EDITORIAL

DO WE DISCUSS ETHICAL PROBLEMS REGARDING END-OF-LIFE CARE IN A PERSPECTIVE BROAD ENOUGH?

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When we consider the ethical problems related to end-of-life care, the first issue that usually comes to mind is euthanasia. Respect for autonomy, futile treatment, withdrawing/witholding treatment, and DNR could be added to the list. Yet the ethical problems at the end-of-life covers a vast area including a variety of topics, which is also deeper than it might seem. Lancet Commission on the Value of Death confirms that phenomenon by stating *"Society and medicine have an unhealthy relationship with death"* (1). The Commission defines the problems as global inequality in how people die, overtreatment, medicine's perception of death as a failure rather than normal, misallocation of resources, neglected spiritual needs, physicians' poor communication skills, lack of palliative care, and unnecessarily increasing costs. The three largest Anesthesiology and Reanimation specialty societies in Turkey identify a similar picture for Turkey as well (2-4). Along with the other topics such as ageism, opiophobia, and brain death, it is possible to compile those problems shown as Fig.1.

Access to healthcare needed
- Insufficient ICU units, palliative care, and healthcare workers
- Unfair distribution of resources
- Ageism

Determining the scope of healthcare/ limits of medicine
- Witholding treatment
- Withdrawing treatment
- DNR
- Futile treatment
- Overtreatment
- Death as a failure

Autonomy
- Determining competency
- Telling the truth
- Informing → Consent and refusal
- Minors
- Legal representatives / Proxy decision-makers
- Advance directives

Confidentiality and privacy
- Respect to rights of personhood

Death with dignity
- Inappropritate management of pain & symptoms
- Opiophobia
- Double-effect
- Palliative care
- Hospice
- Euthanasia / Physician assisted dying

Brain death
- Determining brain death
- Organ transplantation

Healthcare-related harm
- Malpractice / complication
- Defensive medicine

Patient relatives
- Informing / Delivering bad news
- Organ transplantation

Scientific researches
- Respect to autonomy
- Countering mortality rather than morbidity
- Pursuing immortality

Figure 1. Ethically problematic issues regarding end-of-life care.

When we consider the mainstream current debates over ethical issues on end-of-life, it is possible to claim that those issues are held in a narrow scope which is limited to patient-physician relationships. For instance, euthanasia, together with witholding / withdrawing treatment, is one of the most frequent topic discussed by questions such as *'Should there be a right to have a physician's help to die?', 'Is there a duty for physicians to help patients who would like to die with ending their painful life in a terminal condition', 'In which conditions it is justifiable?'*.

Related to this "neon" subject, medicine's failure to recognize death as natural is discussed only in the context of medicine's nature. Elements of a "good death" are *"effective pain and symptom management", "at home, surrounded by family and friends", "in a manner that resonates with the person's individuality"*, with *"open acknowledgment of the imminence of death"*, and an awareness *"in which personal conflicts and unfinished business are resolved"* (5, 6). On the other hand, *"dying (…) has become medicine's enemy, distorted from a natural event of social and cultural significance, into the endpoint of untreatable or inadequately treated disease or injury, serving as a reminder of the limitations of medicine"* (7), therefore *"Diagnosing dying is an important clinical skill"* (8). Medicalization of dying has reached a level so high that F. Nauck defined it as *"something akin to an industrial accident"* (5). This phenomenon is partly rooted in the very nature of medicine, and the traditional medical education accordingly, which equalise 'patient's best interest' to 'medical beneficence' without taking into consideration patients' preferences. It is also true that hesitating in witholding or withdrawing treatment and applying futile treatments are related to the concerns of violence towards healthcare workers and lawsuits against them. Yet the issue is more fuzzy, surrounded by various determinants beyond the patient-physician relationship.

Approaches to ageism is another example for the similar problem. I use a case scenario in my class with medical students in order to make them aware how easily they might discriminate among their patients based on their ages. In the scenario students need to choose one patient among four to allocate a rare vital resource (i.e. an organ to transplant), they usually try to choose between a child and a young person while eliminating Mr. Ahmet without even discussing, who is 67, a retired primary school teacher living alone with his birds. This preference never changes throughout the years I have been giving the class. Some argue that their rationale is based on solely medical justifications, yet the majority of students defend that elder people are "done / had enough", assuming that younger people have productive years ahead so they should be prioritized. The case creates a good opportunity to discuss why protecting the non-discrimination principle in the medical profession is a must, as it was strongly stated in the Physician's Oath: *"I will not permit considerations of age, (…) to intervene between my duty and my patient"* (9). What the students are not aware is that they are not only discriminating based on age, but also ignoring the social determinants of health, and -at least implicitly- prioritizing an economic dimension, while making choices upon the value of life.

As those issues exemplify, the ethical problems regarding end-of-life care are discussed in a narrow perspective limited to patient-physician relationship on the micro level. However, those issues which create moral tensions for patients and physicians are shaped under the heavy influence of a utilitarian approach and social determinants of health. Today healthcare services are provided by the measure of ability to pay, cost-effectivity, DALY&QALY, and profitability. Reimbursement policies are limited to a basic package which is justified by the discourse of "limitedness of resources", while availability and accessibility of services are diminishing. Those macro policies create an extra burden for elderly people who are already discriminated against by ageism. Yet the effects of utilitarian policies in the end-of-life care, which is called "legitimizing the shameful" by M. Epstein (10), are rarely taken into consideration, despite the fact that they influence the emergence of ethical problems shown in Figure 1 directly or indirectly.

The UN calls upon Member States *"to address the well-being and adequate health care of older persons, (…) by designing more effective prevention strategies and stronger laws and policies to address these problems and their underlying factor"* (11), and identifies challenges as *"the affordability of care, the availability of services and the need to take a more human rights-based approach to long-term and palliative care"* (12).

If we genuinely intend to improve the ethically problematic issues related to end-of-life care, then policies based on cost effectivity should be replaced by a rights-based approach prioritizing availability and accessibility, while considering social determinants of health. Adopting Geriatrics' approach, which focus on the specific needs of the elderly, will definitely provide guidance in this endeavor.

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