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REWIEW

End-of-Life Decisions and Their Legal Status in Turkey

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ABSTRACT

With the developments in medical technology, most deaths have started to take place in the intensive care units of hospitals. Therefore medical staff have become decision-makers of the time and type of death. Such decisions put medical staff into conflicting situations in ethico-legal terms. In Turkey there is no specific law, which regulates the decisions made by the medical staff at the end-of-life. Instead, existing laws are adapted to healthcare. However, the rapid development in medical technology and the concomitant ethical problems has not made it easier for the law to keep pace with these developments. Ethical guidelines which are prepared by medical associations and related institutions should lead the way for medical staff in such decisions. In this article, after describing the ethical decisions which are taken at the end-of-life and the criteria for such decisions, the existing legal regulations in Turkey will be specified.

Key words: End of Life Care, Withholding Treatment, Withdrawing Treatment, Futile Treatment, Euthanasia, Do Not Resuscitate (DNR) Orders

Introduction

With the developments in technology, end-of-life palliative care has enabled an extention in lifespan and as a result an ability to delay death (1). Deaths are taking place in the intensive care units of hospitals rather than in homes of patients. Therefore, medical staff and the relatives of the patients have become the decision-makers for the death of the patients. Withholding treatment, withdrawing treatment, futile treatment, euthanasia, Do Not Resuscitate (DNR) orders are among the decisions, which are made at the end-of-life situations on the ward.

It is possible to see withholding treatment and withdrawing treatment as a type of abandoning, leading to the death of the patient. The ethical discussions about this issue can be collected under two main groups. While the first group claims that there is no ethical difference between withholding treatment and withdrawing treatment, the second group claims the contrary. For most clinicians, not to start treatment is ethically more defendable while they believe withdrawing treatment is almost equal to killing the patient. According to others, it is not possible to estimate to which extent the treatment will work before starting it, though once it is understood that the treatment will only delay death it can be withdrawn (2).

The end-of-life decisions are complicated and multi-faceted. It is not possible to consider such decisions as only medical decisions or decisions, which concern only the patients and their relatives. The four topics: case analysis method which is used for ethical decision-making in clinics takes into consideration these various factors. These are "medical indications", "preferences of the patient", "the concept of quality of life" and "contextual features". Under the heading of the preferences of the patient, answers for the following questions are sought: What can we say about the personality, values, wishes of the patient? Is the patient able to understand the information which is provided? Is the patient mentally capable? Who is the appropriate surrogate of the patient if he/she is incapacitated for decision-making? (3). Quality of life of the individual is about the adequacy of the physical, social and mental functions of the patient or his/her ability to survive independently.

The conception of quality of life changes in accordance with the values, beliefs, experiences and expectations of the individual (4). Here appears the question, whose understanding of quality of life is at issue? The following are also questions related to such decisions: Is it the understanding of the physician or the patient or again his/her relatives? Does the family understand the other factors about the case? Are their any prohibitions emanating from their religious beliefs? Is the cost of healthcare a factor in their decision? What do court decisions, laws or institutional policies say? How does the society approach the issue? Are there any problems in terms of allocation of resources? All these factors should be taken into consideration when making decisions in end-of-life situations.

Ethical decision-making at the end-of-life in various countries has been subject of extensive research (5-9). For example, in a study from 16 European countries which was conducted in 1999 by Vincent (10), it was found that various factors like the physician's age, education, religious belief, the pressure from spouses and family, patient's age, quality of life and wishes plays a significant role in decision-making in end-of-life situations. In addition, DNR orders can be given verbally or in written form in different countries and among physicians. According to this research DNR orders, withdrawing treatment and the use of drugs untill death are not commonly expressed verbally in Greece, Italy, Portugal and Spain. In these countries, patients or their relatives do not participate in decision-making at the end-of-life situations for these are considered medical decisions (10). In a 2003 study, which was conducted in 17 European countries including Turkey, similar 'ethical' results were found (11). Similarly, in another study on European countries, it was observed that patients and their relatives were excluded from the decision-making process and that they were only informed about the decisions already made (12). According to another study which was conducted in Turkey, physicians prefer to express the DNR orders verbally and to retain or limit treatment instead of withdrawing treatment or using morphine (13). In short, decision-making in end-of-life situations vary in different countries with respect to cultural and legal differences.

As can be seen in the examples above, end-of-life decisions are regarded as medical decisions in our country and they are made by medical staff, especially physicians. Thus, these decisions are not discussed with patients or their relatives. As a part of the autonomy of the patient which is one of the principles of biomedical ethics, the patients and their relatives are expected to participate in end-of-life decisions. However, in paternalist cultures, principles of being useful and not causing harm have precedence over the autonomy of the patient (14). According to a study, which was conducted at Hacettepe University by Odabaşı and Büken (15), physicians and patients attribute priority to the authority of the family and the physician over the autonomy of the patient. As a result, making decisions in end-of-life situations are regarded as medical decisions and they are made by physicians in Turkey.

The aim of this paper is to discuss end of life decisions and to underline the lack of legal status in Turkey and also the importance of ethical guidelines.

The Legal Status in END-OF-LIFE Issues in Turkey

In Turkey there is no law, which specifically regulates the decisions made in end-of-life situations. Instead, the existing regulations are adapted to such situations. As a result, medical staff and the practitioners of law may have different interpretations about the issue. The existence of different views leads to greater problems in the field of medicine, as it is not possible to find regulations for each specific case.

According to an interpretation, there are some ordinances in the 81st, 83rd and 84th articles of the law number 5237 of the Turkish Criminal Law (TCL) which limits the decision/actions of physicians. In the 81st article, it is stated that in a case of premeditated murder the offender is punished with life sentence. Others claim that this article cannot be applied to physicians and that it would be more appropriate to speak about negligence in these cases. The 83rd article, on the other hand, describes the cases of causing death by negligence and states that in order for a person to be held responsible for causing death by not following his/her executive duties, these responsibilities should be established by laws and contracts and that these acts should be endangering the lives of others. Some jurists evaluate the case of passive euthanasia with this article. According to this view, there is an attorney agreement between the physician and the patient and if the physician applies passive euthanasia by withdrawing treatment, this case should be evaluated by using this regulation. Thus, these jurists consider withdrawing treatment or DNR orders as passive euthanasia. On the

other hand, patients are sometimes discharged from the hospital and sent home or DNR orders are given verbally with the consent of their relatives without the knowledge of the patient in the cases in which the illness of the patient could not be specified. These cases can be defined as passive euthanasia even though they are not expressed as so.

In the first clause of the 84th article of the law about suicide in TCL, the following statement is given: "*the person who instigates or encourages suicide, helps someone to make the decision or commit suicide in any way will be sentenced for two to five years of imprisonment*". Based on this statement, it is argued that suicide with the assistance of the physician is a crime to be punished by imprisonment.

Euthanasia is the annihilation of the life of a patient whose illness cannot be cured under the current conditions and who suffers from severe pain with the valid demand of the patient or persons who are entitled to make decisions for the patient. Euthanasia can be classified as passive and active in terms of the actions of the physician; voluntary, non-voluntary and involuntary in terms of the approval of the patient; direct or indirect in terms of the type of the action (2). In the 13th article of the Regulation on Patients' Rights -"Euthanasia Prohibition"- (17) the following statement is given: "*Euthanasia is prohibited. The right to live cannot be relinquished for medical or other reasons. The life of a person cannot be terminated by the consent of the person in question or anyone else*". However, in the 25th article of the same regulation which is entitled as "Refusal and Withdrawal of Treatment", the following statement is given: "*Except in legally compulsory situations and given that the patient is responsible for the negative consequences, the patient has a right to refuse and demand the withdrawal of treatment which is or planned to be applied. Under these conditions, the patients or their legal representatives or their relatives should be informed about the consequences of withdrawing of treatment and a written document which explains the situation should be acquired. The usage of this right cannot be used against the patient in case the patient applies to the healthcare institution again*". In other words, the patient has a right to refuse and demand the withdrawal of treatment. After being informed about the situation sufficiently, the patient may demand the withdrawal of the life support care by his/her own will. The transfer of the right to make such decisions to the patient's relatives is possible only if the patient does not have the ability to make sensible decisions. In the case of the patient or relatives who are entitled to make decisions in the name of the patient, use the right to refuse or demand the withdrawal of treatment when they are fully informed about the situation, medical staff will not be considered guilty before the law.

As expressed above, the lack of regulations, which are specifically prepared for healthcare, and the adaptation of other regulations to these cases brings about the occurrence of different views and confusion. The legal regulations in Israel on this subject can be regarded as an example. The Dying Patient Act was developed in 6 years; all interested parties took part in the discussions. A committee of 59 people was divided into 4 commissions under the titles of medicine/science, philosophy/ethics, law and Halakha (Jewish Law). The law defines two types of treatment. The first one is continuous life sustaining therapies: these services cannot be terminated for this will be regarded as shortening the lifespan. The second one is intermittent life sustaining therapies: treatment like dialysis, chemotherapy and radiotherapy can be terminated. Although active euthanasia and suicide with the assistance of the physician is prohibited in this law, if the patient has the ability to make decisions and if he/she refuses treatment including sustenance and fluid replacement, the patient's decision is respected (18).

However, it should not be forgotten that the main source defining ethical boundaries of the actions of the physician should be based upon ethical guidelines, because ethical problems are becoming diversified with the rapid development of medical technology. In most cases, law cannot draw the boundaries of medical actions. Therefore, ethical guidelines, which are prepared by the ethics committees of hospitals/clinics and medical associations, will guide medical staff concerning their decisions about end-of-life situations. In this regard, the declarations on ethics prepared by the Ethics Committee of the Turkish Medical Association (TMA) can be given as an example (19). According to TMA's Declaration on the Ethics of End-of-Life;

1. In case of medical inexpediency, ventilator support can be withheld or terminated;
2. Artificial sustenance/fluid replacement, which extends the pain of the patient and delays the expected death, can be terminated;
3. If the patient's quality of life is very low and life support cannot enhance it, the patient may not be resuscitated.

Conclusion and Evaluation

Ethical decision-making at the end-of-life is a multi-faceted, multilateral and a complex issue. There are different issues according to the age group and discussions regarding children should ideally be handled seperately. In this article we discuss in general. While making such decisions, medical staff, patients and relatives should take into consideration not only the medical conditions, but also the environmental factors and legal issues. There is no specific regulation concerning the end-of-life decisions in Turkey. The adaptation of existing regulations to these cases creates obscurities and differences in opinions. This puts medical staff, especially physicians who are in the decision-making position into difficult situations. In addition, in a period when the discussions on patients' rights and awareness on this issue have increased, it has become apparent that specific regulations concerning this field of medicine which is agreed upon by all parties, as in the case of Israel, should be developed. However, considering that legal regulations will lag behind the developing technologies, preparation of ethical guidelines by professional organizations and institutions will be more beneficial for medical staff, patients and their relatives. In that sense it would be convenient to consider hospitals/clinics ethics committees (HEC) separately. HECs are useful units for diminishing the pressure on medical staff in decision-making in end-of-life situations. In Turkey HECs are in a development process and they are not widely used (20). These multi-disciplinary structured committees will surely be useful for medical staff, patients and their relatives in end-of-life decision-making with the ethical guidelines they prepare and the ethics consultation services they will provide. The ethical discussions about end-of-life decision-making and the ethical guidelines may also shed light on the legal regulations which will be developed in the future.

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