PALLIATIVE CARE IN LEBANON
The Law and the Patient

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Palliative care, to be differentiated from euthanasia or physician-assisted suicide, aims at improving the quality of life of patients with terminal illnesses by taking care of the various aspects of the disease (psychological, physical and social) [1]. In Lebanon, palliative care was recognized as a medicine specialty by the government in July 2013 and is regulated by the law no 240 dated October 22, 2012 under the title of Code of medical ethics.

Many countries in the region still do not recognize the practice of palliative care, when others have started to integrate it in their medical education curriculum. While all medical laws stress on the respect of human dignity, the practice of end of life care varies from one country to another. Variability is even noticed among the different regions of a country depending on the environment and cultural distribution. The Council of Europe stated in 1999 that human beings have the right and should be enabled to “die with dignity.”

How to respect and enforce this dignity? This should be regulated by various laws and codes to ensure the best setting. In this paper, we will explore “end of life care” from the legal standpoint in Lebanon comparing it to other models where palliative care has long been established such as France, the United Kingdom and the United States of America.

THE LEBANESE MODEL

The Lebanese medical code of ethics clearly states that the physician should always respect the patient’s will as per article 27.4 [2]. Patients have the right to refuse any treatment provided they were informed about the consequences by their physician. On the other hand, when a patient suffers from a life-threatening illness, with no hope of recovery, the role of the primary physician should shift towards reducing physical and mental pain and providing comfort [2].

This decision should be coordinated however between the patient or his/her surrogate and two physicians, the treating physician and the head of the concerned department. The law strictly prohibits the physician from assisting to put an end to the life of the patient, which is euthanasia [2].

Lebanese hospitals must have “internal regulations” that shall not contradict the medical code of ethics. It is by these “internal regulations” that the practice of end of life care has been accommodated to the various regions in Lebanon depending on their sociocultural image.

LEBANON AND THE WEST: SIMILARITIES AND DIFFERENCES

The American Medical Association (AMA) policy on end of life care, the General Medical Council (GMC) of the UK as well as the French law 2005-370 (Leonetti’s law) have set guidelines concerning the practice of end of life medicine. Comparing these regulations to the Lebanese code of ethics, one can note many similarities as well as major differences.

All agree on the principle of shifting the intent of care toward comfort once the intervention to prolong life becomes futile. This decision should be the patient’s choice solely, and it should be respected by the treating physician according to the USA, France and UK laws. However, in Lebanon, this decision involves three persons who are the patient, his physician and the head of the concerning department. On the other hand, if a patient refuses a treatment “deemed non-futile,” the physician is allowed to stop providing the therapy in question to that patient after consulting with another physician for the purpose of convincing the patient otherwise according to the article 28.3. [2]

Maybe the major difference between Lebanon and the Western countries resides in the concept of “advance directives”. These are written instructions set by persons concerning their will and type of treatment they wish to have in case they are not able to express themselves when in severe illness. In Lebanon, the decision to instigate palliative care on a patient should be made in the context of the disease when all other means of curative treatment have failed, even if the patient’s wishes were expressed or documented before his illness. This is not the case in the other countries we are discussing.

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For example in the UK, an advance care plan can be stated by the patient and it needs to be reviewed and updated as the patient’s situation or views change [3]. This is also the case in the USA where advance care planning is encouraged to tailor palliative care as per patient’s preferences [4]. According to the US medical code of ethics, advance care planning should always be raised with the competent patient during outpatient visits.

In France, the article 7 of the law 2005-370 allows every person to prepare advance directives which remain in effect for three years unless revoked by the person himself/herself [5].

Should the patient be incapacitated to express his/her will, the Lebanese guidelines assign the decision to the nearest living relative. However, this is not the case in the UK where the process of surrogacy can be summarized as follows. The doctor in charge reviews the medical history of the patient with his care provider (person supporting him, taking care of him) and discusses previous medical decisions made by the patient. If previous advance directives were made, the physician role is to make “judgment” about their validity and applicability in the current setting [5]. Finally the doctor must involve members of the medical team as well as the legal proxy in the discussion before coming out with a final decision that shall be applied. In short, the decision is mainly taken by the physician himself.

According to the French law, the “trusted person or the family” should be consulted first as well as the advance directives if available. The opinion of the appointed trusted person should always be respected except in cases of emergencies as per article 8 [5].

The same applies to the USA ; if advance care planning was not available, major decisions are to be made based on “the best evidence of what the patient would have chosen.” [4]. This is called substituted judgment. Failure to reach these substituted judgments in addition to an absent input from the health care proxy would lead to an absent input from the health care proxy would lead to an absent input from the health care proxy would lead to an absent input from the health care proxy would lead to a more stressful condition rather than relieving the patient’s suffering. “Myths and taboos” are the reasons behind masking the diagnosis from the patient or switching to alternative diagnoses [6].

The AMA as well as the GMC guidelines and the French law agree that whenever there is a conflict between sustaining life and relieving suffering, the patient preferences should be respected. Thus, they all allow the physician to withhold life-sustaining medical treatment at the request of the patient. This is not the case in Lebanon; the Lebanese code of medical ethics is still not very clear about this subject. It does not state explicitly that it is forbidden to withdraw life-sustaining medical treatment nor does it authorize it by any article. This keeps the door open for self-analysis of the laws and allows the physician to act according to the way he/she finds appropriate. This issue is stated in the first part of the GMC guidance, under the topic of fundamental principles. It clearly states that whenever the “patient’s views, if they are known or can be found out” to be towards accelerating death and relief of suffering the presumption towards prolonging life should not be an obstacle [3]. This is also the case in the opinion E-2.20 in the AMA guidelines which stresses on the freedom of choice of the patient in case of conflict between sustaining life and accelerating death. The French “Leonetti” law allows the physician to provide any treatment in order to relieve the suffering of the patient even if “as a side effect” these treatments might hasten death [5]. It also authorizes the withholding of life-sustaining treatment as well. This is not to be confused with euthanasia or physician-assisted suicide which is considered illegal in France, UK and USA.

DISCUSSION AND RECOMMENDATIONS

After reviewing the different articles and opinions concerning the practice of end of life care in various western countries and in Lebanon, one could conclude that palliative care in Lebanon is still at the beginning of its development. It is recognized as a medical specialty and regulated by the Lebanese code of medical ethics; however the practice on the field is still to be assessed in different hospitals and regions. Taking the British, French
and American systems as models, the following recommendations and adjustments to the code of medical ethics can be proposed.

**Advance directives**

It might be difficult to instate the concept of advance health directive in a society such as the Lebanese one where the family plays an important role in any decision concerning its members. The Lebanese code of medical ethics should legalize written documents expressing the person’s wishes concerning medical treatment in case he/she will not be able to express them at difficult and critical moments. This will relieve the burden from the “parents” who were assigned as per article 27, the role of making vital decisions. It will also highlight the concept of autonomy and human dignity.

**Withholding life sustaining treatment**

The Lebanese law is still not clear about the right of the patient to choose or of the physician to recommend stopping any life-sustaining treatment including mechanical means. This is mainly due to the religious and cultural convictions dominating the Lebanese mentality, which vary between different regions of the country. Explicitly allowing the physician to withdraw life sustaining medical or mechanical treatment is a bridge that we need to plan crossing with high caution.

**Knowledge of the diagnosis**

An adjustment of the article 44 of the Lebanese code of medical ethics towards mandating that the physician discloses dangerous diagnosis results or inevitable death is recommended to enhance the practice of palliative care in Lebanon. The physician should invariably inform the patient about the accurate diagnosis (especially if severe or advanced) and the available treatments unless the patient asks not to be informed. This goes along with the principle of human dignity and autonomy. Knowing about his/her condition, a patient might elect to go into aggressive medical life sustaining treatment or might request the alternative palliative care and comfort.

**CONCLUSION**

Though recently approved and recognized by the government as a medical specialty, palliative care has been practiced in various hospitals in Lebanon according to the regulations acknowledged by the Lebanese code of medical ethics. Comparing these regulations to those of countries where palliative care is known to be well and long established, one could see many similarities but more importantly major differences and gaps, to be filled with more clarifications and explicit statements in the legal text.

**REFERENCES**