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Report on the Pontifical Academy for Life International Congress, XIV General Assembly, 2008

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Pope John Paul II established the Pontifical Academy for Life (*Pontificia Academia Pro Vita*, PAV) on February 11, 1994 in light of Christian morality and the directives of the Magisterium. It is an autonomous body closely connected to the Pontifical Council for Pastoral Assistance to Health Care Workers. The specific task of the *Pontificia Academia Pro Vita* is "…to study and to provide information and training about the principal problems of law and biomedicine pertaining to the promotion and protection of life…."[1]

Since 1994, the PAV has convened fourteen general assemblies and published numerous documents dealing with bioethical issues. Five of these assemblies have dealt with end-of-life issues. The most recent general assembly was convened in February 25-27, 2008 on the theme, "Close by the Incurable Sick Person and the Dying: Scientific and Ethical Aspects." Participants came from all continents and included theologians, philosophers, bioethicists and physicians.

In his opening address Pope Benedict XVI outlined the Catholic view on responsibility towards the ill and dying: "[T]he whole of society, in fact, is required through its health-care and civil institutions to respect the life and dignity of the seriously sick and the dying…In practice, it is a question of guaranteeing to every person who needs it the necessary support, through appropriate treatment and medical interventions, diagnosed and treated in accordance with the criteria of medical proportionality, always taking into account the moral duty of administering (on the part of the doctor) and of accepting (on the part of the patient) those means for the preservation of life that are 'ordinary' in the specific situation." Pope Benedict continued his remarks by reminding participants of Catholic teaching that "…recourse to treatment with a high risk factor or which it would be prudent to judge as 'extraordinary,' is to be considered morally licit but optional."[2]

One of the most interesting presentations was by Dr. Gonzalo Herranz of Spain, on the integration of palliative and intensive care medicine.[3] He suggested that most people do not understand how the philosophy of intensive care medicine (ICM) and palliative care medicine (PCM) interact. Instead, they are often seen as opposites. Dr. Herranz's analysis showed that they can be integrated for the benefit of the patient. As lack of response to intensive care becomes more evident, the importance of wellbeing, including spiritual wellbeing, and palliative, compassionate care increases, and unrealistic expectations from caregivers and family should decrease.

The ethos of intensive care is to treat patients who are critically ill with the intention of reducing mortality. This is viewed as the most aggressive form of medicine, the peak of mainstream medicine. Its ideal is to preserve life at all costs, by means of instrumental monitoring, data evaluation, and aggressive intervention to overcome organ failure. The role of the intensive care physician is to admit patients whose potential for recovery is high. Ethical decisions have to be made by the physician and family on whether the patient can benefit from

extraordinary interventions and the possible risks involved. The patient who enters intensive care is viewed as fighting for life. Intensive care focuses on stabilizing the physiology of the patient. It is not until treatment is deemed futile that the decision to shift the patient to palliative treatment is made. The decisions that have to be made at this point, decisions of futility, ordinary and extraordinary measures, and cost are often ethically difficult.

The ethos of palliative care medicine is active, holistic care of the patient with a progressive, terminal illness. Its aim is to alleviate suffering and to control symptoms in order to achieve the best quality of life possible for the patient. Palliative care intends neither to hasten nor postpone death. It encompasses the physical, psychological, social, and spiritual wellbeing of the person and this aim requires an interdisciplinary team of doctors, nurses, social workers, and chaplains. There is consultation and continuous dialogue among the team members and with patients and their families. Treatments are not aggressive or intrusive, yet may be used in conjunction with life-prolonging treatment such as radiation or chemotherapy and may positively influence the course of the illness.

Dr. Herranz believes that in intensive care the conviction that a good death involves a courageous fight against disease with the help of biomedical technology, and that it is an event to be postponed as long as possible, often overshadows the benefits that palliative care can bring to the dying and their families. The growing numbers of hospices and palliative care units in hospitals point to the fact that palliative care medicine is increasingly viewed as something desirable and even indispensable. Physicians, caregivers, and patients are more aware of futile treatment and the palliative ethos could help to make easier the decisions to withdraw intensive care when the patient no longer responds to it.

Dr. Herranz reaffirmed that patients in the ICU are then entitled to receive as early as possible the best palliative care, together with the most compassionate care for their families. In the hospital the palliative care physician can and should exert an impact not only in the ICU but also in the system as a whole. Dr. Herranz also affirmed the responsibility of spiritual support for the patient and family in the ICU. Christian end-of-life rituals must be included where requested out of respect for the patient's religious practices. To that end, it is important that intensive care units be open to all members of the palliative care team, including the chaplain.

Overall the PAV conference was of great interest to anyone involved in end-of-life issues. In particular, Dr Herranz's presentation reminded us that the philosophies of palliative care and intensive care need to be more fully integrated in order to provide the best possible care at these times. ■

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[1] Pope John Paul II, *Pontificia Academia Pro Vita* (PAV), February 11, 1994.
[2] Pope Benedict XVI, address to those taking part in the Congress of the Pontifical Academy for Life on the theme, *"Close by the Incurable Sick Person and the Dying: Scientific and Ethical Aspects"*.
[3] Gonzalo Rodriguez Herranz, *Developments of Modern Medicine in Life Support: Conquests and Risks.*

For more information go to www.academiavita.org. Click on "General Assembly" to reach the 2008 International Congress. Click on "Papers" for Dr Herranz's presentation.

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