Article

Unreasonable obstinacy: Ethical, deontological and forensic medical problems

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Significance for public health

The aim of our research is to contribute to identify the technical parameters and the ethical and deontological aspects useful to qualify a treatment as *obstinate*, to ensure on the one hand a treatment process that does not exceed the patient's requests or expectations (especially if unexpressed), and on the other hand to protect health workers from charges of professional liability for overtreatment damages, while avoiding attitudes of defensive medicine. Reference to the current code of Italian medical deontology is helpful in making therapeutic choices. It recommends the physician not to undertake diagnostic procedures and therapeutic interventions that are clinically inappropriate and ethically disproportionate and against the current laws, according to which the patient cannot demand healthcare treatments contrary to the law, deontology and good clinical-care practices.

Abstract

Especially in oncology and in critical care, the provision of medical care can require therapeutic choices that could go beyond the patient's will or intentions of the protection of his health, with the possible adoption of medical behaviors interpreted as *unreasonable obstinac*y or, at the opposite extreme, as euthanasia. In some cases, the demand for obstinate therapeutic services could come from the patient or from his relatives, in which case the dilemma arises for the health professional between rejecting such a request, in respect of their professional autonomy, or abiding by it for fear of a professional care responsibility for therapeutic abandonment. We analyzed and commented on emblematic clinical cases brought to court for alleged wrong medical conduct due to breach of the prohibition of *unreasonable obstinacy*. In healthcare it is impossible to fix a general rule defining any therapeutic act as appropriate, because on one hand there are technical assessments of medical competence, and on the other the perception of the patient and of his family members of the usefulness of the health care provided, which may be in contrast. The medical act cannot make treatments that are inappropriate for the needs of care or even be *unreasonable*; conversely, before the request by the patient or by his family members for disproportionate health services in relation to the results they may give in practice, in compliance with the legislative and deontological provisions, the doctor can refuse them, thus safeguarding both his decision-making autonomy and, therefore, his professional dignity.

Introduction

In oncology and in critical care, patients treated have a short life expectancy or in some others treatment is no longer capable of counteracting the progressive worsening of their clinical conditions.

In those circumstances there is a substantial risk of making therapeutic choices that could go beyond the patient's will, with the possible adoption of euthanasia or of medical conducts even characterized by attitudes of *unreasonable obstinacy* with the infliction of unnecessary suffering and pain.[1]

In case this occurred, is it conceivable that there is a remedy to the suffering caused by *unreasonable obstinacy* or, on the legal front, a right to compensation for damages deriving from this behavior?

In some cases, the demand for *obstinate* therapeutic services could come from the patient or from his relatives.[2,3] In such a case, the health professional is faced with the dilemma between rejecting their request according to his own clinical conviction or accepting it for fear of a charge for professional negligence.[4]

In some respects, this is a new problem, connected to the duties of doctors and to the limits to their security position. It is a problem concerning any profiles of civil and/or criminal liability of those who intervene pharmacologically and/or surgically in an attempt to delay the moment of death despite that, according to medical science, no benefit for the patient can be expected from that given treatment.

Design and Methods

In this context it seemed useful to refer to clinical events with judicial implications in terms of unreasonable obstinacy.

The selected clinical cases appear interesting as they are emblematic of behaviors of unreasonable obstinacy, however, in some cases solicited by the patient and uncritically implemented by the doctor. In the field of civil law, particularly interesting is the clinical case of Michael,[5] a child born in 2002 in a French public hospital. When his mother asked for assistance to give birth, the doctors, who were occupied elsewhere, did not arrive in time to diagnose an abnormality of the fetal heart rhythm.

Michael was born in a state of *apparent death*, *i.e*. in a clinical condition characterized by absence of pulse, flat and immobile thorax, no excretions, loss of heat, elasticity and flexibility, rigidity, cooling, onset of lividity on the face and eye opacity.

The team made any attempt to revive the baby, but to no avail: twenty minutes after delivery, the gynecologist informed the parents of the baby's death. However, as this news was reported, the doctors continued their resuscitation efforts, until after twenty more minutes of intensive care, Michael's heart began beating again. The brain, however, had suffered serious irreversible hypoxic damage on an ischemic basis resulting in *infantile cerebral palsy*.

This clinical case arrived in court for a claim of compensation for damages, submitted by the parents against the health workers, arising from clinically obstinate therapeutic interventions.

Another emblematic and painful story took place in Italy, protagonist one-month old baby (Davide), born in 2009 with the

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Potter Syndrome.[6] The mother of Davide, at the 20th week of pregnancy, received ultrasound diagnosis of the absence of amniotic fluid, probably attributable to the rupture of the amniotic sac or to the lack of the kidneys of the unborn child. The pregnant woman was reassured by subsequent ultrasound evidence of the presence of the organs of the urinary tract of the unborn child and decided to continue her pregnancy.[7]

The newly born Davide was immediately transferred to the Neonatal Intensive Care Unit, where he was intubated, had his pleural space drained and was subjected to pharmacological therapy to promote lung expansion.

Subsequently, the mother of David went to the facility to visit her son and to have an interview with the doctor. On that occasion she was informed that her child was affected by "Potter Syndrome" and, consequently, without kidneys, with only buds of the ureters and bladder, and severe alterations in his respiratory function. In the presence of this very serious clinical picture, the doctor strongly advised against any attempt at dialysis therapy, since according to the literature the pathology is defined by the World Health Organization as a fetal pathology incompatible with life and leads to sudden death after childbirth or at the most within a few weeks. He also added that if one of his children had been affected by this Syndrome, he would not have administered any treatment and would have let him die without further suffering.

The following day, however, the same physician, in contradiction with what he had previously said, asked Davide's parents to authorize him to transfer the infant to another hospital specialized in pediatric nephrology and dialysis, located in another city, for the child to be subjected to dialysis.[8]

The director of the operative unit where Davide was admitted confided optimally in the renal transplant when he grew up.[9,10]

Disconcerted by his request, the parents obtained a day from the same doctor to evaluate whether to accept his proposal.[11]

However, the following day they were amazed to learn that a measure had been issued by the competent Juvenile Court, on initiative of the hospital managers, who, among others, had not consulted the Ethical Committee competent for the territory. Such measure at the same time, not only had suspended their parental authority (now called *parental responsibility*) but had also ordered the immediate transfer of the minor to the hospital facility, located in another city, and equipped for the implementation of the *heroic therapies* prescribed by the treating physicians. After the transfer, the Juvenile Court reinstated the parents of the child in their parental authority. However, they were ordered: «*to continue to provide the maximum collaboration towards the health professionals, and to adhere to all the instructions they received, with the warning that in the case of non-compliance, measures restricting parental authority could be adopted again against them*». Unfortunately, as was foreseeable, less than two months later the child ceased to live, despite having been subjected to artificial nutrition and feeding, as well as daily dialysis, sometimes for 12 consecutive hours. Moreover, Davide was unreasonably subjected to orchidopexy surgery for simultaneous testicular retention. Clinically inappropriate therapeutic interventions could otherwise be requested by the patient or by his family members.

This is the case of a 43-year-old woman, mother of two girls, suffering from end-stage pancreatic neoplasia with multiple widespread metastases, who asked the doctors of an Italian hospital for the removal of some of the multiple metastases as she was *«willing to do anything to obtain an even short extension of her life»*, because of the deep affection she felt for her minor offspring. During surgery, unfortunately, injuries were caused to the spleen and to the falciform ligament which produced a lethal hemorrhage in the already severely debilitated patient.

The cause of death was undeniably identified in a *«cardio-circulatory failure occurred in a patient suffering from pancreatic neoplasia with widespread multiple metastases in the peritoneum, pleural cavities, intestines, ovaries, liver and lungs, who had undergone oophorectomy and removal of a pre-sigmoid neoplastic mass, with postoperative course complicated by bleeding due to lesions in the falciform ligament and to the laceration of the inferior pole of the spleen»*.

The existence of the causal link was also recognized in «*the omitted, timely identification of the lesions, especially the splenic one, which caused the hemorrhage, also in consideration of the patient's clinical conditions, made manifest also in the diagnosis of multiple neoplastic pathologies, as well as in the diagnosis made also by a foreign researcher and surgeon who worked on pancreatic cancer; in the conditions of the patient that were already known before surgery and, above all, in her blood values in the and symptoms of progressive anemia she had presented (hypotension, sense of oppression, etc.) in the postoperative course, before the first cardiac massage (...), as well as in the omission to alert the surgical emergency department*», considering that, «*if the necessary hemostasis maneuvers had been done, the bleeding would have been stopped and probably the patient would not have died*».

The case was brought to Court where the possibility emerged of configuring a (negligent) criminal liability ascribable to the health care provider for what in the literature has been defined as *allowed therapeutic overkill*.[12]

Results

The clinical case that had Michael as its protagonist was brought before judicial court by his parents who claimed compensation for damages, against the doctors for clinically inappropriate therapeutic interventions. The judges concluded that the doctors had practiced the resuscitative activity without considering the highly predictable harmful consequences for the newborn − currently suffering from serious physical and mental impairments − and, in so doing, had acted in violation of art. 37 of the French Code of Medical Deontology of 1995,[13] containing the prohibition to carry out treatments consisting of *unreasonable obstinacy* in the therapy.

Based on this consideration, the judges of the Tribunal Administratif de Nîmes (Gard), with judgment of 2 June 2009 n. 622251,[14] after declaring inadmissible the request for compensation for the damage filed by the parents against the physicians, for lack of jurisdiction, judged the hospital responsible for the unreasonable obstinacy put in place by the summoned doctors.

In the clinical affair that had Davide as its protagonist, the newborn suffering from Potter Syndrome, the provision issued by the Juvenile Court, which the parental responsibility was reinstated with, takes a peculiar form, as they are required to *«continue fully cooperating with the doctors, adhering to all the indications given to them, with the warning that, in case of non-compliance, measures restricting their parental authority could be adopted again against them»*.

The substantial depletion of parental responsibility by the judge forced the parents to give consent to all the treatments planned by the doctors of the hospital where the child was hospitalized and, therefore, also to those they considered *inappropriate* in fear that any dissent could have given rise to revocation of their parental authority.

Davide was subjected to central venous catheter implantation, orotracheal intubation with mechanical ventilation support, cre-

ation of vascular access for dialysis therapy, surgical intervention of peritoneal catheterization for bilateral dialysis and orchidopexy, daily hemodialysis treatments, antibiotic therapy.

The last clinical case considered, characterized by the deliberate request by the patient for treatments not proportionate to the benefits achievable, was the subject of three degrees of judgment in criminal proceedings, which ended with sentence n. 13746 of the IV criminal section of the Italian Court of Cassation,[15] on January 13, 2011.

The resolution of the case, in the second instance judgment, concluded with the sentence of the Court of Appeal of Rome on 28 May 2009, seemed relatively simple. Reference to an error in the surgery, and to a failure to promptly activate the block of the bleeding, as the cause of death, recalls a classic hypothesis of generic guilt for violation of the *leges artis*. This means that, the appeal judges, in their motivations, could have related to the traditional canons of ascertaining negligent responsibility in the medical field, and therefore reason in terms of predictability and avoidance of the concrete event, *i.e*. death because of hemorrhage. But a further profile of guilt has been identified in the violation of the rules of prudence, as well as of the provisions dictated by science and by the conscience of the operator, and this is the most argumentative passage in the sentence of conviction.

This because, according to the assumption of the Court of Appeal of Rome, given the precarious conditions of the patient, whom only few months of life remained and as such, had to be considered inoperable, there were no good reasons to expect that surgery, although chosen by the patient, could produce a benefit for her health and/or an improvement in her quality of life. Consequently, it was stated that, in carrying out the operation, the surgeons had ended up acting in contempt of art. 16 of the then applicable code of medical deontology,[16] which expressly forbids treatments consisting of a «*useless diagnostic and therapeutic obstinacy*».

The Supreme Court of Cassation, far from recognizing the legitimacy of the appealed judgement by the Court of Appeal of Rome with reference to the criminal responsibility of the accused, has not addressed *ex professo* the subject of the aggressive treatment, but has limited itself to acquitting the doctors for intervened prescription of the crime.

Discussion and Conclusions

The judicial provision adopted by the judges of the Tribunal Administratif de Nîmes in their judgment No. 62251 of 2nd June 2009 is emblematic, since the failure to comply with the prohibition of disproportionate treatments, with the consequent unjust suffering caused by the artificial prolongation of life by means of invasive technologies, although is not rare in practice, has not yet been the subject of judgments in other countries.

In the Italian legal system, the violation of the prohibition of disproportionate treatments - which art. 16 of the current Code of Medical Deontology is dedicated to - from the point of view of civil law, entails not only the violation of the aforementioned law, but also the failure to comply with art. 2 of the recent law n. 219/2017 (on informed consent and advance directives) and the non-compliance with the right to live even the last phases of life with dignity.[17] The latter is the cardinal value of modern Constitutions and of the Charter of Nice. If, then, as sometimes happens, unreasonable obstinacy in the therapy is also matched by lack of information or even by an explicit dissent manifested by the patient, the violation of the aforementioned provisions adds to the non-compliance with the principle of self-determination of the patient about his own care, with the consequent possible hypothesis, in both cases, of a serious breach that legitimizes specific and independent requests for compensation for damage. See Articles 2, 13 and 32 of the Italian Constitution, appropriately referred to by the recent Law No. 219/17, Article 1.

The Italian case Davide, still pending civil judgement before the competent judicial bodies, could be examined in the light of this address, aimed at admitting compensation for damage due to the violation of the prohibition of stubborn treatments. It can provide an opportunity for also Italian jurisprudence to open up to compensation for damage caused by unreasonable obstinacy.

The intervention of the tutelary judge requested directly by the doctors, rather than being an expedient to provide *legal cover* for the administration of extraordinary and disproportionate health treatments, should have instead met the need to achieve a synergy between different professional figures, meant to relieve the suffering of little David and of his parents.

Therefore, the stubborn decision of the doctors to expose the newborn to further and utterly useless suffering, caused by daily dialyses and Artificial Nutrition and Hydration (ANH) does not seem to be supported by any plausible reason - other than the censurable one - to carry out a sort of atypical experiment. Their decision is so much the more reprehensible as it contrasts with the unanimous opposite orientation expressed by the child's parents, and is therefore in breach of both the legal obligation to obtain parental consent to the treatments to be carried out on Davide, and of the deontological duty to evaluate with the parents the *proportionality* or not of the treatment in relation to the expected results.

Parental dissent for life-saving treatments of the child cannot be accepted uncritically.[18]

An equally severe judgment must be expressed also about the work of the Juvenile Court, which did not even feel the need to acquire the opinion of the parents and of the Ethics Committee of the hospital which the child was entrusted to, regarding the reasonableness of the choice unilaterally made by the medical therapists, to the end of taking a considered and informed decision.

In urgent terms, then, the question arises of determining whether, in the clinical practice, we should rely exclusively on so-called technical assessments, and therefore on parameters reserved to the competence of the attending physicians, or whether importance should also be attached to the perception that every single patient has of treatments or, if *incompetent*, his legal representative.[19]

In the Italian literature, eloquent, in this regard, is what Cardinal Martini wrote a few years ago, in relation to the lacerating *Welby case*:[20] «*The point is that to determine if a medical intervention is appropriate you cannot refer to a general, almost mathematical rule, which to deduce the appropriate behavior from, but careful discernment is necessary that considers the concrete conditions, the circumstances and the intentions of the subjects involved. In particular, the will of the patient cannot be disregarded, as it is up to him to assess whether the treatments offered to him, in such cases of exceptional gravity, are effectively proportionate, also from the legal point of view and with well-defined exceptions*».[21]

It is necessary to ask ourselves what importance is to be attached to the patient's will, which could well be contained also in the anticipated treatment provisions, whereby, despite having acquired full awareness of the uselessness of the therapies, also on the basis of accessible and complete information provided by his physician, rather than expressing his disagreement to undergo them - as it would be logical to expect - not only manifests adhesion to them, but even requests them.[22]

In this context, the quality of the information provided and

their understanding by the patient are of primary interest.[23-25]

The use of simplified and appropriate modules at the cultural level of the patient, integrating the oral interview with the doctor, could facilitate the transmission of the information elements so as to obtain its full self-determination.[26]

Apart from the consideration that if the will of the patient were to prevail in any case, one would end up completely neutralizing the preceptive value of the art. 2, paragraph 2, of the recent law n. 219 of 22 December 2017, according to which: *«In cases of patients with poor or short-term prognosis of imminent death, the doctor must refrain from any unreasonable obstinacy in the administration of treatments and from the use of unnecessary or disproportionate treatments»,* it seems more appropriate, instead, to offer the treating physician an indicative criterion inferable from the same law, as well as from the aforementioned code of medical deontology (articles 16 and 22). We are herein referring to the possibility of a reasonable connection of the above-mentioned art. 2, paragraph 2, with art. 1, paragraph 6, of the same law, where it is stated that «*The patient cannot demand health treatments contrary to the law, professional ethics or good clinical care practices. In the face of such requests, the doctor has no professional obligation*».

It may well be deduced, then, that, in response to a patient's request for disproportionate treatments in relation to the results obtainable in practice, in accordance with the dictate of the aforementioned law, the doctor can oppose his refusal, thus safeguarding his autonomy. and therefore, his dignity both as a person and as a professional.

The opinion of the Italian Constitutional Court therefore deserves being carefully considered, where - although not with specific reference to unreasonable obstinacy - it has observed that *«it is not normally the legislator that can directly and specifically establish what therapeutic practices are admitted and with what limits and under what conditions. Since the practice of medical art is based on scientific and experimental acquisitions that are constantly evolving, the basic rule in this matter is the autonomy and responsibility of the doctor who makes professional choices based on the available state of knowledge, always with the consent of his patient*».[27]

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