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Moral Aspects and Ethical Principles of Terminal Patient Care in Palliative Medicine

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Abstract: *Palliative medicine, as a holistic embodiment of medicine, consists of several types of care, such as basic medical care, psychological, emotional, social and spiritual support in favour of terminal patients with chronic, progressive and life threatening maladies. The fundamental moral principle that ought to govern the above mentioned types of support is absolute compliance with patients' values, faith and religious convictions as well as for their decisions regarding treatment and end-of-life care that they choose to pursue as per their belief. If faced with several options that abide to medical ethics, the attending physician has the moral duty to select the option that respects the (properly informed) patient's wish, as it always prevails upon his health status. This consideration is based upon a deep respect for the modern principle of bioethics, i.e. the autonomy principle. The four cardinal principles of bioethics: autonomy, beneficence, non-maleficence and equity or justice (Beauchamp & Childress, 1979), which are also applied in palliative medicine, are prima facie principles, meaning that each of the principles has to be complied with as long as it does not contradict another bioethical principle, in which case one shall have to choose only one out of the two. These cardinal principles could offer support for a*

formulation of bioethical rules: truth, confidentiality, intimacy, loyalty.

Finding a way for complying with bioethical principles and rules in the midst of clinical, actual practice has always sparked debates that must be covered by a doctor-patient-family agreement, which can only be achieved by means of a proper communication between all three parties involved. Clinical ethics method helps us apply bioethical principles when life-prolonging therapies must be interrupted, stopped or withheld, for instance, when: the patient refuses treatment, his suffering overpasses the benefits, treatments are destined to fail, life no longer has meaning, the evolution of the disease is uncertain, the patient's family is "fighting" with the physician, prior requests lead to ethical dilemmas, or the suffering and the overall pain is overwhelming. We would also like to add the likelihood when a dying patient becomes a potential organ donor, a fact that will completely modify the current care procedures to mirror and support the whole view of organ harvesting. Thus, palliative medicine overpowers the temptation of euthanasia and assisted suicide that are currently gaining more and more ground by offering an actual alternative, enabling positive conditions for a dignified death which would indeed be the closest to a natural passing. All aspects regarding care

procedures for terminal patients rise a series of ethical issues at various levels, which require a careful examination and application thereof.

Keywords: palliative medicine, fundamental principles of bioethics, therapeutic persistence, clinical ethics method.

Palliative medicine, as a holistic embodiment of medicine, consists of several types of care, such as basic medical care, psychological, emotional, social and spiritual support in favour of terminal patients with chronic, progressive and life threatening diseases. Therefore, the beneficiaries of palliative care are usually chronic patients with lethal risk and an uncontrollable symptomatology, and, added to their somatic pain, they also experience psychological, social and spiritual pain. Examples of such patients include the neoplasia stricken and also geriatric patients, non-oncological patients, patients with cardio-vascular degenerative disorders, neurological disorders, dementia, organ-related insufficiency, AIDS, severe congenital malformations, as well as other chronic disorders that require continuous care or their symptomatology has an unpredictable evolution. (Twycross & Wilcock, 2003).

The fundamental moral principle that ought to govern the above mentioned types of support is

absolute compliance with patients' values, faith and religious convictions as well as for their decisions regarding treatment and end-of-life care that they choose to pursue as per their values, faith, and religious convictions, personal, cultural and religious practice. If faced with several options that abide to medical ethics, the attending physician has the moral duty to select the option that respects the (properly informed) patient's wish, as it always prevails upon his health status. This consideration is based upon a deep respect for the modern principle of bioethics, i.e. the autonomy principle of self-determination, the obligation to respect the decision-making capacity of autonomous persons over their course of treatment and/or care, after thorough and adequate counselling in order to support an informed consent. Along with the principle of autonomy, one must add the other cardinal three principles of bioethics that apply in palliative medicine: first, beneficence, which is the physician's duty to generate and maximize the benefits of his patient; second, the principle of non-maleficence, which requires to avoid inflicting any damage by reducing the risks of a medical intervention to a minimum. These two principles of traditional origins require a *sine qua non* comparison between risks and benefits of a medical intervention and

the issue of avoiding an overwhelming proportion of risks as opposed to the projected benefits (Veatch, 1989). Modern ethics also add the fourth fundamental principle of justice and utility or equity, which translates into patients' right to equal access to care and resources, and ultimately the achievement of a maximum benefit for a maximum number of treated individuals in the case of limited resources. These four fundamental principles of bioethics (Beauchamp & Childress, 1979) that underlie palliative care focus on providing an adequate quality of life for both the patient and his family. These principles are *prima facie* principles, meaning that each of the principles has to be complied with as long as it does not contradict another bioethical principle, in which case one shall have to choose one out of the two.

Based on the cardinal principles, one could offer support for a formulation of bioethical rules: first and foremost, truth, as a doctor-patient relationship can only be based on mutual trust; then, confidentiality, which renders the doctor and the entire care staff to respect the patient's intimacy (with some clearly specified exceptions); thirdly, loyalty, which translates in the doctor's obligation to go along with the patient and his entire family on their journey to the end of life as well as the obligation to use his entire

set of skills and expertise in order to ease the patient's suffering till his last breath according to his competence in attending a terminal patient, which can only be accomplished through training in the field of palliative medicine, which is a valuable instrument that confers a continuous resource of skills and knowledge that are necessary in ensuring a dignified death.

Palliative medicine can also ensure that a patient can maintain his dignity, regardless of the decay that had been generated by his disease or infirmity by means of a respectful, affectionate and loving manner of the care staff and most of all thanks to the possibility of ending their life in a lucid way, in peace and in a specifically designed welcoming environment, accompanied by a number of persons and volunteers that have a free and unencumbered interest in helping terminal patients as they face great vulnerabilities.

To die in dignity has already become a motto for the fight against attempts to prolongue life by means of current advances and technologies, although there are instances when the patient is no longer functional and the disease no longer allows him to exert control over his own existence (by persistence or therapeutic zeal).

Finding a way for complying with bioethical principles and rules in the

midst of clinical, actual practice has always sparked debates that must be covered by a doctor-patient-family agreement, which can only be achieved by means of a proper communication between all three parties involved.

Clinical ethics help us to apply bioethical principles when life-prolonging therapies must be interrupted, stopped or withheld, for instance, when:

- The (competent) patient refuses the treatment, in which case the principle of autonomy prevails. A classic expression of the principle of autonomy belongs to a famous judge, namely Benjamin Cardozo, who stated: "Any human being of adult age and mentally sane has the right to decide about what is to be done with their body". The patient's autonomy refers to his involvement in decision-making process, which also requires him to be adequately informed on matters of diagnosis, prognosis, therapeutic options and alternatives as well as other relevant aspects which pertain to care procedures.
- To respect a patient's autonomy also requires the existence of a series of practical skills, among which the most important is good communication with the subject and their family. A good flow

allows the patient and his family to be adequately informed about the proposed intervention and its more or less positive consequences. A good flow also lets us know when a patient does not wish to be informed. For instance, there are cases in which the patient does not want to be informed about a severe prognosis or he does not wish to take a decision by himself in which concerns choosing between several courses of therapy and he prefers to pass the responsibility to the physician and the staff. As for incompetent, comatose, permanently vegetative patients, children and mentally ill subjects, a decision is reached by their substitutes such as legal caregivers, parents, guardians, relatives or significant, or, should there be a conflict of interests, by means of a court order.

- When his suffering overpasses the benefits, the principle of proportionality reminds us that extending a certain course of treatment is ill advised if the suffering it inflicts surpasses its benefits, and it is directly derived from the fundamental principle of non-maleficence, which clearly stipulates against harm. As we apply this principle for terminally-ill patients, the reason for which therapeutic insensibility is

growingly challenged. Heroic or extraordinary treatments that are designed to extend life regardless of their cost, usually applied by those who obsess about ultimate salvation actually tend to extend the process of death rather than life. This therapeutic persistence has been an instrument used by modern medicine to create, as someone has stated, „human beings that are at the same time incapable of living and incapable of a natural death“ (Jean-Claude Larchet, 2010).

- When treatments are destined to fail. It is generally accepted that a patient is not obligated to endure futile treatments just as it is generally accepted that a doctor is not obligated to initiate or continue such schemes. The futility of an intervention is assessed by considering clinical targets for each patient. Currently, medical practice, including palliative medicine, willingly accepts that doctors have the obligation to only offer their patients a course of treatment that has reasonable odds of yielding a benefit. The concept of futility has two parts, i.e. the physiological effect and the patient's benefit. Some treatments are futile as they do not generate the desired physiological effect, for instance, they cannot put an ending to a metastasis of a patient

with advanced neoplasia. Another example is provided by antibiotics, which can cure pneumonia for a patient with irreversible and profound coma, yet they cannot bring him back to an active or at least partially independent existence. Such is the case with cardiorespiratory resuscitation, which is useless for a patient in an advanced stage of cancer that falls under a cardiac arrest. Resuscitation will not help him die in peace, pain-free, eventually just extending his agony. Interrupting a course of treatment or not starting it due to futility concerns does not signify that a patient has been abandoned, it only indicates the fact that care procedures focus no longer on curing but on the palliative area that aims at increasing or maintaining the patient's quality of life and promoting their dignity.

- When life has no meaning. Survival in a persistent state of absence of awareness is not of any significance for humanity and more often than not, it is said that it is worse than death. Persistent vegetative states do not require advanced intensive therapy actions and, although debates are still ongoing on this topic in palliative medicine, not even hydration or assisted feeding is not required in such states. However,

if there is an agreement with their family, hydrating and assisted feeding for a dying patient shall be considered as necessary, accompanied by other measures for pain relief.

- The evolution of the disease is uncertain. The patient's clinical evolution usually involves a moment when life support treatment must be interrupted so that he could die in peace. In the case of a "captive" patient who is completely aware of his environment, who has a medullar lesion or a neuromuscular disease that makes him rely on assisted ventilation, there is no universally unique protocol, as only a few considerations can be counted on: neither a doctor, nor a patient's family has the professional or moral obligation to engage into an escalation of growingly complex care for a patient who is highly likely to stay in intensive care, and from an ethical point of view, there is no matter about a difference between not starting or interrupting a life-prolonging treatment; the actual purpose of intensive therapy and resuscitation is to redeem a reasonable normal life to a human being. Intensive care is thought to have reached its peak if its only result is to maintain a "captive" patient who is reliant on life-support machines. At times,

patients understand their own situation and they can help their doctor and family to reach a final decision.

- The patient's family is „fighting“ with the physician. In a perfect context, a decision should be reached by the doctor and the patient's family, after the doctor has provided any and all necessary explanations and after carefully considering its advantages and risks. There are situations in which some families have particular interests and when an important member of the family falls ill, a fight for power arises even in the presence of the patient, as people forget or are unfamiliar with the fact that hearing is the last sense to perish. The most undesirable context is the one where the family substitutes the physician and as such, demands the implementation of certain procedures or medical techniques in an imperative and authoritarian manner. In this case, the patient is subjected to unnecessary pain and the doctor-family relationship is damaged by conflicts that are conducted not only in private, but unfortunately in public, in the media or in court.
- When prior requests lead to ethical dilemmas. Prior request strategy consists of a written list of the patient regarding who and what decisions should be made in which

concerns losing consciousness or acceptable courses of treatment. This process involves discussions regarding diagnosis, prognosis, treatment alternatives, their risks and benefits, placed in the context of the patient's personal values. As the disease evolves, a patient can change his opinion and they might want to resort to treatments that otherwise seemed unacceptable. The same goes for a delegate who might grow uncertain in which concerns the patient's wish or they just might not be able to take a clear decision. To support their patients, some authors have designed key principles of prior care planning and the principles of a decent death.

- When the suffering and the overall pain is overwhelming. An old ethical dilemma discusses whether a dying patient should or should not be heavily sedated. Despite actual aggressive efforts to identify a tolerable therapy that would not compromise awareness, pain and other symptoms cannot be adequately controlled. Selecting sedatives and their dosage depends on the doctor's experience and the patient's personality. This dilemma about administering a high dosage of sedatives until symptoms (e.g. dispnea, delirium) are under full control can be solved by conducting a series of

scientific studies regarding the effects of sedatives. When anxiety, depression and pain persist and become overwhelming, despite a course of treatment that envisioned maintaining consciousness, massive sedation of a dying patient is in place. For most professionals in palliative care, sedation has no connection to euthanasia. As an ultimate form of pain and symptom management, they believe that sedation renders euthanasia as useless. Others consider it as a form of "slow euthanasia" (Billings & Bloch, 1996), "a disguised, inhuman and hypocrite form of euthanasia". Having these controversial aspects in mind, some other authors choose for introducing the notion of „palliative sedation" (Broeckaert, 2000), defined as "voluntary administering of pain relief medication within the necessary dosage and combination to reduce the awareness of a terminal patient as long as it is required in order to ameliorate one or several symptoms that do not respond to other types of therapy" (Broeckaert, 2000).

We would also like to add the likelihood when a dying patient becomes a potential organ donor, a fact that will completely modify the current care procedures to mirror and support the whole view of organ

prelevation. The "deceased" patient, subject to organ prelevation, is reanimated and artificially supported until prelevation can take place, a fact that dismisses both ethical principles regarding therapeutic persistence as well as a doctor's moral duty, also written in Hippocrates' oath of doing no effort to extend agony. However, for ethically acceptable prelevations, bioethicists are unanimous in their opinion about performing prelevation with the full respect for a human being, whether alive or declared as deceased. "Post-decease organ donation can be authorized as long as respectful treatment is performed prior, during and after prelevation surgery".

Thus, palliative medicine overpowers the temptation of euthanasia and assisted suicide that are currently gaining more and more ground by offering an actual alternative, conferring positive conditions for a dignified death which would indeed be the closest to a natural passing away. All aspects regarding care procedures for terminal patients rise a series of ethical issues at various levels, which require a careful examination and application thereof.

References

1. Bogdan C. (coord.) Elemente de îngrijiri paliative oncologice și non-oncologice, Edit. Universitara, București, 2006:18-21.
2. Broeckaert B. Decizia de tratament la sfârșitul vieții. Cadrul teoretic. Sedarea paliativă. in *Tratat de îngrijiri paliative pentru asistenții medicali. Principii și dovezi pentru practica clinică*, Ediția I, edit. Sheila Paine, Jane Saymour, Christine Ingleton, Fundația Hospice Casa Speranței, 2012:463-465.
3. David JR, McDonald N. Ethical issues in palliative care, in *Oxford Textbook of Palliative Medicine*, Derek Doyle, Geoffrey Hanks, Nathan Cherny, Oxford University Press, 1998.
4. Ioan Beatrice, Moisa Ștefana, Dumitraș Silvia, Enache Mariana. Cadrul etic și legal al deciziilor privind tratamentul medical la finalul vieții în *Dileme etice la finalul vieții*, Beatrice Ioan, Vasile Astărăstoae (editori), Polirom, 2013:123-125.
5. Larchet J-C. Sfârșit creștinesc vieții noastre fără durere, neînfruntat, în pace. Edit. Basilica, București, 2012:208-209, 280.
6. Materstvedt LJ, Bosshard G. Euthanasia and palliative care in *Oxford Textbook of Palliative Medicine*, Fifth Edition, Edited by Nathan I. Cherny, Marie T. Fallon s.a., Oxford University Press, 2015:314-315.
7. Morar S. Dimensiuni etice ale stărilor terminale, în *Medicii și Biserica*, vol. VI *Perspectiva ortodoxă contemporană asupra sfârșitului vieții* (coord. Mircea Gelu Buta), Edit. Renașterea, Cluj-Napoca, 2008:140-145.
8. Mosoiu D. ABC-ul medicinei paliative, Edit. Lux Libris, Brașov, 1999:60-61.
9. Oana CS. Aspecte etice și juridice legate de perioada de sfârșit a vieții și de deces, în *Compendiu. Îngrijiri paliative la domiciliu pentru echipa multidisciplinară*, Editia I, sub red. Marinela Olăroiu, Edit. Viața medicală românească, București, 2004:278-282.

10. Poroach V, Parvu A. Îngrijirile paliative, în Dileme etice la finalul vieții, Beatrice Ioan, Vasile Astărăstoae (editori), Polirom, 2013:74-79.
11. Saunders C. Principles of Symptoms Control in Terminal Care, Medical Clinics of North America, 1982:1169-1171.
12. Taboada P. Bioethical principles in palliative care in Textbook of Palliative Medicine and Supportive Care, Edit. by Eduardo Bruera, Irene Higginson, Charles F.von Gunten, Tatsuya Morita, CRC Press Taylor & Francis Group, Second Edition, 2016:106-111, 116.
13. Zeppetella G. Îngrijirea paliativă în practica clinică. Edit. Farma Media, Tg. Mureș, 2014:188-190.