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The preservation of life as a duty and a right

Giuseppe Basile

Legal Medicine Unit, Clinical Institute San Siro - Trauma Surgery at Traumatology Unit, IRCCS Orthopedic Institute Galeazzi, Milan, Italy

Abstract. With considerable insight for the time, 65 years ago Pope Pius XII outlined a proposal of evaluation criteria based on the distinction between ordinary means of care, i.e. those who do not entail unreasonable sacrifices which would be unacceptable for most professionals and patients, and extraordinary care procedures which, although not mandatory, could be used if one had the intellectual, moral, spiritual, scientific and organizational awareness, capabilities and strength to put them in place. The Pope thus addressed the extremely complex set of bioethical issues stemming from the implementation of resuscitation procedures for those who have no hope to recover. The core belief was that every decision based on free consent to treatment should be made within the framework of an underlying and essential linkage between the rights and duties of doctors and those of patients. The identification of the patient as the ultimate decision-maker, when it comes to their health and the therapeutic interventions to be administered, has been the result of a cultural and legal evolution, in keeping with the principle of consent enshrined in art. 32 of the Italian Constitution, according to which "no one can be obliged to undergo any given health treatment except by law. The law cannot therefore exceed the limits imposed by "respect for all human beings". On March 10th, 2022, the Italian Chamber of Deputies enacted the unified text C. 2-A and abb., which codified provisions on "medically assisted voluntary death" regulating the right to request medical assistance in dying, provided that specific requirements and conditions be met. This short report is meant as an attempt to put into perspective such fundamental values, against the backdrop of the therapeutic alliance between doctors and patients and the ethical, legislative, and regulatory complexities which are bound to arise.

Key words: end-of-life ethics, conscientious objection, medical assistance in dying

Introduction

The bioethical issues arising from resuscitation procedures for patients whose health is irremediably compromised were already addressed 65 years ago by Pope Pius XII (1). The Pope, with considerable analytical depth, laid out a proposal of evaluation criteria based on the distinction between ordinary means of care, which do not impose unreasonable sacrifices unsustainable by most, and extraordinary care procedures; the latter, although not mandatory, could be used if one had the intellectual, moral, spiritual, scientific, and organizational wherewithal to support them. This short report has been conceived as an attempt to put into perspective such fundamental values, within the essential framework of the therapeutic alliance between doctors and patients and the ethical, legislative, and regulatory complexities which are bound to arise and must be addressed by lawmakers.

It was believed that every choice based on free consent to treatment should be made within the framework of the essential correlation between the rights and duties of doctors and patients. The cultural and legal evolution has led to the identification of the patient as the ultimate decision-maker when it comes to their health and the therapeutic interventions to

be administered. Such an association is in keeping with the principle of consent already sanctioned by art. 32 of the Italian Constitution (2), which states that "no one can be obliged to undergo any given health treatment except by law" and that the law cannot in any case exceed the limits imposed by "respect for the human person". Such a rationale is adherent to other international treaties such as the European Convention for the protection of human rights and dignity of the human being with regard to the application of biology and medicine, also known as the "Oviedo Convention", conceived to foster and uphold human rights in biomedicine at a transnational level and signed on 4th April 1997 (3). Not only does the Convention codify the underpinnings of consent to treatment, but it also defines standards for catering to those incapable of providing legal consent (under Article 6 – Protection of persons not able to consent). The Italian Chamber of Deputies enacted on March 10th, 2022, the unified text C. 2-A, which codified provisions on "medically assisted voluntary death" regulating the right to request medical assistance aimed at the voluntary and autonomous termination of one's life, provided that specific requirements and conditions be met (4). Such new legislation enacted to govern medical assistance in dying has been conceived according to the fundamental principles set forth bythe Italian Constitutional Court, which also includes the right of healthcare operators to invoke conscientious objection (5), as well as Code of Medical Ethics in its latest updated version (6). Still, concerns have been raised about the possibility that conscientious objection could make the law almost inapplicable, as it is already the case with voluntary termination of pregnancy (7). In fact, especially in some areas of the country, abortion, or even emergency contraception, are difficult to access because of the high number of objecting gynecologists and obstetricians (8, 9).

Those who hold religious beliefs usually view life as a gift from God; non-believer on the other hand view it as an unfathomable mystery. From a conceptual perspective, end-of-life issues should be approached in a different way. The preservation of life is both an obligation and a right, for the patient as well as their doctors, interpreted in the light of reason and taking into account historical times and the evolution of ethics values and science.

Pius XII's perspective is still current

In the "*Discours du Pape Pie XII en réponse à trois questions de morale médicale sur la réanimation*" (Speech by Pope Pius XII in response to three questions of medical morality on resuscitation), held in the Salle Royale on 24th November 1957 (1, 10), i.e. nearly 65 years ago, issues of bioethics on the end of life and on doctor-patient-family relationships were addressed, by the enunciation of proposals meant to provide solutions to the several problems that anticipated some legislative choices over time and which were inspired by such a degree of spirituality and sense of reality as to be still essential today. The Pope spoke in response to questions posed by Dr. Bruno Haid, head of the anesthesiology section of the University Surgical Clinic of Innsbruck.

Pius XII argued that "natural reason and Christian morality say that a human being (and whoever is tasked with caring for others) has both the right and the obligation, in case of serious illness, to receive the necessary care to preserve the life and health…" But usually only resorting to ordinary means is deemed obligatory (according to the circumstances of people, places, times, culture), i.e. means and measures that do not impose any extraordinary burden on oneself or on others. A heavier obligation would likely be too burdensome for most of us and would make it too difficult to pursue and achieve the superior good. Life, health, every temporal activity, are in fact subordinated to spiritual ends. On the other hand, it is not forbidden to do more than strictly necessary to preserve life and health, provided that it does not lead to failure in more serious duties ... Does an anesthesiologist have the right, or even the obligation, in all cases of profound unconsciousness, even in those completely hopeless in the opinion of a competent doctor, to use modern artificial respiration devices, even against the will of the patient's family? In ordinary cases it will be admitted that the anesthesiologist has indeed the right to do so, but they are not bound to do so, unless it is the only way to satisfy some other certain moral duty. The doctor's rights and duties are related to those

of their patients. Doctors, in fact, have no separate or autonomous right towards their patients; in general, they can only act if the patients authorize them to do so, whether explicitly or implicitly, (i.e. directly or indirectly). The resuscitation techniques herein discussed have nothing immoral *per se*; even the patient - if capable of making personal decisions - could choose them and lawfully authorize the doctor to implement them. Furthermore, since these forms of treatment go beyond the ordinary means which one is bound to implement, it cannot be argued that it is mandatory to use them and, consequently, that doctors should be previously authorized to do so. The rights and obligations of the family, in general, depend on the presumed will of the unconscious patient of legal age and "*sui iuris*" (i.e. not under any legal disability, or subject to the authority of another person). If, however the resuscitation attempt seems to be such a burden for the family that it cannot be imposed in good conscience, they can legitimately insist that the doctor stop their attempts and the doctor should legitimately comply. In this case, there could be no direct disposition of the patient's life, including euthanasia, which would ever be lawful; even when it leads to the cessation of vital functions such as blood circulation, the interruption of resuscitation attempts is always and only an indirect cause of the cessation of life, and in this case the principle of double effect and that of the "voluntarium in cause" must be applied.

Discussion

The above cited excerpts show how Pius XII explained that according to natural reason and Christian morality, one is obliged to use ordinary means and measures of care (11). Such options are in his thoughts those possible according to the circumstances of each individual patient, places, times and culture; they are not concepts inspired by an ethical situational relativism, but rather by an honest and respectful realism concerning the human person: patients and doctors are not asked anything more than they can give to preserve life and health. Doctors and patients must agree, become allied and cooperate towards achieving the maximum possible positive result, according to the material and intellectual strengths of both, bearing in mind that the relationship between doctor and patient is the convergence of two consciences. The obligation to use ordinary means must be related to the state of knowledge, the organizational capabilities that vary from place to place, from time to time, according to cultural orientation. Certainly in 1957 the medical resuscitation and surgical procedures were still in their infancy, as was the knowledge of oncology, including the role of viruses in the etiopathogenesis of many diseases and tumors (12), kidney transplants (13); hence, no discussion of viral infections in kidney transplants (14) occurred, for instance. At the time, procedures which we routinely implement were extraordinary means bordering on futile care, whereas today they are highly specialized treatment methods, widespread all over the world.

Each choice must be subordinated to previous authorization (i.e. consent as intended nowadays) (15), whether explicitly or implicitly, directly or indirectly, by the patient to undergo medical procedures: the rights and duties of the doctor are thus closely related to those of the patient. Such a strong link between the caregiver and the patient, which according to Pius XII was inspired by Christian brotherhood, but also by natural human interpersonal solidarity, can enable us to achieve that which is prescribed by laws and regulations by ordinary means. This however should not prevent us from doing more than strictly necessary to preserve life and health, provided that we do not fail in more serious duties. Those who have the moral strength, the intellectual skills, and the organizational capabilities to harness extraordinary means (in the case of medicine: researchers, scholars, highly specialized experts) must find the courage to seek new solutions. Over time and in the common sense of patients, such novel paths will then become ordinary means.

Conclusions: our core ethics values as the cornerstone of new standards as knowledge and technologies progress

We need to reflect and draw upon such concepts from 65 years ago, rather than "delegating" the morality of medical action to the compilation of forms, to formal compliance with directives often detached from the medical and human reality of individual cases.

As already argued by other authors (16, 17), the challenge which needs to be addressed is how to reconcile the patient's right to self-determination with the ethical principles which constitute the basis of medicine; such principles do not need to be applied in absolute terms, but rather include various views, beliefs, and approaches on end-of-life issues.

It is necessary to start an open and broad-ranging dialogue meant to elaborate on ethical and medical issue by drawing the attention of the entire medical scientific community to this issue; the fundamental purpose must be to devise adequate guidelines and policies to provide guidance and protection for patients and doctors (17-19).

We as scholars must take it upon ourselves to contribute by disseminating research centered around cases in which we have been, or at least tried to be, consistent with the concepts herein briefly discussed.

Conflict of Interest: The author declares that he has no conflict of interest regarding this manuscript

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Correspondence:
Giuseppe Basile. Legal Medicine Unit, Clinical Institute San Siro - Trauma Surgery at Traumatology Unit, IRCCS Orthopedic Institute Galeazzi, Milan, Italy
E-mail: basiletraumaforense@gmail.com