Right to live, right to die? 
The medicalisation of the end of life

“O Lord, grant death to each in one’s own way. Grant that one may pass away from a life that was filled with love, meaning, and desire. For we are only hull and leaf. The large death, which each carries within, is the fruit around which all it spins.”

Rainer Maria Rilke, Das Stundenbuch, Von der Armut und dem Tode

O Herr, gib jedem seinen eignen Tod. Das Sterben, das aus jenem Leben geht, darin er Liebe hatte, Sinn und Not.

It could be your mother, sister, friend...

Maria K.; age 82, academic, physically active, socially engaged,
- Heavy smoker, COPD, since 4 years suffering from lung cancer
- Decision with her family physician for only symptomatic treatment,
- Advanced directive notarized against any invasive therapy, artificial ventilation
- Lately increasingly problems of breathing (COPD)
- One evening in February admission at (her usual) private hospital - where the advance directive is known - because of pneumonia

- During the night cardiac arrest, resuscitated by physician on night shift (with broken ribs and sternum), sedated and intubated in ICU
- Next day, tubes are removed, palliative care provided
- Maria K. dies within 24 hours

Medicalisation of the end of life

Disproportionate treatment versus „Salus aegroti ultima lex“
Where do people die? An international comparison of the percentage of deaths occurring in hospital and residential aged care settings.

Broad JB et al; Int J Public health. 2013

Perceived process issues leading to inappropriate life-prolonging treatment.

Perceived responsible parties for inappropriate life-prolonging treatment.

Where do people die? An international comparison of the percentage of deaths occurring in hospital and residential aged care settings.

Broad JB et al; Int J Public health. 2013

Disproportionate treatment

"It is a clear and undisputed principle that treatments which are not (or no longer) indicated or treatments which the patient refuses must not be performed.

There are still cases where disproportionate treatment is initiated. This results in diagnostic, therapeutic or care-related interventions whose benefit for the individual patient is highly questionable and which may expose the patient to a stressful situation that becomes problematic."
The two following aspects are of crucial importance:

- The outdated and imprecise terms "active and passive euthanasia" need to be revised in accordance with the "Recommendations for the terminology of medical decisions in end-of-life situations" released by the Bioethics Commission.
- This shall be taken into particular account in the education and training programs for the legal and medical professions.

Trust and legal certainty in cases of limitation or discontinuation of medical measures which are no longer justified has to be established and to be exempted from legal punishment, when

- The therapeutic decision is based on a comprehensible, substantiated and to the individual situation corresponding decision-making process.
- Ethical standards and guidelines by professional associations, academic ethical institutions or supranational institutions are followed.
- Adherence to decision-making process is guaranteed.

Compliance with clear guidelines should lead to the presumption of trust and to legal certainty for the treating physician.

Advance planning of medical end-of-life decisions shall be promoted through the following initiatives:

- reducing the formal and financial hurdles to the establishment of legally binding living wills and powers of attorney
- defining and checking quality standards and qualifications to assure proper information of healthcare and legal professionals
- raising public awareness through a national program
Respect of the patients’ will
Appropriate care for the patient

Doctors’ Personal End-of-Life Preferences

Thank you for your attention!

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