

# WMA DECLARATION OF VENICE ON END OF LIFE MEDICAL CARE

*Adopted by the 35<sup>th</sup> World Medical Assembly, Venice, Italy, October 1983*

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*and by the 73<sup>rd</sup> WMA General Assembly, Berlin, Germany, October 2022*

## PREAMBLE

When a patient is seriously ill and the restoration of health may not be possible, the physician and the patient are often faced with a complex set of decisions regarding medical treatment.

The end of life must be recognized and respected as an important part of a person's life.

Advances in medical science have improved the ability of physicians to address many issues associated with end-of-life care. While the priority of research to cure disease should not be compromised, more attention must be paid to developing palliative treatments and improving assessment and response to the physical, psychological, social and spiritual or existential components of terminal illnesses and other conditions at the end of life.

WMA remains firmly opposed to euthanasia and physician-assisted suicide, as set forth in the WMA Declaration on Euthanasia and Physician-Assisted Suicide.

Ethically-appropriate care at the end of life should routinely promote patient autonomy and shared decision-making, and be respectful of the values of the patient, his or her family or intimate associates, and surrogate(s). The WMA recognizes that attitudes and beliefs toward death and dying vary widely from culture to culture and among different religions, and palliative care resources are unevenly distributed. The approach to medical care at the end of life will be influenced significantly by these factors, and thus attempting to develop detailed universal guidelines on terminal care is neither practical nor wise. Therefore, the WMA articulates the following:

## RECOMMENDATIONS

### Pain and Symptom Management

1. Palliative care at the end of life is part of good medical care. The objective of palliative care is to maintain patient dignity and freedom from distressing symptoms. Care plans should emphasize keeping a patient as comfortable as possible and the patient's pain controlled while recognizing the importance of attention to the social, psychological and spiritual needs of the patient, and his or her family and intimate associates.
2. The clinical management of pain in patients at the end of life is of paramount importance in terms of alleviating suffering. The WMA Resolution on Access to Adequate Pain Treatment (2020) makes recommendations for physicians and governments that optimize treatment of pain and other distressing symptoms. Physicians and National Medical Associations should promote the dissemination and sharing of information regarding pain management to ensure that all physicians involved in end-of-life care have access to best practice guidelines and the most current treatments and methods available. National Medical Associations should oppose laws or regulations that unduly inhibit physicians from providing intensive, clinically appropriate symptoms management for patients at the end of life in keeping with recognized best practices.
3. When a patient at the end of life experiences severe pain or other distressing clinical symptoms that do not respond to intensive, symptom-specific palliation, it can be appropriate to offer sedation to unconsciousness as an intervention of last resort. Sedation to unconsciousness must never be used to intentionally cause a patient's death and should be restricted to patients in the final stages of life. Thorough efforts should be made to obtain consent of the patient or the patient's surrogate(s).
4. Palliative care is often provided by multidisciplinary healthcare teams. When possible, the physician should be the leader of the team, being responsible, amongst other obligations, for diagnosis and medical treatment plans. A carefully kept medical record is of the utmost importance. The rationale for all symptom

management interventions, including medications for symptom relief, should be documented in the medical record, including the degree and length of sedation and specific expectations for continuing, withdrawing, or withholding future life-sustaining treatments.

5. The health care team should promote collaborative care of the patient and offer bereavement support after the patient's death. The needs of children and families or intimate associates may require special attention and competence, both when children are patients and when they are dependents of patients.

## Education and Research

6. Education of healthcare professionals should include the teaching of end-of-life medical care. Where it does not exist, the establishment of palliative medicine as a medical specialty should be considered. In countries where palliative medicine is not a recognized specialty, post-graduate training in palliative medicine can nevertheless improve the quality of palliative care provided.
7. Physician education should help to develop the skills necessary to increase the prevalence and quality of meaningful patient advance care planning for patients with life-threatening illness and the right of patients to use written advance directives that describe their wishes and goals regarding care in the event that they are unable to communicate. Physicians should receive education to encourage their patients to formally document their goals, values and treatment preferences and to appoint a substitute health care decision maker with whom the patient can discuss in advance his or her values regarding health care and treatment.
8. Governments and research institutions are encouraged to invest additional resources in developing treatments to improve end-of-life care. This includes, but is not limited to, supporting research on general medical care, specific treatments, psychological implications and organization to improve end-of-life care.
9. When employing treatments, the physician must carefully consider the balance between the intended benefits to the patient and the potential harm. National Medical Associations should support the formulation of palliative treatment guidelines.
10. The physician must also communicate to the patient a willingness to discuss at any time the natural course of the disease and what to expect during the dying process, while also providing guidance about treatments and alternatives that could ease the patient's suffering, including palliative care or psychotherapy. If a patient indicates a desire to die or expresses suicidal thoughts, the physician has a duty to engage in open and confidential discussions with the patient to understand the motives and reasoning behind these thoughts.
11. Physicians should assist the dying patient in maintaining an optimal quality of life by controlling symptoms and addressing psychosocial and spiritual needs, to enable the patient to die with dignity and in comfort. Physicians should inform patients of the availability, benefits and other aspects of palliative care. Discussions about patient preferences should be initiated early, routinely offered to all patients and should be revisited regularly to explore any changes patients may have in their wishes, especially as their clinical condition changes. Information and communication among the patient, his or her family or intimate associates, surrogates and members of the health care team are one of the fundamental pillars of quality care at the end of life.
12. Physicians should endeavor to identify, understand and address the psychosocial and spiritual needs of their patients, especially as they relate to patients' physical symptoms. Physicians should try to ensure that psychological, social and spiritual resources are available to patients, their families and intimate associates, to help them deal with the anxiety, fear and grief associated with the end of life.
13. Physicians should encourage patients to designate a substitute decision-maker/surrogate to make decisions that are not expressed in an advance directive. In particular, physicians should discuss the patient's wishes regarding the approach to life-sustaining interventions as well as palliative measures that might have the additional effect of accelerating death. Because documented advance directives are sometimes not available in emergency situations, physicians should emphasize to patients the importance of discussing treatment preferences with individuals who are likely to act as substitute health care decision-makers/surrogates. Whenever possible and consented to by the patient, the patient's substitute decision-makers/surrogates should be included in these conversations.
14. If a patient has decision-making capacity, his or her autonomous right to refuse any medical treatments or interventions must be respected even if the patient's life may be shortened. Physicians should make sure

that the patient is adequately treated for pain and discomfort before consent for end-of-life care is obtained in order to ensure that unnecessary physical and mental suffering do not interfere with decision making. Laws regarding the decision-making capacity of minor patients vary greatly, but discussions with the family, and child, if possible, are encouraged.

15. Upon a patient's death, physicians may apply such means as are necessary to keep organs viable for transplantation, provided that they act in accordance with the ethical guidelines established in the WMA Declaration of Sydney on the Determination of Death and the Recovery of Organs. In addition, any transplantation must be in accordance with the principles in the WMA Statement on Organ and Tissue Donation.