. By contrast, maintaining patients in a state of relative dehydration may be of some benefit as it rather limits vomiting and urinary incontinence. Also, relative dehydration may stimulate the release of endorphins (endogenous opioids) and contribute to painless and peaceful death.

patient is offered the option of palliative care (letting die). Needless to say that, as with any medical act, the patient or his/her relatives have to agree. Given the fact that, in these circumstances, consent is psychologically painful for it presupposes acceptance of the approaching end, the process (framework) of decision-making is extremely crucial.

Usually, people come to such decisions gradually and the situation requires communication expertise on behalf of the medical staff. Crucially, the patient or his/her relatives should determine the goal of treatment together with the physician/s. That is, the patient should participate in weighing the desirable against the feasible in the borderline situation of the end of life of those suffering from incurable diseases[3].

But what happens in case of disagreement? Is the physician or the hospital obliged to go on providing futile treatments? And, if yes, is this obligation an ethical or a legal duty? When is a curative treatment futile and who determines that?

The criterion of medical futility

In the early '80s some members of the medical community expressed the view that the physician is obliged to provide only treatments that are likely to be of therapeutic benefit to patients. Hence, in case of serious indications that a medical act is ineffective in the particular circumstances, it may be considered futile. Indeed, from an ethical viewpoint, physicians should refrain from such treatments according to the principle of not-to-harm since all treatments entail some risk for the patient (e.g. side-effects) and it is unfair to expose patients to risk when no benefits are to be expected.

Thus, the criterion of medical futility was mainly aimed at covering physicians from an ethical point of view when they refused to provide medical treatment if they considered it futile and the patient's relatives wanted to prolong the patient's life "with all means".

[3] In many developed countries, relatives are assisted in their decision through successive meetings with psychologists, the attending physicians and consulting services from ethics hospital boards. The effort is directed at determining what the patient would have wanted since relatives have a better knowledge of the patient's values and perceptions of a desirable life. The emphasis here is placed on anticipating and settling eventual conflicts. This, however, presupposes appropriate infrastructure, availability of time and, in addition, avoiding to conceal the impact of the patient's age or financial state in the final decision. These processes and decisions can be facilitated by the wishes patients may have expressed in advance (advance directives). These wishes, although not binding in the legal sense of the term, are ethically binding for physicians and relatives alike and prevent them from acts that would clearly contradict the concerned person's value system. However, even the existence of mechanisms for reaching consensus during the decision-making process does not warrant success.

The key-point to this argument lies in the definition of therapeutic benefit (principle of beneficence) which is distinguished from the therapeutic result which is located in some area of the patient's body, and is meant as an overall improvement of their condition. So, maintaining certain functions such as cardiac beat or respiration is not thought to be of any therapeutic benefit and is, therefore, futile when the patient is in a vegetative state or cannot survive outside the intensive care unit.

Typical examples are patients in persistent or permanent vegetative state[4] where the time of death can potentially be delayed *ad infinitum* through the use of life-sustaining treatments, in which case deciding whether to prolong the patient's life or not is not straightforward.

According to the argument of medically futile acts, precisely because the therapeutic benefit is distinguished from the therapeutic result, the notion of benefit for the patient depends on the latter's personal values. Therefore, the desirable result cannot be decided unilaterally by the physician. In case of difference of opinion between the physician and relatives, precisely because the physician or the hospital cannot legitimately decide to withdraw life-sustaining treatments unilaterally, a court decision is usually required[5]. However, the liability of the physician or the hospital for withdrawing a life-sustaining treatment is by no means apparent[6].

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[4] The term vegetative state covers three clinical situations: a) acute vegetative state which is characterized by sudden onset and severe brain damage (e.g. due to trauma), b) degenerative vegetative state which is characterized by progressive deterioration with time (e.g. terminal stages of Alzheimer), and, c) congenital vegetative state in babies born with the greater part of their brain missing. The vegetative state is considered persistent when it lasts more than one month in the acute form and permanent when it is irreversible (cases b) and c)).

[5] The case of Baby K.: Baby K. was born in Virginia, USA, in 1992, in the state we call anencephalic. Namely, the biggest part of the brain except the brain stem was missing. Although the mother knew in advance that the baby would be born with anencephaly, she decided not to interrupt her pregnancy, despite the physicians' advice, because her religious beliefs did not allow it. As was expected, the mother wanted the newborn to be life-sustained by mechanical ventilation but also "with all means" including cardiopulmonary resuscitation. The hospital held that sustaining the infant's life by mechanical support was medically futile and, moreover, a waste of limited hospital resources. The hospital believed that its only obligation vis-à-vis the infant was to provide palliative care until death. When the case has heard in court, the ruling vindicated the mother. The court based its reasoning on the Act on emergency care and ordered the hospital to provide mechanical support to the infant whenever necessary. The infant died at the age of 2.5 having survived much longer than similar cases.

The case of Helga Wanglie: In 1989, Mrs. Wanglie, age 86, suffered a fracture and after hospitalization for some time was transferred to a facility for the elderly. A month later she presented respiratory complications and was again committed to the hospital where it was decided that it was necessary to support her respiration mechanically. While she was in the ICU, her heart beat stopped. She recovered with cardio-pulmonary resuscitation but the lack of oxygenation in the brain caused permanent and irreversible damage which resulted in a vegetative state. At the same time, her respiratory function continued to depend on mechanical support. The hospital suggested to relatives that they should consider withdrawal of treatment (mechanical ventilation) as her condition was not going to improve. The family, however, decided to continue treatment because it seemed that at some moment Mrs. Wanglie had said, "if something happens to me, I want to try everything". The hospital filed a suit

The criterion of unbearable pain

In certain cases, as with cancer patients, the terminal and irreversible condition can additionally be accompanied by excruciating pain. Physical and mental pain can both be treated medically by strong analgesics and/or antidepressants. However, the severity of pain is determined by the sufferer and sometimes the administration of strong analgesics (e.g. morphine) although relieving physical pain can exacerbate mental suffering because the effect of psychotropic substances affects communication of the patient with the environment and their relatives. Moreover, if the medical diagnosis excludes depression as the source of mental suffering, one may say with relative certainty that it is impossible to eliminate suffering since it is due to the terminal and irreversible condition of the patient. In these cases, physicians are met with persistent demands by patients to hasten the inevitable impending end.

The medical dilemma on this occasion stems from the fact that the only treatment they are asked to offer to patients is directed at the part of mental suffering; this, however, lies outside the scope of medicine since it consists of direct or indirect assistance to elimination of life (active or passive physician-assisted suicide). Is the framework for practicing medicine determined by medical ethics or by law?

Considering that the severity of pain is ultimately determined by the sufferer means that the patient's "interest" contains personal value-judgments on quality of life. Is it possible to find a "commonly" accepted solution in case of conflict between the patient's "interest" and medical "duty"?

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asking permission to withdraw treatment. The court ruled that the hospital had to maintain mechanical ventilation and designated her husband as proxy. In the end, Mrs. Wanglie died in 1991 of multiple organ failure.

[6] The case of Gilgunn: Mrs. Gilgunn's health was already weared down – she had a heart problem, diabetes, suffered from chronic renal infections, Parkinson's disease, had undergone a heart attack and treatment for breast cancer – when she broke her hip for the third time. Until treatment for her fracture was determined, Mrs. Gilgunn suffered several sudden strokes causing severe cerebral damage and sank into coma. Her family wanted to do "whatever was necessary" to prolong her life (mechanical ventilation) and refused to sign the waiver of resuscitation in case of cardiorespiratory crisis. The physicians gave Mrs. Gilgunn no more than a few weeks and considered, besides, that prolonging her life "with all means" was cruel. While the family was negotiating the transfer of Mrs. Gilgunn to a long-term care facility that would take her in, the attending physician began to reduce mechanical ventilation and Mrs. Gilgunn passed away three days later. The case was brought to court (Gilgunn v. Massachussetts General Hospital) and both the physician and the hospital were acquitted on the grounds that her state was irreversible, therefore, the hospital was not obliged to provide "futile" health care even if the patient's relatives wanted to.

PART B

The second important question we need to address is who decides to prolong the life of a terminal patient.

Either the decision is made by the patient or, when the patient is incapable of expressing his/her will, by others (according to the former's directives or without directives), the patient's autonomy must be respected according to the principle of "informed consent", which governs contemporary medical ethics and law. This means, in particular, that in regard to life prolongation, physicians are not allowed to take these matters into their own hands.

Patient's decision and medical liability

By expressing their autonomy in person, patients may decide on medical acts that support or sustain the organism's functions provided they are appropriately informed beforehand and are capable of expressing their free will.

This is the simplest version according to the "informed consent" principle (art. 5 of the Oviedo Convention). In this version, the physician still bears full responsibility for informing the patient, among other things, that continuation of curative care is futile.

If, upon having been informed of the futility of treatment and the possibility of palliative care, the patient consents, this means that they have accepted the inevitability of the end of life due to the disease and have directed their attention to the most painless possible coming of this end, both physically and mentally.

It is unequivocal in legal terms that the aim of withdrawing futile treatment and beginning to offer palliative care does not qualify as "murder with consent" in the sense of art. 300 of the Criminal Code: the physician neither "decides" nor "executes" murder out of pity "upon significant and persistent demand by the victim". Death cannot be viewed as the objective of medical intervention here: it is nothing more than the inevitable consequence of incurable illness; the real goal of medical intervention is to offer relief to the patient[7]. In this sense, criminal (or other legal) liability on part of

[7] Indeed, in this context, a physician might even hope for a "miracle" that would save the patient's life (depending on their philosophical or religious beliefs). In fact, the physician's acts exclude nothing so long as the patient is alive and, in this, they are different from acts hastening death.

the physician for violating art. 300 of the Criminal Code can hardly be established[8]. In ethical terms, if palliative care with the patient's consent constitutes the genuine goal of medical intervention, it appears as the only choice of the physician to honour their ethical duty of "beneficence, not-to-harm" when all other cures are considered futile. To the extent that death as "damage" is inevitable, the physician can only be morally vindicated by pursuing this "very real" benefit for the patient. On the contrary, the physician's insistence on futile and, at the same time, painful treatment when they know death is inevitable, cannot in any way be understood as bestowing any "benefit" to the patient.

In conclusion, the physician's compliance with the patient's will may be viewed, as an instance of "letting die" since the goal of medical intervention is not death. In this context, the medical act appears justified both legally and ethically.

Advance directives

i) The concept

Patients may not be capable of expressing their wishes for life prolongation at the critical moment (e.g. because they are in coma). In this case, the decision will have to be made by others but there may still be some scope for compliance with the autonomy of the person through the so-called "advance directives".

The term refers to oral or written instructions given by someone with regard to future medical acts that might concern them. These instructions are drawn up in advance in the event that the person concerned becomes incapable of expressing their will in the future. Thus, people may set out their personal values and wishes, prevent undesirable or burdensome, in their view, treatments and even designate an agent for the process of medical decision-making.

These directions concern, in particular, medical acts and life-supporting treatments. They usually refer to cardio-pulmonary resuscitation, administration of drugs to maintain heartbeat, arterial tension or/and treatment for microbial infections,

[8] This argument is corroborated by the official recognition of palliative care (art. 29(1), Code of Medical Ethics). This rule corresponds to the ethical duty of any physician to "stand by the patient until the end of their life and to ensure that they maintain their dignity until such time". Clearly, this duty makes sense when "futile treatment" has been abandoned. In this sense, the Code of Medical Ethics acknowledges futile treatment.

administration of oxygen, administration of nutrients and liquids with artificial means and dialysis. They reflect personal principles and values – for example, what one considers as acceptable quality of life, when one feels that their dignity or beliefs are offended by medical acts aimed at supporting or sustaining organic functions – and bring out all the ethical and legal dilemmas that accompany decisions at the end of life.

In fact, these directives fill the "gap" of informed consent and provide some form of guidance to the patient's relatives and to the physician in case of uncertainty on whether a medical act serves the patient's interest. Apart from filling the "gap" of consent, these directives also cover the right to refuse treatment. In any event, conflicts are possible between the patient's directives, on the one hand, and the legal and/or ethical liability of the physician, on the other hand.

For instance, in advanced states of degenerative senility (e.g. terminal stages of Alzheimer), one of the symptoms at the terminal stage is experiencing difficulty in deglutition. Hence, it is often necessary to artificially administer nutrition and liquids through tubes placed directly into the abdominal area through an incision. Now, as these patients are mentally impaired, they are unable to understand why these tubes were placed in their abdomen and pull at them, so they have to be tied down in a forced feeding position. Many patients, however, before they reach this condition, consider this as a violation of their dignity. Typically, a study showed that 95% of people over 65 years of age, when asked whether they would accept such aggressive treatments if they were in this condition, answered in the negative (Gjerdingen et al. 1999).

Despite evidence that artificial feeding does not help to improve the clinical situation of patients (i.e., it is a futile medical act), there is no agreement on whether and to what extent it deteriorates their condition. Therefore, the dilemma as to whether the physician should withdraw artificial feeding and administration of liquids (in view of the "not-to-harm" principle) remains. To what extent, then, may the medical and nursing staff comply with an advance directive to refuse feeding?

Another question that arises is whether the wishes expressed at a time prior to illness are in harmony with the person's wishes at subsequent stages. For instance, fear of a future or unexpected disease which, furthermore, is accompanied by the loss of capacity to express one's wishes, may lead the patient to reject future treatment, but at the critical moment he/she may want the treatment. Persons capable of expressing

their will often change their minds before or after the onset of disease, something which probably also happens to those who lose this capacity.
Hence, the binding nature of advance directives remains problematic. And, even assuming that such directives should and can be binding to some degree, what level of detail is required? This question arises because they are often general wishes and it is highly improbable that they predict the clinical situation accurately; therefore, they cover sufficiently only part of the medical decisions that may have to be made.

ii) Legal context and problems

Advance directives remain rather unknown in European continental law. Only Germany, Denmark and the Netherlands have adopted provisions to that effect. By contrast, countries in the Anglo-Saxon legal tradition (especially the US but also some States of Canada and Australia and, also, New Zealand) have relative experience both in terms of legislation and case law.
This institution reflects the increasing importance of the principle of informed consent in medical law and, in extension, the "allocation" of responsibilities between patients and physicians. Its development, particularly in the Anglo-Saxon world, might be explained by both the flexibility ensured by the case-law tradition (in order to decide cases that are different from each other) and the relatively wider influence of the patient's autonomy in medical law and ethics.
Advance directives are recognized by the Oviedo Convention (art. 9). They are treated as a special circumstance in Chapter II on "consent". Pursuant to this article:

"The previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account."

The wording lends itself to the conclusion that the persons responsible for treatment (relatives, physicians, nurses) may not ignore the patient's wishes, if they were expressed at a time when they had the capacity to express their will. This does not necessarily imply that these wishes are binding, but they must "be taken into account".
It may ensue from this article that the Oviedo Convention urges the national legislator to specify the term "taken into account". Therefore, the national legislator will have to

adopt specific regulations. In case the legislator remains idle, certainty of law will be impaired because the courts will lack a criterion to specify the term "taken into account" in specific disputes that may arise (e.g. between the physician and relatives or between relatives or between physicians). Some of the problems that special legislation may need to address are the following:

a) *What type of advance directives: "consent by proxy" or "living will"?*

In the first case, the party concerned simply designates a proxy who will decide on the course of future treatments if the patient loses the capacity of will. The proxy does not have to be a family member but also a friend. It would be easier to discuss the course of treatment with this representative, as the physician would not have to "interpret" the patient's wishes. The risk involved here is that the real will of the patient is substituted by the will of the representative.

In the second case of the so-called "living will", the party concerned provides instructions on the course of future treatments. Here the problem is presented in reversed form: the instructions must be "interpreted" (and so it appears necessary to ensure as much clarity and formality in the wording as possible, and to opt for strict interpretation) but it is certain that they do reflect the authentic will of the party concerned.

In any event, the content of the directives may vary: from persistent (to outright "heroic") continuation of treatment to avoidance of certain treatments (usually considered as violating dignity or as particularly painful) down to cessation life prolongation.

b) *Critical time for putting the directives into effect: how is the moment of loss of mental functions to be determined?*

The problem here may be divided in two parts.

The first part regards the criteria of loss of capacity as well as the eventuality of regaining consciousness – even if momentarily (as in this case patients may want to change their initial wishes). These questions may be regulated in broad lines based on medical or other scientific data (e.g. psychology) but in some borderline situations it may be necessary to call in a specialist or a scientific team to decide *in concreto*.

The second part regards the certification of critical time. This should preferably be the responsibility of more than one specialist as is the case with transplantations[9].

c) *Binding nature: when are third parties obliged not merely to "take into account" but to apply the directives?*

Undeniably, certain kinds of directives should not merely "be taken into account" by third parties but faithfully adhered to. These include, for instance, instructions to continue treatment or accept palliative care. The constitutional right of patients to health (art. 5(5) of the Constitution), the fundamental right to life (art. 5(2) of the Constitution, art. 2 of the ECHR) and the ethical duty of the physician to protect goods such as life, health and dignity justify this position[10].

A second set of directives must be evaluated separately, i.e. instructions to interrupt treatment or even to hasten death. The issue here is not different, in principle, from the general consideration of "active" euthanasia. So long as the latter is prohibited by law (art. 300 of the Criminal Code), the patient's wish cannot be binding because the physician remains liable under criminal law.

d) *How are directives safely communicated: how to ensure notification at the appropriate time and to the responsible persons?*

The issue is also linked to the form of directives. Written form seems to be the critical requirement, if certainty of law is to be minimally ensured. Plain oral statements (even before witnesses[11]) complicate things unreasonably, since there is no question of emergency.

At any rate, in some cases the written form might seem insufficient. It may be pertinent to require a notarial act with a concurrent duty on behalf of the notary to inform a special central archive. The creation of such an archive (e.g. in the Ministry for Health) would ensure immediate notification of advance directives, especially to physicians dealing with incapacitated patients, but also to third parties (e.g. heirs, remote relatives, insurance companies), in order to facilitate evidence in related

[9] See art. 12(6) of Act 2737/1999.
[10] See art. 2 and 9 of Act 3418/2005.
[11] The same is applicable in trasplants from a living donor. See art. 10 (5)(c) Act 2737/1999.

disputes. In any event, special care (perhaps a special legal stipulation) should be provided to protect personal data (needless to say, they are "sensitive" data).

Decision by third parties

What happens if third parties must decide on life prolongation because the patient is incapacitated and, moreover, has not made known their wishes in advance?
Here, there is total lack of expression of autonomy and the authentic will of the person concerned is necessarily substituted by the will of third parties. The Oviedo Convention and the common legislator have adopted specific provisions on who decides matters of medical intervention in place of the person directly affected and how.

a) "Who" decides?

Pursuant to the Convention (art.(6)), when the capacity to consent to an intervention is lacking, the intervention may *"only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law*."
In principle, minors are represented by their parents (or custodians) whereas adults are represented by their spouse or parents or children or the court's appointee[12]. These persons are generally empowered by law to care for the party concerned. As to medical interventions specifically, the issue is governed by the Code of Medical Ethics[13], but also by specific legislation (e.g. law on mental patients, transplants, etc.).
A question that arises here is whether such a serious decision on life prolongation should be treated in the same way as any other medical decision, i.e. whether it may be left to the general empowerment of third parties. If the answer is negative, the only solution consists in advance directives given by the person concerned; otherwise no third party may be allowed to make such a decision. This, however, would ultimately lead to a legal *lacuna* since it is not possible to force patients to issue prior instructions. Thus, since the above question must be answered in the affirmative, the problem of disagreement between "responsible" third parties must be addressed explicitly. One solution might be the absolute requirement of unanimity for

[12] See respectively arts. 1510 sqq., and 1387, 1507, 1666 of the Civil Code.
[13] See arts. 12 (2)(bb) together with art. 1(4)(b).

interrupting artificial life prolongation. In any case, in absence of unanimity, the physician should maintain the option to resign if they think that further treatment is futile[14].

b) "How" to decide?

The Oviedo Convention lays down three principles on this matter; third parties i) are previously informed as if they were the party concerned, ii) decide by themselves provided the incapacity of the party concerned continues, and, iii) decide in the latter's interest.

With regard to the question we are concerned with, as far as (i) is concerned, "appropriate" information obviously requires a framework (with corresponding infrastructure) of psychological support to the patient's relatives to help them deal with sobriety with the conclusion of "futile treatment", certainty of death and the options of palliative care. If this framework is not in place, it is uncertain whether information on the patient's condition contributes in making a decision.

As to (ii), the seriousness of the decision is such that the faintest prospect of the patient concerned being able to understand the situation and genuinely express their views (in any way whatsoever) supersedes the role of relatives; namely, the person concerned does not merely "participate" in the decision – as with other forms of medical intervention – but their will takes absolute priority[15].

In regard to (iii), it is doubtful whether relatives interpret the patient's "presumed" will as the latter's "interest" (based on the patient's beliefs and values which, however, are not proved by advance directives) or "translate" their own perceptions and values or (in the worst scenario) their own interests as the latter's "interest". Objectivity is ensured through the medical findings of the attending physician or, eventually, by the requirement of unanimity in case there are more than one attending physicians.

[14] Cf. art. 9(4) of the Code of Medical Ethics.
[15] As already applicable in clinical research (art. 17 of the Oviedo Convention).

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