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End-of-life: still an Italian dilemma

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Introduction

Although decisions to forego life-sustaining therapies are increasingly made, there is still wide variation to withholding and withdrawing of life-sustaining treatments in intensive care units (ICUs) across Europe [1–3]. It is presently very clear that limiting such treatments is generally more acceptable among U.S. and Northern European societies rather than in southern European and Middle Eastern countries [1–3]. This is probably due to the fact that end-of-life care encompasses many nonmedical aspects, such as religious beliefs, cultural expectations, legal constraints, and personal values. Religion certainly has a powerful influence in ethical decision making in this field, as religious beliefs are reflected in the clinical practice. In particular, Catholic tradition emphasizes the sanctity of human life and considers euthanasia, assisted suicide, and, in some cases, interruption of the therapy, morally unacceptable. An additional problem when discussing either stopping or withholding treatment is misunderstanding and failure of terminology; thus, terms such as withholding or withdrawing treatment, palliative therapy, and euthanasia are often erroneously confused. Moreover, the untoward terminological variation is not only seen in doctors but also in journalists and laymen. This confusion often leads to the conclusion that end-of-life in many countries is chaotic, confused, and highly variable from clinician to clinician, also within the same institution. Furthermore, the lack of communication with families and within the medical team, an uninformed public about end-of-life issues, and insufficient training of ICU staff are crucial barriers to end-of-life development [1–3].

The statement from the 5th International Consensus Conference in Critical Care (Brussels, Belgium, 2003) highlights the differences between and within countries with regard to end-of-life decision making and especially recommends a collaborative approach between the caregiver team and the patient's family, respect for patient autonomy, pain-free death, and prohibition of treatments designed to hasten death [4]. Two milestones in the regulation of end-of-life practices have been the Oviedo Convention (1997), which supports the Advance Directives and the Living Will in different countries, and the Dutch Euthanasia Act, which came into effect in Netherlands in 2002 and whose long-term effects have been recently reported [5].

In Italy, it is in the latest news (*La Repubblica*, 24 July 2007, "Prosciolto il medico Riccio: staccò la spina a Welby"): the absolution of Dr. Mario Riccio, the anesthetist who on 23 December 2006 administered an intravenous cocktail of sedatives and removed the ventilator that had been keeping the 60-year-old Mr. Welby, who had been paralyzed by a severe form of muscular dystrophy, alive.

End-of-life in Italy

In Italy the debate on the end-of-life scenario is still in progress. Many political and religious personalities or associations have expressed a wide range of opinions [6–9]. The different views are influenced mainly by the strong religious and cultural traditions of Italian society. The same Catholic Church, which is obviously very sensitive to the issue, seems to have a clear position toward sedation and analgesia in terminally ill patients. In 1957, Pope Pius XII dealt with this issue stating at the Italian Congress of Society of Anesthesiology that "If the use of narcotics would cause the relief of pain and the shortness of life it would be legitimate." More recently, Pope John Paul II wrote that ". . . an effective way of relieving pain is intended, using analgesics made available by the medicine" (from "Evangelium Vitae", Chapter III, 65, 25 March 1995).

It is somehow surprising, however, that many doctors often have no definite position on this issue, and sometimes insufficient knowledge about it [7, 9]. Indeed, although Italy ratified the Oviedo Convention, a major problem is that, as with many other countries, Italy does not yet have clear-cut laws related to end-of-life care, thus making it very difficult or impossible to define whether a physician has the authority to make decisions about end-of-life care regarding limiting or withholding support in terminally ill patients. In fact, as euthanasia and physician-assisted suicide are illegal in Italy, any policy dealing with withdrawal or withholding of therapies must first prove that these current laws have not been violated. Additionally, Italian law currently does not recognize a legal right of relatives of incompetent patients as decision makers [8]. A recent survey by the National Federation of Corporations (FNOMCE) and the University of Udine revealed that 0.7% of the physicians interviewed admitted to having prescribed therapies intentionally and deliberately leading to death, and about 20% of them agree with "allowing their patients to die, by appropriately with-

holding or withdrawing life support (*Corriere della Sera*, 7 July 2007, "Medici: lo 0.7 per cento ha praticato l'eutanasia").

In the past few years much has been said and written about medical responsibilities and end-of-life-related issues, indicating that the awareness of the problem has reached the level of public opinion in Italy. In particular, some recent cases generated unprecedented public interest featured prominently in either national and European press [7, 9], thus indicating the urgent need for clear regulation of end-of-life care in Italy.

Furthermore, in this complex scenario, an additional factor creating confusion is the strong debate and the different points of view between anesthetists operating in university ICUs and those working in community hospitals. Thus, if on one hand Vincenzo Carpino, president of Italian Hospital Anaesthetists and Intensivists Association, declares absolute opposition to treatments aimed at inducing death in the patient (*L'Avvenire*, 8 March 2007, "Colleghi anestesisti, non staccate mai la spina"), and on the other hand, Prof. Luciano Gattinoni, president of Italian Society of Anaesthesia, Analgesia, Resuscitation, and Intensive Care, proclaims the freedom to choose when limiting (i.e., stopping or not starting) therapies in the case, these personal opinions are considered not to yield significant benefit to the dying patient; therefore, reasons for withholding or withdrawing therapy may include patient refusal, the unlikelihood that a patient will benefit from a therapy because of a poor prognosis, or the failure of a therapy to improve a patient's condition after a reasonable trial. The decision to limit treatment must be taken carefully with the patient's desires and values ideally guiding the process (SIAARTI document, Milano, 15 December 2006).

More recently, also the most important association of Italian catholic physicians recognizes that "the freedom of end-of-life decision is not in contrast with the sanctity of life" (*Corriere della Sera*, 20 July 2007, "Il medico cattolico: sì al testamento biologico").

Recently, the absolution of the anesthetist Dr. Riccio is giving rise to fierce debate. At the end of 2006, Dr. Riccio removed the ventilator that had kept the 60-year-old Piergiorgio Welby, paralyzed by a severe form of muscular dystrophy, alive for almost 10 years [9]. On 22 September 2006, as his condition had taken a turn for the worse, Mr. Welby made a plea to his country's president to be allowed to die. The man speaking via a computer that interpreted Welby's eye movements appeared several times on television news asking for "peace for a tortured and shattered body".

Despite the rejection of a court in Rome of Welby's request to have physicians switch off his life-support machine, on 23 December 2006 Dr. Riccio, an anesthetist from the Hospital of Cremona, administered an intravenous cocktail of sedatives and disconnected the respirator keeping the 60-year-old man alive (*Il Sole 24 Ore Sanità*, "L'ultima notte di Piergiorgio Welby," 26 December 2006). Dr. Riccio's justification is that Article 32 of the Italian Constitution gives patients the right to refuse medical treatment, and that physicians from the ethical point of view must spare terminally ill patients when their condition cannot be improved and death is inevitable (*Il Sole 24 Ore Sanità*, "Codice di deontologia medica: I diritti e doveri dei professionisti in 75 articoli e due linee guida," 26 December 2004); however, for this act, the physician risked up to 15 years imprisonment since both active euthanasia and physician-assisted suicide are illegal in Italy. The recent news of his absolution at a preliminary stage of the trial had great impact on public opinion, giving raise to a heated debate involving political, ethical, religious, and medical aspects (*La Repubblica*, 24 July 2007, "L'eredità di Welby e il diritto di morire").

Professional guidelines and towards a national law

At the political level, Italy ratified the Oviedo Convention supporting the Advance Directives and the Living Will. Furthermore, the Italian National Committee for Bioethics recently supported and encouraged the Parliament to legislate in order to recognize the advance directives as well as to regulate the end-of-life issues ("Dichiarazioni anticipate di trattamento", 18 December 2003; http://www.governo.it/bioetica/testi/Dichiarazioni_anticipate_trattamento.pdf) [7]. The debate is very complex and some medical societies have felt the need to take up a position on this issue to guide intensivists and all physicians who deal with terminally ill patients on a daily basis [10]. Also the Italian Society of Anaesthesia, Analgesia, Resuscitation, and Intensive Care recently set up a bioethical board to develop a consensus position statement of intensivists on end-of-life care in Italian ICUs. On the basis of these guidelines and following the example of other European countries, such as France [11, 12], a draft bill on "Treatment of Terminally Ill Patients" proposed by the Senator Giorgio Benvenuto has been developed in Italy (Atto Senato n. 357; Disposizioni in materia di dichiarazione anticipata di volontà sui trattamenti sanitari; http://www.senato.it/japp/bgt/showdoc/showText?tipodoc=Ddlpres&leg=15&id=00209092&offset=434&length=19968&parse=no). The proposal of law has obtained a broad consensus among Members of Parliament and the support of the Minister of Health and is due to be discussed in Parliament at the soonest opportunity, hopefully culminating in appropriate legislations in the next few months.

Conclusions and future directions

The ideal guidelines when dealing with the end-of-life issues should take into account several aspects, including adequate pain management, relieving

burden, and, last but not the least, appropriate information/consultation with the patient's family. Moreover, special awareness of professionals and innovative ideas are mandatory to promote a high standard of end-of-life situation. An effective strategy in this important aspect of the practice of critical care medicine should thereby help not only to save costly resources, but also to prevent unnecessary suffering to the patient and the family.

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