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A Law for End of Life Care in France

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After a case of euthanasia attracted attention in France in 2003, the Parliament adopted a legislation last November, which allows withdrawal of life support in terminally ill patients. The new law will guarantee judicial security to physicians who comply with its provisions.

Introduction

In November 2004, the lower Chamber of the French Parliament voted unanimously for a law on the "Rights of patients and end of life" (http://www.assemblee-nat.fr/12/dossiers/accompagnement_fin_vie.asp). Although the law still requires approval by the Senate, the Higher Court, it is highly likely that this law will not be altered and that its main provisions will remain. This will be a major step forward for French critical care physicians, as it clearly allows the withdrawal of life support in desperate situations, when prolongation of intensive care is deemed "futile", or as it is described in France, only due to physicians' "unreasonable obstinacy". In spite of the fact that nearly all scientific societies concerned with end of life care have issued consensus documents and recommendations (American Medical Association 1991; British Medical Association 1999; Ferrand 2002; Lanken 1991; Orsi 2002; SCCM 1998; Swiss Academy of Medical Sciences 1995), national legislations are usually relatively unclear. The laws on "active" euthanasia issued in the Netherlands and more recently in Belgium proved to be of little help in ICUs. Recent rulings in several countries have also shown that Justice, by and large, is not at ease with withdrawal of life support (Damas et al. 2001; Maggiore and Antonelli 2005; Rocker 2003), increasing the physicians' feeling of judicial insecurity.

In September 2003, the Vincent Humbert criminal case generated the momentum needed to push France into undertaking a major legislative advancement. It was reported that Vincent Humbert, a twenty year-old fireman, had died after his physician, Frederic Chaussoy, withdrew mechanical ventilation (Blanchard 2003). Three years earlier, following a car accident, Vincent had been left quadriplegic, blind and mute, but he had recovered full consciousness and could communicate with his mother through movements of his thumb. When he realized that his condition would never improve, he asked for his life to be terminated, which his physician refused. Ultimately, only his mother accepted his request; she administered a fatal dose of Nesdonal® through his gastric tube. However, when it was disclosed that Vincent was dying, he was intubated and rushed to an ICU. After 36 hours of mechanical ventilation, the intensive care physician in charge, Dr Frederic Chaussoy, under huge pressure from Vincent's family and the media, decided to withdraw life support, injected Nesdonal® and, as it was learnt later, intra venous potassium chloride. Marie Humbert, Vincent's mother, was charged with "attempted murder", and Frederic Chaussoy was charged with "poisoning", the penalty for which could be a life sentence. The case raised considerable emotion all over the country, with both of the accused being overwhelmingly supported by people and physicians. Ministers disclosed publicly their division over the case and in October 2002, Parliament nominated a Commission which would advise the Government on whether or not to rule on euthanasia and end of life medical decisions. The Commission, led by Jean Leonetti, gave its conclusion in July 2004 and proposed a law on "Rights of patients and end of life". After an exceptionally short time, the law was approved by the lower Chamber in November.

The new law states that physicians can withhold or withdraw any treatment deemed "useless or disproportionate", thus ending physicians' "unreasonable obstinacy", when it has only the prospect of the perpetuation of agony. It is interesting to note here that North American documents, consensus statements (Lanken 1991) and rulings describe useless care which can be withdrawn as "futile" (Helft et al. 2000; AMA 1999), a relatively objective concept. Conversely, Europeans, or at least those from the Southern part of Europe (France included), refer to it as "unreasonable obstinacy", a psychological or moral attitude.

Another essential provision states that alleviation of pain or suffering can be achieved via escalating doses of sedatives/ analgesics (opioids), even if it can shorten the patient's life. The explicit intent of the law maker is to encourage and promote the use of opioids at the end of life, by

curbing the physicians' fears that they could be sued for homicide when doing so. This is recognition of the "double effect", a concept stemming from catholic theology, adapted specifically for end of life decisions in ICUs by the Pope Pie XII in 1957, and since recognized by the US Supreme Court (Quill et al. 1997).

Another innovation is the statement that any treatment, when futile, can be withdrawn. Any treatment, as explained by the law makers themselves, includes artificial nutrition, which, accordingly, can also be withdrawn. This will potentially help when clinicians and families are facing agonizing decisions concerning patients with permanent vegetative states (PVS). Common law in the US (Luce and Alpers 2001) and the UK (Wade 2001) has for a long time accepted that stopping nutrition and fluids is permissible if requested jointly by the caring team and the family. However, the recent Schiavo case in Florida has revealed that even in the US the acceptance of the removal of a gastric tube in a case of PVS may be debated (Silverman 2005). A recent study performed in the US state of Oregon, where medical assisted suicide is legally accepted, has demonstrated that deaths were peaceful when patients at the end of their lives chose voluntarily to stop drinking and eating (Ganzini et al. 2003).

Physicians' respect of a patient's refusal of care, even if death could ensue, has been reiterated in the new law. Although already written in an earlier French law ("Rights of patients", March 2002), this was never applicable, because it was too vague. During the summer of 2002, based on the "Rights of the patients" law just passed, a Jehovah witness who was transfused – and saved – against her will sued the physician who ordered the blood transfusion. However the charge was dismissed by the Higher Court, on the basis that he had saved his patient's life, which had a higher value than respecting her will and autonomy (Lemaire 2003). In order to prevent such a situation from happening again, the new law now states that when life is at stake, refusal of care has to be repeated after a "reasonable delay" before it is accepted. This guarantees that such decisions cannot be taken in an emergency. Of course, tradition, culture and law are markedly different in Southern Europe and in the more northern countries and the US, where the respect of autonomy justifies that a physician is legally allowed not to oppose his or her patient's death (Knuti et al. 2003).

A major breakthrough is that the new law will authorize the limitation and withdrawal of life support in patients unable to consent by themselves. We have seen that laws worldwide may be clear on the obligation for physicians to respect any refusal of care expressed directly by the patient him- or herself, but they are usually far more imprecise when he or she is unconscious. The new

French law states that "...at the end stage of hopeless diseases, the physician is allowed to withhold or withdraw useless or disproportionate treatment..." Of course there are stringent conditions, which are: first, the decision has to be taken on a collegial basis; second: the family needs to be informed, and the advice of family members taken into consideration; and third, the decision must be written in the patient's medical files. Note that family members have no decision-making capacity here. This is a common European attitude, shared by the British Medical Association (1999), which states: "In England...no other individual has the power to give or withhold consent for the treatment of an adult who lacks decision-making capacity... Those close to the patient can provide important information whether

the patient would have considered life support treatment to be beneficial. Whilst the views of those close to the patient are an important factor to take into account in reaching treatment decisions... ultimately, the treatment decision is not their right or their responsibility. Rather, the decision will be made by the clinician in charge of the patient's care on the basis of what he or she considers will benefit the patient." This is clearly at odds with the North American standard, which gives pre-eminence to family members, with the physician only advising. In the US, the decision making capacity is given to the family as an extension of patient's autonomy (Lanken 1991; SCCM 1988; Wade 2001).

The law will take effect when it is enacted by the Higher Chamber; physicians will then no longer fear accusation of murder when withdrawing useless treatments, as long as they act in compliance with the new rules. The law will certainly clarify the debate on euthanasia, which will be focused on what it is: giving death to a person at his or her request, which has nothing to do with ending useless care to critically ill patients, but is rather the difference between terminating life or letting someone die.

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