Chapter

End-of-Life Ethical Dilemmas

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Abstract

Although known and debated since ancient Greece and Rome, the end-of-life ethical dilemmas are increasingly exposed to disputes and controversies. The main reason is the technoscientific progress that has been progressively increasing the life expectancy but not, in the same measure, the quality of life. The process of death, that can be lengthened or shortened by technical procedures, is in the forefront of the end-of-life ethical dilemmas. The meditations and opinions about these questions are sometimes based on misconceptions. A broad and inclusive analysis should consider, among others, a historical review of these topics and point out how various sectors of the society observe and scrutinize these plights. An analysis, about any controversy, is not conscientious if it does not point out a solution or at least a proposition to mitigate the disputes. It is in this context that, in the lack of biomarkers that can predict with accuracy the end-of-life, I recommend in this essay, the living will and other advanced health care directives, as a reasonable solution to lighten to a certain extent the ethical dilemmas of end-of-life.

Keywords: end-of-life, life-sustaining treatments, medical futility, treatment stubbornness, withdrawing and withholding treatments, drugs double effects, religions and end-of-life, health care advanced directives

1. Introduction

Since the dawn of the hominization, one of the main distinguishing features of the humankind, was its concern with death.

Medically, death is defined as the irreversible cessation of all vital functions especially as indicated by permanent stoppage of the heart, respiration, and brain activity.

The focus on end-of-life ethical dilemmas are not mainly centered on the moment of death but rather in the process of death, the interval of time that encompasses the lifetime from the diagnosis of a disease that will irreversibly end, in a relatively short period of time, in the death of the person.

To understand the ethical problems of end of life, the discussion about the topic of this chapter reviewed the precepts of a medical procedure and the bioethical principles that professionals should refer to in case of confusion or conflict.

Although, currently very much in vogue, the end-of-life ethical dilemmas can be traced back to ancient Greece and Rome. Physicians and medical procedures about the end-of-life were a theme of opinion and cogitation and subjected to a code of conduct.

In those ancient civilizations, the apprehension which was initially centered on the metaphysics of moment of death shifted progressively to the quality and consequence of how one lived his life, in other words, there ought to be a nexus between the precepts that guided an individual life and his death.

In the western world, throughout the ages, the ethics of end-of-life was connected to the ideas the societies had about the philosophy of life.

With the evolution of science and technology the epicenter of the debate shifted from philosophy to the consequences of the inventions of technoscience. The innovations of devices that can replace the organs in failure, thus prolonging (dysthanasia) or shortening (euthanasia) of death process and medical procedures like withdrawing and withholding life-sustaining treatments, as well as the mechanisms and consequences of new and potent drugs, became the center of the controversy.

The arguments have considered the role of various sectors of the societies, from scientific to philosophical, including the religious perspectives and the best ways to overcome or at least mitigate the suffering that result from the dialectics of technoscience – the living will or health advanced directives.

The concluding remark of this manuscript is a tentative to explain the reason for the existence of dilemmas.

2. Medical procedures and ethical principles

A medical procedure is not, merely, an interaction between the physician and the patient. In this intercommunication, there is also a third party involved, who may or may not be physically involved. On the other side, the outcome of this talk is also dependent on many interrelated vectors, where each one has an important and specific role [1].

For a better perception of the involved elements and circumstances let us consider them individually:

The importance of the third party in this relation is depicted with some examples: The third element can be the family, a financing partner or even the public opinion. Any one of them can influence the medical procedure.

It is well acknowledged the influence of the family in the principle of autonomy when the patient has no cognitive capacity and has no living will.

Other examples are the restrictions that the insurances companies impose on financial limits of a medical procedures. So, the outcome of a medical act, on ethical grounds, is dependent on the limits of the insurance card. Naturally, in most countries with a national health service, at least partially, this is not a major problem.

The fallout of the interaction between the physician and the patient depends also on cognitive, emotional, and cultural capacities, the communication skill, and the medical knowledge of the physician.

Another important vector to be considered in the outcome of the interaction between the patient and the physician is the venue, since the quality and approach of the medical procedure is different if it takes place at home, in a hospital or by the roadside. It is accepted, without any hesitation, that devices required in life sustaining treatments are not disposable at home or in a roadside procedure. Even in a hospital, the equipment's in a university or a central hospital are different and consequently the expected ethical principles will have to take into consideration the venue where the procedure takes place.

Other relevant vector that ought to be taken in consideration is, if the medical procedure is an urgency, emergency or just a routine medical procedure.

In the context of time, if the medical procedure is an emergency, no one expects the physician to ask and wait for informed consent. In these situations, the principle of autonomy, which clearly is determinant is a normal medical procedure, is considered a presumed consent.

And finally, a medical procedure is not a single act but a summing of diagnosis, treatment, and prognosis.

The diagnosis does not seem to significantly influence the topic in question.

However, the treatment and the prognosis are of utmost importance.

In a medical procedure, the prognosis is a fundamental and decisive component in treatment verdict. The treatment is expected to be proportional to the expected prognosis. In intensive medicine, a good example is the shifting from cure to care when the prognosis is unfavorable. The maintenance of treatment procedures or treatment stubbornness, despite the irreversibility of clinical situation leads to a setting of dysthanasia.

There are various factors that can impair and influence the prognostication, and all of them should be taught about while considering a patient's ultimate prognosis.

In general terms, there are other factors that should be taken in consideration in any medical intervention, namely:

The importance of the cultural background in some bioethical principles: the principle of autonomy is determinant in Anglo-Saxon countries, while in Latin countries of South Europe, the principle of Beneficence has a clear ascendency.

The communications skills are also, progressively, becoming more important in a globalized world, since in more developed countries, more and more migrants, living within their borders, speak different languages or, at least, are not fluent enough in the local language to express their symptoms.

3. Historical background

The end-of-life has been a matter of reflection since the dawn of humanity. In the primitive settlements of mankind, the concerns were regarding the moment of death. As the process of civilization advanced to a high state of culture, in the Western world, since the time of Greco-Roman antiquity, the debate was mainly centered on the philosopher's concept of life.

The quality of life was valued much more than the extension of life at the cost of suffering; from this perspective, treatment stubbornness was not accepted,

The knowledge of the physicians was not based on science but rather on empirical experience of its practitioners, and, as such he was considered as a craftsman and not a specially designed technician. As a result, the quality of life had a primacy over the stretching of life with suffering.

In this regard, Plato's opinion is clear when he states that in terminal stages "*Bodies diseased inwardly and throughout should not be treated with gradual evacuations and infusions, to prolong a miserable existence*" [2].

Thus, the ethical concerns with death can be traced somewhere between the fourth and fifth century BC.

In the Medieval Europe, with the Christianization of the Roman empire, the sanctity turned to be the *leit motif* of life; the ethics of end of life were now focused on God, or to be more precise on the doctrine of Church.

In Renaissance and Illuminism, the new knowledge in Medicine led the great Master of Philosophy like Thomas Moore and Francis Bacon to introduce the discussion of euthanasia in cases where medical science had nothing more to offer. In Modern times, from the mid-twentieth century to the present day, the technological advances in sustaining the organ failures and pharmacological improvements and discovery of new drugs that can back up the biochemistry of the human body made exceptional advances in overcoming the organ failure.

On the other side, state-of-the art surgery techniques, and the control of tissue rejection through new immunological drugs turned the organ transplant into a reality: the scenario that was now perfect for the conquest of senescence, renewed the debates in ethical dilemmas such as dysthanasia (from Greek making death

difficult) wherein, the withholding and withdrawing life-sustaining treatments are the daily bread of intensive care units. Euthanasia, legalized in few countries is a subject of discussion, while ethical concerns about topics like drugs double effects and induced coma also deserve a reflection.

The discussion about the ethical dilemmas about end of life care in terminal diseases have been a subject of concern in all the civilizations, although written documents about the entanglement of the opinion makers, the philosophers and thinkers of the societies, are more easily traced in Western civilizations. Later, with the involvement of the church, the priests had a say regarding the end-of-life and finally with the evolution of medical knowledge the clinicians, had progressively a scientific ascendant regarding the dilemmas about treating terminal illness.

The delaying of the process of death with lengthening of the suffering is, now-a-days at the center of end-of-life ethical debates: the non-acceptance of suffering which can windup with the treatment limitation, at the request of the patient or as a decision of medical team, or as a request of euthanasia, also known as a merciful death, at the request of patient.

In the democratic societies, the decision itself has been subject of discussion. Who should be responsible for decision? The epistemic authority of those who have the knowledge. Or the moral authority of the patient, the family, the surrogate, or a judge in the name of state?

In a nearby future this is a debate that will continue to focus the attention of the modern societies.

4. Withdrawing and withholding life-sustaining treatments

As described previously, in a medical procedure, the treatment is a consequence of diagnosis and should also take into consideration the expected prognosis. Moreover, the treatment strategy is not linear, that is, it can suffer abrupt changes mainly in intensive medicine where life sustaining treatments are involved: they may shift from maintenance of vital functions to palliative care.

As far as life sustaining treatments are concerned, there is a study in the USA, that revealed that in a five years interval of time, deaths in two intensive care units in a period of one year that resulted after withholding or withdrawing these treatments increased, in the same period, from 51 to 90% [3].

A French study involving 43 ICU's revealed that 52% of patients died after they had their treatment withdrawn or withheld [4].

Despite various meetings to standardize the criteria regarding the withdrawal or withholding of end-of-life treatments, cultural and religious barriers have made it difficult to have a uniform code of conduct. However, there is a consensus regarding the guidelines relevant to general principles of treatment renouncement, which can be summarized as: [5].

- The treatment renouncement should result when the treatments have no longer any medical indication or do not offer any well-being to the patient
- The withholding of future treatment is morally and legally equivalent to the withdrawal of treatment
- A mindset, whose only aim is to hasten death, is morally and legally condemnable.
- Any treatment can be withdrawn or withheld

- The withdrawal or withholding of life sustaining treatments is a medical procedure

- In case of any deterrence to withhold life sustaining treatment, the withdrawal of the treatment already prescribed with the same objective should be reconsidered.

The decision of treatment renouncement deserves some reflections and considerations.

These decisions are seldom an urgent decision and, as such, it should not be a hasty and sudden verdict. As far as possible, it should be a consequence of a broad consensus. Any doubt, from any staff member, should be respected and the reason for the apprehension analyzed in minutia.

Ethically, the withdrawal and withholding of treatment are identical attitudes, although, for some clinicians, it is more admissible to withhold than to withdraw treatment.

The treatment renouncement is considered, by some, as passive euthanasia. It is extremely important to realize that the intent of treatment renouncement is to withdraw or withhold an undesired treatment that can lead to the death of the patient, but not to induce the death of the patient. The distinction between dysthanasia and euthanasia is that in the latter there is an intention to administer a drug or a poison with the sole purpose to hasten or cause death.

On ethical reasoning, in intentions and acts, there is a clear divergence between treatment renouncement and an attitude whose main and sole purpose is to cause death.

The treatment renouncement decision has been a seat of disagreeing between the Anglo- Saxon and Central and Southern European countries.

For the former countries (particularly the United States) the decisions, after the due explanations, rests entirely on the patient, while in European countries, particularly those in Southern Europe, the physicians are accountable for the decision. In ethical rationale, so far as the authorship of decision is concerned there is a confrontation between the two principles: autonomy from the Anglo-Saxon and beneficence from the Mediterranean Europe side.

In my opinion, considering that the treatment renouncement is a medical procedure, the responsibility should be on the physician, after all the necessary information is provided to the family.

Is it morally acceptable, that the epistemic knowledge being on the physician side, the decision should rest on the patient or family part? Moreover, when any one of them (patient or family) are extremely fragile, weak and exhausted?

It is be retained and emphasized that treatment limitation is not synonymous with ceasing of any form of treatment. It is a shift from cure to care as the primary goal of providing health services.

5. Dysthanasia and euthanasia

In medicine, end-of-life care is made up of two constituents: the process of death and the moment of death.

The process of death is a stage wherein an individual has been diagnosed with an infirmity, that by the existing biomarkers death will be a natural outcome in a rather short interval of time.

The physicians, with the technological equipment's and procedures at their disposition, can lengthen or hasten the process of death.

On the other hand, it is impossible to portray the moment of death. It is a moment of irreversibility that belongs to the sphere of the unknown.

5.1 Dysthanasia

In this context, the word dysthanasia that emanates from Greek – *dys,* in medical terms, painful and *Thanatos* meaning death – in common language means to retard as much as possible the process of death.

Although conceptually slightly different, treatment stubbornness, therapeutic doggedness, or medical futility have been used as synonymous. In dysthanasia, the attention is focused on the process of death, while in its synonymous, the point of convergence on persistency of cure-oriented treatment decisions, whose consequence may drag out the process of death.

In a context of a medical act, dysthanasia should be perceived as an approach where there is an excessive treatment in relation to the clinical condition and its expected outcome. From the perspective of a medical procedure and in the light of deontological precepts, treatment should consider the expected prognosis, as highlighted previously.

A basic rationale for dysthanasia can be a treatment that presents no beneficial odd for the patient.

For some time, dysthanasia was considered, in a broadest sense, futile care that does not benefits the patient. However, the term futile raised some polemic, since, futile, refers to anything that is unable or ineffective of bringing forth any useful result. Nonetheless, there are treatments that can cause some effect on patients' biological parameters without any beneficial good. This evidence highlights the argument that the effects and the benefits are different facts. The prolongation of life without any cognitive capacity and confined to an intensive care bed cannot, in my opinion, be considered the aim of Medicine. I am fully aware that this is a value judgment, and, as such, it is intrinsically difficult to reach a consensus.

The cause effect correlation, to be unequivocal, should be clearly defined and reproducible. The dispute around treatment stubbornness has been focused around difficulty in deciding what should be considered a medical futility and who should be responsible for this decision.

Regarding the definition, there is a distinction between quantitative and qualitative futility. The previous (quantitative) futility is based on statistical premises – a treatment is futile when the last 100 cases of a certain medical treatment for a distinct medical situation have been unsuccessful. On the other side, qualitative futility is related to a treatment that maintains a patient unconscious or does not withdraw his total dependency in relation to intensive care measures.

Summarizing, should the definition be mathematical or clinical?

Mathematics is a science of certainties while medicine (clinical) is a science of probabilities.

Can there be a minimum common denominator among this epistemic ambivalence?

Another worrisome dispute is related to the decision-making: who should have the ultimate say about the futility of a treatment: someone who has the scientific knowledge about the treatment and its effect (epistemic authority) or one, or his surrogate, who is the subject of treatment (moral authority)?

In this dispute I sign up the point of view of Theodore Brown. In his statement:

"*Moral authority is the capacity to convince others of how the world should be. This distinguishes it from expert or epistemic authority, which could be defined as the capacity to convince the others of how the world is*" [6].

From all the consideration, previously exposed, it seems obvious that an act of dysthanasia or treatment stubbornness can be considered as an act of medical malpractice. How can this demeanor by the physicians be explained?

In my opinion, a feasible and rational justification for dysthanasia can be met, on one side, at the light of philosophical underpinnings and, on the other side, as a safeguard against a complaint of substandard medical practice [7].

Philosophically, dysthanasia can be explained, among others, by the phenomenology of knowledge. Edgar Morin, the French sociologist, noted that "*The great contribution of knowledge left by the twentieth century was the knowledge of limits of knowledge. The major certainty is that uncertainties are unable to be eliminated not only in action but in knowledge*" [8].

On the other side, the good or bad application of technique can be understood by the dialectic. Ethically, every man of science, in this case the physicians, serves two gods: the first god is that of ethics of knowledge – everything should be sacrificed to safe the thirstiness for knowledge. The second god is that of civic and human ethics. In dysthanasia prevails the first one.

Axiology, the philosophical study of value, can also be of relevance in explaining the treatment stubbornness. Since the Hippocratic oath, life is considered as a supreme value. By opposition, death has no value or is a non-value. If this rationale is righteous and undistorted, then treatment stubbornness can be justified.

Finally, a foundation for treatment stubbornness can be explained at the light of hope and escape. For Ernst Bloch, the German philosopher, hope is the most human of all emotions and the denial of anguish [9].

The physicians, particularly those dealing with severe cases, know from their experience, that there is, however small, a probability that the process of death may not be irreversible. Dysthanasia can find an underlying rationale in this hope or in other existential attitudes like escape or absurd rebellion.

As pointed out previously, an argument for treatment stubbornness can rest in a reaction to an accusation of medical malpractice – defensive medicine. Currently, doctors are afraid of malpractice lawsuits; a physician response, entirely or to a certain extent, is based on medical procedures to evade any blame rather than to help the patient in his illness.

Defensive medicine can be positive or negative. In the first setting unnecessary procedures are carried out by the doctors to safeguard himself against any complaint. In the second case, he abstains, from procedures and patients, to protect himself from the same recrimination.

In brief, in defensive medicine, the procedures result not from his innate values and beliefs, but from self-protection against accusation of misconduct in the advent of a detrimental outcome [7].

5.2 Euthanasia

Perhaps, the most disputed end-of-life dilemma in the Western contemporary societies, is around euthanasia. However, its debate can be traced to the Renaissance and Age of Enlightenment, as mentioned earlier.

There are multifold descriptions of Euthanasia. In a medical understanding, it is an intentional act to end a life, to relief pain and suffering. The death is brought about by a doctor, family member or friend through a lethal injection and is at the request of the patient who suffers an incurable disease manifested through unrelievable psychic or physical pain.

The word comes Greek "eu" (goodly or well) and "Thanatos" (death). It has referred as "assisted death" or "friendly death".

In this definition, in my opinion, the most inclusive, there are two premises – unrelievable pain and incurable disease – that need an added analysis and clarification.

Besides dissecting this definition, many a times the expression passive euthanasia is used to describe withholding of some medical procedures or treatments, which was already addressed in a previous section (Withdrawing and withholding life-sustaining treatments) that will need further consideration.

Unrelievable pain.

The state-of-the art in pharmacology has presented the medical science with drugs that can control entirely the pain. The main obstacle with the use of one or more pain killers lies with its side effects when there is a need to increase progressively the dose or upgrade the drugs. The most frightening side effect is the respiratory arrest.

In short, the drug outcome can result in a double effect. Reliving the pain but with a significant odd of causing death. Is it morally acceptable?

Besides the relief of pain, the terminal sedation has also been questioned.

This reflection and discussion will be done in next section.

Incurable diseases.

In Medicine, in a classic definition "incurable" implies an illness without cure that will lead, in a short span of time, to death. In natural history, some diseases, when untreated, end up with the failure of the organ and, ultimately, in the death of the patient. The organ failure can be a consequence of an acute condition or an end-stage chronic situation. With modern technological achievements, many organs can be temporarily or permanently substituted by devices or transplants.

In my point of view, illnesses resulting from an end-stage chronic organ failure cannot be strictly defined as incurable in the sense that the outcome will be, unquestionably, the death of the patient, since the devices that substitute the failing organs can do their function.

The question in debate is whether there is any limitation to the use of these devices.

The permanent use of mechanical devices should consider the prognosis, the quality of life from the perspective of the patient and, first and foremost, the patient autonomy.

As previously stated, the treatment should be proportional to the expected prognosis.

It is accepted by some medical associations and by the Catholic Church, that "the use of extraordinary means to maintain life should be discontinued in an unrecoverable situation of a nearby, certainly fatal, prognosis and when the persistence of such treatments will not bring any benefit to the patient" [10].

Let us consider a situation of a patient with a chronic end stage disease but in full possession of his cognitive abilities who refuses any mechanical device to maintain his life. Should his will be denied because the withdrawal of the mechanical device will be considered by the physician or society an act of euthanasia? If, the alternative to a failing organ was its transplant, could the patient be forced to accept it?

Can a society or a physician impose their will? Is the informed consent a mere rhetoric?

By refusing the mechanical device the patient is rejecting to live permanently with a mechanical device. He is not asking to be killed, although he knows that the consequence of his wish will be his death.

In my opinion, the removal of a device that does nor suppress the evolution of the illness, instead prolongs the process of death cannot be considered an act of euthanasia.

To recognize the restrain of science and technology is an act of matureness. To comply with the patient request is to respect the principle of autonomy, which, according to Kant is the only principle of morality.

It is my view, that many disputes and polemics in relation to end-of-life ethical dilemmas have its outset in the premise that the refusal of dysthanasia is an act of passive euthanasia. The objection of treatment stubbornness is act of good medical praxis and meets the *leges artis.* It cannot and should not be labeled as act of euthanasia, unless in bad faith.

6. Drugs double effects

All medicines used in a treatment may cause unwanted symptoms. They are also called "adverse effects" or "adverse reactions". Side effects happen when a treatment causes a problem because it does more than treat the target issue. Side effects can range from mild to life-threatening conditions.

In end stage diseases, when symptoms like pain or breathlessness are a source of great suffering of the patient, the physician is compelled to prescribe powerful analgesics or sedatives and these medicines may cause an undesired double effect.

In case of an analgesic, besides alleviating the pain, they may depress the respiratory center and cause a respiratory arrest and ultimately the death of the patient.

A major doubt, at the light of ethical principles, is whether the double effect of a drug is acceptable or not?

The principle or doctrine of double effect, often abbreviated as DDE, is a set of ethical criteria which Christian philosophers, like Thomas Aquinas' in his work *Summa Theologica*, have advocated for evaluating the permissibility of acting when one's otherwise legitimate act (for example, relieving a terminally ill patient's pain) may also cause an effect that he would, otherwise, be obliged to avoid (sedation and a slightly shortened life) [11].

In his assessment, this set of criteria is justifiable if the following are true:

The nature of the act is itself good, or at least morally neutral.

The agent intends the good effect and does not intend the bad effect either to do good or as the end in itself.

The good effect outweighs the bad effect, in circumstances sufficiently grave to justify causing the bad effect, and the agent exercises due diligence to minimize the harm.

Resuming, the DDE is based on the idea that there is, morally, a pertinent difference between an "intended" outcome of an act and one that is foreseen by the actor but not deliberately planned to achieve his motive.

This doctrine has been criticized by the consequentialist, like John Stuart Mill, advocate of the utilitarian version of consequentialism. He argues that our moral analysis should ignore matters of motivation, which appeals to a distinction between intended and unintended consequences. In his opinion the scrutiny of motives will reveal a man's character, but utilitarianism does not judge character, only the rightness or wrongness of actions [12]. Thus, he concludes that the DDE should be rejected.

Analyzing and reflecting the DDE at the light of ethical principles, namely of beneficence and nonmaleficence, it is clear that there is a clash between the duty to suppress harm or suffering (do good) and, perhaps, the oldest of codes of conduct that reminds the physician that his main attitude towards the patient should be not to harm him (*primum non nocere*).

In my opinion, even in common jurisprudence there a clear distinction between intention and motive. The intention is the basic element for making a person

liable for the crime, which is commonly contrasted with motive. While intention means the purpose of doing something, motive determines the reason for committing an act.

If, there is no other way to suppress the suffering of the patient, than the prescription of an analgesic, should take in consideration the minimal dose to achieve the effect.

In this situation, it is my point of view that the procedure is morally acceptable even knowing that it might be a cause of respiratory arrest and death.

6.1 Terminal sedation

Terminal sedation, sometimes considered as an act of euthanasia, is a procedure wherein a patient is prescribed with a drug to induce sleep or unconsciousness until death occurs as result of the primary disease, while maintaining all other palliative medications. A typical example is a respiratory failure in end stage pulmonary fibrosis. In this stage, the breathlessness induces a suffering that a patient cannot tolerate. The only procedure is to sedate with a minimum effective dose that will induce the patient to lose his cognitive capacities but will preserve his organic functions. The drug prescribed has a short biological half-life. If, for any reason, the medication is brought to a standstill, the patient recovers in no time from his unconsciousness. Thus, this is not an irreversible procedure. Can this practice be considered as euthanasia? In my judgment it does not seems judicious to consider terminal sedation as an act of euthanasia.

7. Religious perspectives on end-of-life dilemmas

Is there any special reason to include religious perspectives in a document on end-of-life ethical dilemmas? In other words, is there any space for religious overview in a field based in a scientific knowledge?

From my point of view there is every reason to entail religious perspectives in a reflection and discussion of end-of-life ethical dilemmas.

First and foremost, I will enumerate the arguments to entail religion in this discussion and in in a second section how the major religions overview these dilemmas.

It is evident that a human being has biological and cognitive functions. In an instance of biological suffering the response should come entirely from medicine, a science based on knowledge; however, in cognitive discomfort, the psyche also has a say.

According to Pew Research Center, 2015 in 2020, 98,1% of world population will be adherent of a religion, with Christianity with 31,2 and Islam with 24,1% occupying the first and second places, respectively (**Figure 1**).

These numbers display, in my opinion, that the religiosity of people cannot and should not be forsaken when analyzing the end-of-life ethical questions. On the other side, even unbelievers, atheists and agnostics can have spiritual concerns, a need in the human psyche to understand the ultimate meaning of our existence and values in life. Spirituality is intricately linked to religion. It is difficult to imagine someone professing a religion and not being spiritual, while the inverse is possible; it is not imperious for spirituality to be coupled to religion.

In mid-nineties, a new term, spiritual intelligence, was introduced by some philosophers, psychologists, and developmental theorists [13]. Spiritual intelligence relies on the concept of spirituality as being distinct from religiosity - existential intelligence. It is, therefore, reasonable to accept that in human suffering religion

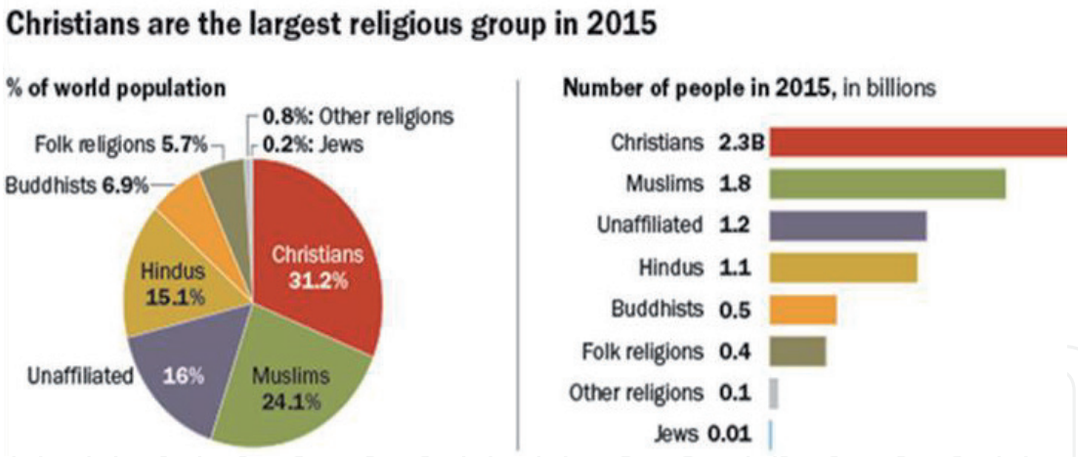

Figure 1.
World population 2015 by religion. Source: Pew research center.

or spirituality and medicine are bound to intersect. To understand the concepts of ethics linked to the end-of-life dilemmas it is fundamental to question "Why?" Get to the bottom to understand the things.

Another good reason to include religious perspective is the historical contribution that Catholic Church thinkers have given to the analysis and discussions of important topics on end-of-life ethical dilemmas.

In the previous section, we had a brief reference to saint Thomas Aquinas on his *Suma Theologica* when he advocated the intention, and not the result, in the doctrine of double effects.

Almost seven centuries later, in 1957, Pope Pious XII in a speech addressed to anesthesiologists, accepted the proposition of double effects of drugs based on principle of liceity of prescription [14].

Another important doctrine in end-of-life ethics, about the difference between ordinary and extraordinary means, was developed by three Spanish Dominican friars (Francisco de Vitória, Domingo de Soto and Domingo Báñez) in the seventeenth century [15].

Other thinking's of Catholic Church, namely regarding treatment stubbornness, were expressed in catholic Catechism and encyclicals (*Evangelium Vitae* by Pope John Paul II) [16].

In the subset of this theme I will make a reference to the most practiced religions and their stand regarding end-of-life ethical dilemmas – treatment stubbornness, euthanasia, drugs double effects, and nutrition and hydration.

7.1 Christian perspective

7.1.1 The Roman Catholic Church

According to the Catholic Catechism *"Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome, can be legitimate; it is the refusal of "over-zealous" treatment"* (treatment stubbornness) [17].

Regarding euthanasia the catechism says that an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator.

The position of Catholic Church in relation to nutrition and hydration through artificial means was clarified by Pope John Paul II when he stated that its

administration, even when provided by artificial means represents a natural means of preserving life, not a medical act. According to him, its use should be considered ordinary and proportionate. However, he added" *insofar as and until it is seen to have attained its proper finality, which in case of a vegetative state consists in providing nourishment to the patient and alleviating his suffering*" [18]. This conditioning has raised some doubts in theologians and clinicians.

7.1.2 The Greek orthodox church (GOC)

The GOC rejects death resulting from human decisions and condemns as unethical any medical procedure that does not commit to the prolongation of life.

According to the bioethics committee of the Greek Church, withholding or withdrawing of treatment including artificial nutrition is not allowed since there is a possibility of a medical mistake, an unforeseen outcome or even a miracle. Euthanasia is not allowed, and pain relief medication prescription is allowed only in doses that are certain not to depress the respiratory center [19].

7.1.3 Protestant churches

In Protestant churches euthanasia is accepted.

7.2 Judaism

According to the Jewish law, euthanasia is not allowed. A significant divergence regarding Western medical and Jewish ethics, resides in withdrawing and withholding treatments, since in Jewish law, treatments may be withheld while withdrawal is not allowed, considering that this deed may be a factual cause of patient death.

Artificial nutrition and hydration are considered as a form of primary care, and, as such, must be provided.

Treatment for the palliation of pain can be prescribed without fear of an eventual respiratory compromise [19].

7.3 Islam

In Islamic principle, life-sustaining treatments can be withheld or withdrawn in terminally ill patients, while euthanasia is proscribed. The withdrawal of nutrition is considered an unlawful act; however, no reference is made in case the nourishment is through artificial methods. Mitigation of pain is admitted even if death is hastened, provided it was not the physician intention [19].

7.4 Buddhism

From a Buddhist ethics perspective, there is no moral obligation to preserve life at all costs (rejection of dysthanasia). The respect for life forbids killing of living things (euthanasia is outlawed). Artificial nutrition and hydration are not imperative, since they may avert the individual from securing the next stage of his life, the rebirth.

The use of pain killers and the principle of double effect is accepted [19].

7.5 Hinduism

In Hinduism there is no single central authority to enforce submission to Hinduism. When making concrete end-of-life decisions, their attitudes are flexible;

this includes the individual circumstantial background to which religious analysis and arguments can be added.

7.6 Confucian and Taoist perspective

Most Chinese do not consider Confucianism a religion but rather a philosophical system. Unlike the West, in China, cultural and social relations sustain the basis for moral judgment. Thus, it is the family who is responsible for decision making.

There is a difference in religious and philosophical Taoism in regard to the end-of-life: in the former case (religious Taoism), one should accede longevity and immortality, while for the latter (philosophical Taoism) death should be perceived with peace of mind and detachment, and, as such, artificial measures that confront the natural course should not be attempted [20].

8. The living will in the end-of-life

The controversies about the end-of-life ethical dilemmas can be traced to ancient Greece and Rome. In that distant past, it was mainly focused in the treatment stubbornness. However, it is with the development of knowledge and research in lifesaving drugs and technologies, that the debates medialize on various fields, the main point of convergence being euthanasia and dysthanasia.

In a nearby future, with an increase in average life expectancy and innovations in medical technoscience it seems little probable that there will be a decrease in these disputes. Anyhow, a realistic hope in the reduction of the controversies should have its mainstay based in prevention. Hence, an objective of all those who have a leading position in the society should be to curtail the disposition towards this confrontation.

How to downsize this problem?

The struggle to curtail has evolved through the years and there has been no consensus for an acceptable agreement. Starting with the denomination of the dilemmas, passing to the definition itself and ending with the parties involved, an acceptable accordance is far from being a reality.

For example, so far as the denomination of futility is concerned there have been various suggestions to shift for a different terminology like non-beneficial treatment, medically inappropriate, medically inadvisable or not medically indicated, among others, but each one with some drawbacks.

In any dispute of end-of-life dilemmas, there is an involvement of three parties, the patient, the family, and the team of physicians and the institution that provides the health care.

In my opinion, the solution to ease this challenging problem will be met, at least partially, by the unveiling of the living will. Henceforth, in this demanding issue, every effort should be directed to engage all the involved parties in supporting and diffusing the living will.

In the western societies there have been a progressive acceptance and legislation of the living will. The main reason for its broad recognition and approval is the affirmation of the principle of autonomy, through the informed consent, in the Anglo-Saxon countries.

Other arguments for its recommendations are religious creeds (no acceptance of blood transfusions by Adventists cult) and those who reject resuscitation maneuvers fearing a bed quality of life that could result from this procedure.

On the other side, in the eastern countries, or societies where there is a predominance of principle of beneficence and family-oriented decision-making, the living will have hardly made any inroad in this matter.

8.1 The living will

The living will or advanced directive specifies what types of medical treatment are desired by a person in circumstances in which he is no longer able to express informed consent.

A living will can be very explicit and precise or very general. The most frequent statement in a living will, appeals that if the patient suffers an incurable, irreversible illness or condition, and the attending physician decides that the condition is terminal, life-sustaining measures, that would serve only to prolong dying, be withheld or discontinued. More explicit living wills may include details regarding an individual's desire for measures such as pain relief, antibiotics, hydration, feeding, and the use of ventilators, blood products, or cardiopulmonary resuscitation.

The intrinsic objective of living will has two main intents: give the concerned person a control regarding his health in an end-of-life setting and take a burden and distress off the shoulders of his family and thus avoid the self-condemnation complex that sometimes curtails a painful decision. Moreover, the living will elude the discords which may arise among family members about the prescription or withholding of specific treatments.

In this circumstance, it is expected that the author of the will is mature enough to interiorize his illness, the natural process of the disease and his own death.

The decision to draft a living will is not a sprint against time; it must be a follow-up of various steps that entails the acceptance of the illness by the patient, the treatment limitation and the evolution of the disease till the death. For all these discernments required, the living will should not, a priori, be addressed in acute settings.

It should be retained that the living will can be revoked or changed as often as the person wishes. However, he should notify all parties who were informed of the living will.

It is desirable, but not indispensable, for the patient to discuss with his physician his apprehensions, fears, and values. No one, better than his physician, to explain him the natural history of his illness, the prognoses, the technical means, and their limits.

Not under any condition, can the physician use his knowledge to shape or imprint the decision in a negative way.

In brief, the living will have, typically, two parts:

On the one hand is named the person who will be answerable to fulfill with treatment orientations and care in the end-of-life. The attorney should be someone in proximity and trustworthy to the person and with awareness of his line of rationale. The attorney, one or more, can be a family member or a close friend. In case of more than one attorney it should be overtly established if the resolution should be collective or individual and how to decide in a case of a stalemate.

On the other hand, there should be clearly stated what diagnostic methods and treatments should be authorized and those that are to be refused.

The living will is not an alchemy for all the dilemmas related to end-of-life ethics, but it is, beyond any doubt, a good means to obviate many scenarios of anguishing treatment decision making and provide the patient a dignified death.

8.2 The physician role in the living will

What can be the role of the physician in the patient's living will?

The living will that is considered in this text is the one dealing with chronic diseases in their advanced stages. In this setting the physician should consider the

timing of the discussion, nature of the illness, quality of life, the end-of-life care, and prognosis.

The dialog should take place not in a specific visit of the patient but through the various follow-up assignments. The physician should explain in a clear and accessible conversation the natural history of the illness with its effect on his quality of life, the end-of-life care that he may eventually need and the treatments options that he may require in the acute exacerbations.

This conversation can be handled by the primary care physician or the specialist consultant who has been following the patient. In my opinion, the consultant physician, with all his experience, will be in a better position to clear the doubts and eagerness of the vulnerable patient.

8.3 The family part in the living will

The feelings and attitudes towards the end-of-life depend on the sociocultural environments of the societies.

In some settings, the family can refuse home nursing the household or allow the treatment limitation and bring back home the family member. This posture can take place for various reasons: spiritual and psychological unpreparedness for the death of their beloved, not knowing how many days would ensue till the patient's death or the physical, familiar and financial concerns that would imply to take care of the patient at home.

8.4 The hospital involvement

The role of the hospital should be focused mainly in preventive measures that should be aimed to remind the physicians, through codes of conduct, to clarify the patient and the family of the evolution of the illness, and, at the proper moment to consider, not enforce, the living will.

In case of disagreement between the family and the physician, the back-office team involving a representative of ethics committee, a psychologist, and an eventual patient religious representative, can have good chances of solving the struggle.

9. Concluding remarks

In Medicine, bioethics is a field of study concerned with the ethics and philosophical implications of certain medical procedures, technologies, and treatments; in this case, the end-of-life ethical dilemmas, are directly or indirectly related to those presumptions.

The main interrogation is to know why these procedures raise so many doubts and uncertainties?

As previously outlined, in the words of French sociologist Edgar Morin, the great bestowal of knowledge left by the twentieth century was the awareness of the limits of knowledge. And he endowed that the major conviction is that uncertainties are unable to be dismissed not only in action but in knowledge.

For this scholar, the knowledge is imbued by three principles of uncertainties:

The brain, the psychic, and the epistemological uncertainties.

In the pursuit of medicine, despite of countless progress in the fields of physiopathology and technical advances that evaluates and modifies the natural history of numerous clinical ailments, the skepticism and the unpredictability can overshadow the result.

In short, the science and its execution entail the uncertainty and sometimes the conflict. This unpredictability leads, from time to time, to question the procedures, the consequences, and the results.

Hence the dilemmas.

Conflict of interest

The author declares that there is no conflict of interest.

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