M. A. Akşit Koleksiyonundan

2

Yaşam Hakkı ile anlamsız, ümitsiz tedavi, hatalı Yaşam, en iyi yaşam standardı çelişkisi*

*The controversy among Right to Live and futile, hopeless treatment, wrongful life, best interest standard **

M. Arif AKŞİT**

***Yaşam Hakkı, var oluşun simgesi iken, bunu zedeleyecek bir yaklaşım kabul edilemez.**

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Bazı endüstriyel kültürel topluluklarda işe yaramayanın atılması gerektiği vurgusu vardır. Buna karşın çöpten yararlanma ve başkasının işine yaraması için bedelsiz bağış gibi yaklaşımların olmadığı da gözlenir. Atılmalı ve kurtulunmalıdır.

Yine birey görüşü ve kararı yerine, ortak akıl, kamu vicdanı gibi gerekçelerle toplumun kuralları ve kalıpları içinde olan kişi, çözüm için danışmanlık gerekecektir. Bu açıdan konsey, kongreler ve meclislerin görüşü önemlidir, ancak bunlar hukuki olarak bizi bağlamaz. Buna karşın diğer görüş, uyarı, öğüt ve danışmanlık yapılabilir ama rıza ve sorumluluk bireydedir, karar hekimdedir. Ancak, suç unsuru olmadıkça karışılamaz. Yaşam Hakkı tartışmasız olup, ne zaman başladığı ve sonlandığı gibi bir karar verilemez, hukuk açısından Kanunlarımızda suç unsurudur.

Sonuçta bu yazıda konu edilen, Yaşam Hakkı olunca tartışma olmayacağı sanılsa da anlamsız tedavi, yararsız yaklaşım, hatalı yaşam, en iyi yaşam standardı boyutu şeklinde tanımlamalar ile polemik boyutu gündeme getirilmektedir. Bu nedenle bu görüşlerin hukuksal olarak bir suç niteliğinde olduğu vurgusu amaçla bu Makale hazırlanmıştır.

Prematüre Yoğun Bakım Ünitesinde özellikle ufak prematürelere yaklaşım yaparken, bu çocukların özürlü olacağı, bu nedenle yaşamamalarının daha doğru olacağını iddia edenler çıkabilmektedir. Onlara söylenen ilk cümle "*onlara engelli demekteyiz, özür bizden, hayat hakkı tanımama yaklaşımı ve peşin*

hükümde bulunmaktan dolayı genel kanıdan dolayı onlardan bizim özür dilememiz gerektiğini söyleriz".

Biyolojide değişim ile yeni yapılanma beklenti ise, bunun malformasyonun olması da doğal sonucu olmaktadır, zaten yaşam gücü olmayan ölür, ölecektir, geçen yaşatma çabası bize bir eğitim, tecrübe kazanma şansı sağlamaktadır.

Özet

Yaşam Hakkı ile anlamsız, ümitsiz tedavi, hatalı Yaşam, en iyi yaşam standardı çelişkisi

Amaç: İnsanlar var oluşlarının başlangıcı fertilize olmak olsa da gebelik ve yenidoğan dönemini sağlıklı geçirmeleri ile çocuk ve yaşayabilir olurlar. Herhangi bir sorun durumunda, ümitsiz tedavi, hatalı yaşam ve en iyi yaşam standardını temin edilmemesi durumunda, yaşam hakkının alınması, ötenazi veya tedavi kesilmesi, ölmesinin sağlanması bir kültürel bakış açısı olarak etik ilke şeklinde karşımıza çıkmaktadır. Bu Makalede, Ülkemizde olduğu gibi suç kapsamındadır ve Hukuk temelinde Dünyada da kabul edilemez boyuttur. Bu vurgu yazıda yapılmaktadır.

Dayanaklar/Kaynaklar: Yaşam Hakkı ile ilgili bildirgeler, hukuk yapısı ve kaynaklar sunularak, varlığın temel unsuru yaşam olduğuna göre, bunun kısıtlanması bile suç kapsamında olduğu işlenmektedir.

Genel Yaklaşım; Bazı kültürel ve toplumsal yaklaşımların çeşitli gerekçeler ile, yaşam Hakkını çeşitli kurallara bağlaması ile bu usuller kabul edilemez boyuta gelmektedir. Gerekçeleri, anlamsız yaşam, ümitsiz tedavi ve hatalı yaşam ile en iyi yaşam standardında olmamak olarak tanımlanmaktadır. Yaşam varlığın temeli ise, bunun engellenmesi kabul edilebilir olmaz. Etik doğru, nedir ve ne yapmalıyım felsefik konusu iken, Hukuk haklar ile suç/ceza kavramında, yasaldır, suç kavramı etik dışıdır, kültürel boyut olması bu durumu değiştiremez.

Sonuç: Yaşam Hakkı ile özellikle prematüre ve Neonatoloji Bilim Dalında söz edilen konular irdelenerek, hukuk yaklaşımı ile hak edene, hakkını vermek ile, adaletli olarak düşünmek, dikkate alınmalıdır ki, yaşam hakkının alınabileceğini söylemek bile suçu övmek olarak suç niteliğindedir.

Yorum: Hekimin vazifesi insan sağlığı ve yaşamı, varlığına hürmet göstermek ise, yaşam hakkını da savunmak ve sağlamak için her türlü çabayı göstermesi de bir işlevi, görevidir. Ölüm bir yaratılış boyutu olarak her canlı için en büyük gerçektir, bu bir etki ve neden ile oluşmamalıdır.

Anahtar Kelimeler: Yaşam hakkı temel haktır, buna bir gerekçe ile sonlandıramazsınız

Outline

The controversy among Right to Live and futile, hopeless treatment, wrongful life, best interest standard

AIM: Fertilization of ovum is the starting point of existence as Human being, thus, intrauterin period and Neonatology duration as for healthy life state, vital important for childhood and adult stage. In case of problems, as, futile treatment, hopeless medication, wrongful life, and best standards of life cannot be reasoning for euthanasia and letting to die. Thus, as cultural perspective and for their ethical concepts, these concepts are presented as ethically. In our County, Right to Live is utmost important and letting to die in any way is legally cruel act, as in legitimate in Universally as un acceptable as in law. In this Article it is indicated as criminal subject.

Grounding Aspects: The Declarations, on Right to Life and legal perspectives and literature indications, noted the fact of life as vital importance, as restrictions are also legal criminal act as noted in this Article.

Introduction: Even in some valuations, under cultural and community contributions, as taken some regulations for presence of life, thus legally not an acceptable concept. Reasoning as futile treatment, wrongful life, and for best standards of life for optimization for letting to die, and ending the decision of life, as in our County as criminal act. Ethics, as concept, what is righteous and ought to do in right way as philosophical evaluation, not in consideration at criminal actions, not making difference as cultural aspects.

Notions: As a conclusion, Right to Life and especially at preterm infants, and Neonatology Section, the euthanasia and letting to die factors are illegal, even positive talking on euthanasia is also at criminal consideration.

Conclusion: As deontological duty, physician must respect the person life, health and reverent to them, care and serve their life, and being on utmost medical action. Death is a creational fact for every living organism, as creational truth, not any acts, contribution for life to leading death.

Key Words: Right to Life is utmost right, not being ended for any reasoning

Giriş

Seçim için oy atma sırasında dururken, bir aile vardı, yanlarında da bir çocuk olduğunu görünce aileden sevebilir miyim diye izin istedim. İletişime geçtim, anne siz 2016 Prematüre Gününde olan hekim misiniz diye sordu. Adımı da söyleyince o benim dedim. Çocukları 630gram doğmuş, 3 ay kadar Yoğun Bakımca kalmış, herhangi bir engeli de yokmuş. Anne kendisi de 4300 gram doğmuş, serviste şeker ve izleme alındığını da belirtti. Anne ve çocuk izlemde olmuşlar.

Burada ifade edilmeye çalışılan husus, eskiden sorun olunca canlandırma ekibi geliyor, 3-5 dakikada gelip, müdahale ediyorken, şimdi gebelikte izlem ile doğumda olan ekip, anında oksijenlenme sağlanıyor, herhangi bir hücresel sorun yaşanmıyor, gözlenmemektedir. Bu açıdan sekel olması için bir neden de olmamaktadır.

Geleceği kimse bilmez, hekimler garanti de vermezler ama fizyolojiyi sağlamak, fizyopatolojik olaylardan da korunması için yapacakları vardır. Mucize gibi ele alınabilinir. 1977 yılında lavaboda öldü denilen matür bebek, kalp 4-6 atımlı iken, canlandırma yapılmış, ağlamaya başlamış, hemşire Hz. İsa mısın demiş, ben de onun yaptığını yapıyorum demiştim. Bizde öğrenelim dediler ve bakış felsefesi değişmeye başlamıştır.

Yaşam Hakkı (Right to Live) ve faydasız yaklaşım (futile), ümitsiz tedavi (hopeless treatment), hatalı/haksız yaşam (wrongful life), ilgili standart Konuları

Peşin olarak Yaşam Hakkı temeldir, yaşamın başlama ve bitişi net bilinmediği, geleceğin bilinmemesi ile, garanti boyutlarının da geçersiz olması gibi, doğrudan canlı prematüre

doğurtulması veya bebeğim KCl ile öldürülüp sonra termine edilmesi dahil, yaklaşımların yapıldığı dikkate alınınca, bu konuların irdelenmesi ile olay daha net anlaşılabilir olacaktır.

Futile medical care, Wikipedia[1]

Futile medical care is the continued provision of medical care or treatment to a patient when there is no reasonable hope of a cure or benefit.

Some proponents of evidence-based medicine suggest discontinuing the use of any treatment that has not been shown to provide a measurable benefit. Futile care discontinuation is distinct from euthanasia because euthanasia involves active intervention to end life, while withholding futile medical care does not encourage or hasten the natural onset of death.[1]

Definition

In the broadest sense, futile care is care that does not benefit the patient as a whole, including physical, spiritual, or other benefits. This may be interpreted differently in various legal, ethical, or religious contexts. Clinicians and health care providers may need to rely on a narrower definition of futile care in order to make decisions about a patient's health care, and this definition often centers around an assessment of the likelihood that a patient could physically recover as a result of treatment. Alternatively, the assessment may be on the likelihood of such treatment to relieve a patient's suffering. Examples of futile care may be a surgeon operating on a terminal cancer patient even when the surgery will not alleviate suffering or doctors keeping a brain-dead person on life-support machines for reasons other than to procure their organs for donation. Futile care is a sensitive area that often causes conflicts among medical practitioners and patients or kin.[*citation needed*]

Many controversies surrounding the concept of futile care center around how futility is assessed differently in specific situations rather than on arguments in favor of providing futile care *per se*. It is difficult to determine when a particular course of action may fall under the definition of futile medical care because it is difficult to define the point at which there is no further benefit to intervention (varying from case to case). For instance, a cancer patient may be willing to undergo more chemotherapy with a very expensive medication for the benefit of a few weeks of life, while medical staff, insurance company staff and close relatives may believe this is a futile course of care.[2]

A 2010 survey of more than 10,000 physicians in the United States found respondents divided on the issue of recommending or giving "life-sustaining therapy when [they] judged that it was futile", with 23.6% saying they would do so, 37% saying they would not, and 39.4% selecting "It depends".[3]

Arguments against providing futile medical care

Arguments against providing futile care include potential harm to patients, family members, or caregivers with little or no likely benefits, and the diversion of resources to support the futile care of patients when resources could be used to provide care to patients that could respond to care.

Futile care does not offer benefits to the patient as a whole, and at the same time the physical, emotional, spiritual, economic, or ethical hardship and harm caused by futile care to the patient or to family members may be significant.

While futile care does not benefit patients, it may cost providers, the state, and patient families significant money and resources. In some cases, futile care involves the expenditure of resources that could be used by other patients with a good likelihood of achieving a positive outcome. For instance, in the case of Baby K, attempts to transfer the infant to other centers were unsuccessful because there were no unoccupied pediatric ICU beds in the region. Many critics of that case insist that the medical expenses used to keep the anencephalic child on life support for over two years could have been better spent on awareness and prevention efforts for her condition.[4]

Futile medical care and euthanasia

The difficulty with the issue of non-treatment lies in the borderline with euthanasia, which is punishable by law in most countries. Euthanasia designates a practice (action or omission) whose aim is to intentionally bring about the death of a person, in principle suffering from an incurable disease which inflicts intolerable suffering, particularly by a doctor or under his or her control. In France, the situation of Vincent Lambert, for example, has been qualified as unreasonable obstinacy by his doctor and by several court rulings, but has remained a source

of legal proceedings and societal debate for several years over whether stopping treatment would be euthanasia or not.

In France, the Code of Medical Ethics rejects the practice of "acharnement thérapeutique", while advocating palliative care . The aim of palliative care is not to hasten a patient's death, but to relieve pain, even if, to do so, caregivers sometimes use doses of analgesics or painkillers that risk bringing the moment of death closer.

Denmark recognizes patients right to refuse treatment.[5]

Issues in futile care considerations

The issue of futile care in clinical medicine generally involves two questions. The first concerns the identification of those clinical scenarios where the care would be futile. The second concerns the range of ethical options when care is determined to be futile.

Assessment of futility in a clinical context

Clinical scenarios vary in degrees and manners of futility. While scenarios like providing ICU care to the brain-dead patient or the anencephalic patient when organ harvesting is not possible or practical are easily identifiable as futile, many other situations are less clear.

A study in the United Kingdom with more than 180,000 patients aimed to define a timeframe for quantitative futility in emergency laparotomy and investigate predictors of futility using the United Kingdom National Emergency Laparotomy Audit (NELA) database. A two-stage methodology was used; stage one defined a timeframe for futility using an online survey and steering group discussion; stage two applied this definition to patients enrolled in NELA December 2013–December 2020 for analysis. Futility was defined as all-cause mortality within 3 days of emergency laparotomy. Results showed that quantitative futility occurred in 4% of patients (7442/180,987) and median age was 74 years. Significant predictors of futility included age, arterial lactate and cardiorespiratory co-morbidity. Frailty was associated with a 38% increased risk of early mortality and surgery for intestinal ischaemia was associated with a two times greater chance of futile surgery. These findings suggest that quantitative futility after emergency laparotomy is associated with quantifiable risk factors available to decision-makers preoperatively and should be incorporated into shared decision-making discussions with extremely high-risk patients.[6]

Over the last four decades, the clinical community has improved the quality of prognostic efforts. As a result, simple but imprecise rules of thumb like "percent mortality = age + percent burn" to judge the futility of burn cases involving elderly patients, have now given way to sophisticated algorithms based on multiple linear regression and other advanced statistical techniques. These are complex clinical algorithms that have been scientifically validated and have considerable clinical predictive value, particularly in the case of patients with severe burns. Such algorithms may provide high-quality prognostic information to aid patients and families in making difficult decisions, and have the potential to be used to guide resource allocation.

These prognostic algorithms estimate the probability of the patient surviving. In a study of patients so severely burned that survival was clinically unprecedented, during the initial lucid period (before sepsis and other complications set in) patients were told that survival was extremely unlikely (i.e., that death was essentially inevitable) and were asked to choose between palliative care and aggressive clinical measures. Most chose aggressive clinical measures, which may suggest that the will to live in patients can be very strong even situations deemed hopeless by the clinician.

Another practical clinical example that often occurs in large hospitals is the decision about whether or not to continue resuscitation when the resuscitation efforts following an in-hospital cardiac arrest have been prolonged. A 1999 study in the *Journal of the American Medical Association* has validated an algorithm developed for these purposes.[7]

As medical care improves and affects more and more chronic conditions, questions of futility have continued to arise. A relatively recent response to this difficulty in the United States is the introduction of the hospice concept, in which palliative care is initiated for someone thought to be within about six months of death. Numerous social and practical barriers exist that complicate the issue of initiating hospice status for someone unlikely to recover.[2]

Options for futile care and futile care as a commodity

Another issue in futile care theory concerns the range of ethical options when care is determined to be futile. Some people argue that futile clinical care should be a market commodity that should be able to be purchased just like cruise vacations or luxury automobiles, as long as the purchaser of the clinical services has the necessary

funds and as long as other patients are not being denied access to clinical resources as a result. In this model, Baby K would be able to get ICU care (primarily ventilatory care) until funding vanished. With rising medical care costs and an increase in extremely expensive new anti-cancer medications, the similar issues of equity often arise in treatment of end-stage cancer.[2]

Options to avoid futile care for yourself or family members

To prevent a possible situation where futile care might be enacted, a signed DNR or Do Not Resuscitate order can prevent these futile actions and treatments from being performed.

Yorum

Ölüm anında bile elini tutmak, ağrıyı geçirmektedir. Morfin verilmesine karşın, ağrı ifade eden kişilere, sevgi gösterilirse, endojen oluşan hormonların etkisi ile morfinden daha etkili değil, morfin ile etkileşimde sinerji olmaktadır: *Uygulamada bir çocuk düşer, annesi öperse, ağrı kesilir.* Burada ölüm üzere olan kişi, helalleşme denilen, son sözlerini iletmesi, karşılıklı olarak yaşam hesabının yapılması ile büyük rahatlama ile son nefesini vermektedir. Diğer boyutta bir sıkıntı ve çırpıntı içinde olmak vardır. *Tüm yaşam ve çabalarım, topluma desteğime karşın, beni tedavi etmiyorlar, ağrımı kesmiyorlar, benden öldürme izni istiyorlar* demektedir.

Kanıta Dayalı Tıp Kavramında vurgusu ile sanki bilim öngörmektedir şekline dönüştürülmektedir, ancak A grubunda bile uymama oranı %5-15 olmaktadır. Bunun anlamı %5-15 çocuğun yaşam hakkı alınmış olmaktadır: *Uygulama olarak aktif öldürme yapılmadığı için, tedavi kesilmesi ile bebeğin yavaş ama öleceği, ventilatörden çıkarmak veya oksijen kesilmesi yaklaşımın, pasif değil, aktif olduğu dikkate alınmalıdır*. Oksijenden çıkarma, hücre ve dokuların anokside kalması ve çırpınarak ölmesi ise, bebeği eziyet ederek öldürmek olmuyor mu diye sormalıdır. Burada ötenazi, hangi şekilde ele alınırsa da insan yaşamını sonlandırmadır. Hukuk (2006 Avrupa Konsey Kararı) yaşamın ne zaman başladığı ve sonlandığı bilinemez, bu açıdan kimsenin hakkı olamaz demektedir.

Kanser hastalarında sık rastlanan bir durum olmaktadır: *Uygulama olarak, komşumuz profesör mühendis olan arkadaşım, pankreas başı kanser olunca, literatüre bakmış ve 2 ay ömrü kaldığı için tedavi gereksiz diye mi diye sordu. Yanıtım, metastazlar çok ağrı verecektir, morfin bile sınırlı etkili olacaktır, ancak ilk kürü alınca, neticeye göre prognozu etkileyecektir dedim. %50'den fazla küçülme oldu, bir yıldan fazla yaşadı, ağrıları da olmadı, ailesi ile helalleşme oldu, çünkü sert kişi olduğundan, çocukları sonra babamızı sevmiyorduk sanırken, bir yılda sevgiyi öğrendik dediler*. Burada %23,6 yapacağını, %37 yapmayacağını, %39,4 oranı ise duruma göre demişlerdir. Üçte biri yaparken diğerleri karşıdırlar. Bir hekim olarak elinizin bağlı olması üzücüdür. Arkadaşın ailesi plasebo almışlar, yurtdışı kaynaklı, esrar türevleri, ben faydası olmaz ama kullanırsan, aileye psikolojik bir şeyler yapıyor diye onlara moral olur dedim. Kullandı, aile bu sayede ağrıları olmadı, bizim katkımız oldu diye sevindiler.

Kelime anlamı olarak yararsız tedavi doğru değildir. Her tıbbi yaklaşım tedavi üzerine değil, ağrıyı kesmek, psikolojik yaklaşım ve bir hastada tatmin oluşturmasıdır: *Uygulama olarak hastaya yararsız yaklaşım yapacak değil, ilaç etki ederse, yaklaşım daha rahat olacak denilir*. Bir kişinin anomalilisi varsa, bacağı yok ise, bunun yerine protez gündeme gelir, zihinsel olarak anenseflaisi olsa bile, birçok anneden elde edilen geri bildirim olarak, *sizler bizim bebeğimizi bir yana itmediniz, beslediniz, baktınız, gereken alet desteği de yaptınız. Sizler bize sevgi ve insanlığı açık göstermiş oldunuz* dediler.

Zakkum konusu: Bir zamanlar zakkumun kanser tedaisi yaptığı belirtildi, olgu sunumları olduğu söylendi. Hacettepe Onkoloji Hastanesinde hastalar bizi zakkum iyileştirdi diyerek TV çekimi yapıldı. Başhekime sorduk, tam tıbbi tedavi görmekteler,

zakkum kullandıklarını bilmiyorduk dedi.: *Uygulama olarak, çay gibi hazırlanıyor, Farmakognozi Profesörü akrabam, çay gibi hazırlandığı, sulu olursa toksik düzeyi düşük dedi. Testlerde yabancı cisim reaksiyonu yaptığı, ama kekiğin 25 kat daha güçlü olduğunu söyledi*.

Bir kişinin tedaviyi reddetme hakkı vardır, bu bir bakıma ötenazi kavramında olmakta, ancak bilinç kapanınca gereken tedavi yapılmaktadır: *Uygulama olarak açlık grevlerinde olduğu gibi, şekerli ve elektrolitli su ile yaşam boyutu uzatılabilmekte, ancak beyin atrofi olduğu için, bilinç kapanınca pek fayda olmamaktadır*. Burada anlamsız tedavi değil, ağrı kesiciler verilebilmektedir.

Burada anlamsız tedavinin iki boyutu ortaya konulmaktadır: 1) klinik olarak anlamsız olduğunu kim tanımlıyor? 2) Etik tercihler arasında hangisine uymaktadır? *Uygulama olarak yaşamın sonlanması boyutunda olanlar için, tedavi edilemeyecek denilmesi, bir insanlık dramı olmaktadır*. Burada psikolojik anlamda, plasebo uygulamalarına gidildiği toplumda sık görülmektedir. Bir ata sözü olarak "kabak suyu içsin" ifadesi kullanılır. Burada kefenlenirken kabak içinde konularak dökülen su kastedilirken, halk onu kabağın suyu içmesi olarak, plasebo anlamında kullanmaktadır.

Burada belirtilen an-ensefalit olması veya kortikal atrofi geçiren hastalardan söz edilmektedir; bunlar beyinde orta kısma geçmesi ile ölüm kaçınılmaz olacaktır. Bu bir süreçtir. Aileler beyin ölümü olmuş ise, geçen bir hafta içinde miras paylaşımı ile sosyolojik hazırlık yapılmakta, cenaze huzur içinde defnedilmektedir. Diğerinde de zaten süreç içinde bir boyut olmaktadır: *Uygulama olarak, yazarın annesi kortikal atrofi nedeni ile sekelli olarak 2,5 yıl kalmış ama aile bakımını destekle yaptırmış, pişman olmamıştır. Ecevit de kortikal atrofisi olmasına karşın işlevine devama ettirilmiştir*. Burada toplumun desteği önemlidir, olmaz ise Ülkemizde Devlet bunu sağlamaktadır.

Palyatif tedavi de bir gündeme gelendir, ağrı ve sızı giderilmesi bile çok önemlidir.

Amerika ailelerden imza almakta, Hastane Etik Kurul tarafından da anlamsız tedavi olarak görülürse, devlet desteğini çekiyor, aile ödemek zorunda kalıyor. 12bin dolar ilaç hariç masrafı günlük olarak ödenmesi imkânsız olduğu için, aile imzalamaktadırlar.

Palyatif tedavi bile yapılmadan, tedavinin reddedilmesi, devlete güveni oldukça sarsmaktadır. 11 Eylül nedeniyle yardım eden acil ekip, oksijen tüpü yetersiz olduğu için, toza maruz kalanlar, silikoza yakalanmaları nedeniyle sorun yaşamış, bu hastalar Kanda ve Küba'ya gitmek zorunda kalmışlar, çünkü orada Devlet ücretsiz baktığı için, vatanlarından kaçmış olmaktadırlar.

Canlandırma Yapmayın (DNRO) aynı şekilde hem aile hem kişi açısından ölürken tüm güveni sarsıcı olmaktadır.

SON SÖZ: **Palyatif tedavi seçeneği varken, tedavi edilmeme kararı bu açıdan bir insanlık ayıbı gibi durduğu söylenebilir.**

Wrongful life, Wikipedia[2]

Wrongful life is the name given to a cause of action in which someone is sued by a severely disabled child (through the child's legal guardian) for failing to prevent the child's birth. Typically, a child and the child's parents will sue a doctor or a hospital for failing to provide information about the disability during the pregnancy, or a

genetic disposition before the pregnancy. Had the mother been aware of this information, it is argued, she would have had an abortion, or chosen not to conceive at all.

The term "wrongful life" is also sometimes applied to what are more accurately described as **wrongful living** claims[1] alleging that doctors or hospitals failed to follow a patient's end-of-life directive (for example, a MOLST or POLST) and kept the patient alive longer than preferred, thereby causing unnecessary and unwanted suffering.[2] However, the confusion between the two is understandable and readily explained. Although wrongful life and wrongful living claims arise at opposite ends of the human lifespan, they are related in the sense that both types of claims seek the same relief: a judgment awarding monetary damages for "unwanted life."[1]

History

Historically, only parents could sue for their *own* damages incurred as a result of the birth of a disabled child (e.g., the mother's own pregnancy medical bills and cost of psychiatric treatment for both parents' emotional distress resulting from the realization that their child was disabled). This cause of action is known as wrongful birth. But the child could not sue for his or her own damages, which were often much more substantial, in terms of the cost of round-the-clock personal care and special education.

In four U.S. states—California, Maine, New Jersey, and Washington—the child is allowed to bring a wrongful life cause of action for such damages.[3] In a 1982 case involving hereditary deafness, the Supreme Court of California was the first state supreme court to endorse the child's right to sue for wrongful life, but in the same decision, limited the child's recovery to special damages.[4][5] This rule implies that the child can recover objectively provable economic damages, but cannot recover general damages like subjective "pain and suffering"—that is, monetary compensation for the entire experience of having a disabled life versus having a healthy mind and/or body.

The Supreme Court of California's 1982 decision, in turn, was based on the landmark California Court of Appeal decision in *Curlender v. Bio-Science Laboratories* (1980).[6] The *Curlender* decision involved a child who was allegedly born with Tay–Sachs disease after the parents relied upon the defendants' representations about the reliability of their genetic tests in refraining from proceeding with amniocentesis.

The most famous passage[7][8][9][10] from the *Curlender* opinion is as follows:

The circumstance that the birth and injury have come hand in hand has caused other courts to deal with the problem by barring recovery. The reality of the "wrongful-life" concept is that such a plaintiff both exists and suffers, due to the negligence of others. It is neither necessary nor just to retreat into meditation on the mysteries of life. We need not be concerned with the fact that had defendants not been negligent, the plaintiff might not have come into existence at all. The certainty of genetic impairment is no longer a mystery. In addition, a reverent appreciation of life compels recognition that plaintiff, however impaired she may be, has come into existence as a living person with certain rights.

Curlender was not the first appellate decision to authorize a cause of action for wrongful life—it noted that a 1977 decision of the intermediate appellate court of New York had taken the same position, and was promptly overruled by the highest court of that state a year later. However, *Curlender* stands as the first such appellate decision which was *not* later overruled.

Most other jurisdictions, including New York,[11] England and Wales,[12] Ontario,[13] and Australia,[14][15] have refused to allow the wrongful life cause of action.

In Germany, the Federal Constitutional Court declared wrongful life claims unconstitutional. The court reasoned that such a claim implies that the life of a disabled person is less valuable than that of a non-disabled one. Therefore, claiming damages for one's life as such violates the human dignity principle codified in the first article of the German Basic Law.[16]

Nevertheless, the German Federal Court stuck to its previous practice of granting to suffered families indemnification in form of living expenses for a child.[17] It emphasized that damages referred to did not imply the existence of the child by itself but the economical obligation of parents to pay maintenance. It was finally upheld by the Constitutional Court in 1998, stating no matter what was the difference between existence of a child and parents' obligation to pay maintenance in terms of damage, because the recognition of a child as a person after Art. 1 I GG did not lay on the undertaking that obligation by parents.[18]

In 2005, the Dutch Supreme Court fully upheld a wrongful life claim in the Netherlands' first wrongful life case ever.[19]

Ethics

Since wrongful life suits are a relatively new application of human rights, doctors and scholars have not come to consensus regarding their place in medical ethics.[20][21] Others have objected to wrongful life claims on conceptual grounds, including the question of whether there exist rights and duties with regards to non-existent persons.[22]

Yorum

Batı toplum görüşü üzerinde karar verdiği dikkate alınınca, Etik Kurullar nasıl sorumlu oluyorlarsa tedavi sonlanabilir kararı ile tedavi kesilebilmektedir.

Amerika'da hastana Etik Kurulunda, bir çocuk bisikleti ile kaza yapmış, bir hafta içinde toparlanmadığı için, yaşamın sonlanması, ventilatör kesilmesi kararı alındı. Benim itirazım oldu, oğlumun sınıf arkadaşı ODTÜ okurken, araba ile nehre düştü, iki ay ventilatörde kaldı, bilinç kapalı idi, sonra toparlandı ve mezun oldu örneğini getirdim. Cevap, sen asli Kurul üyesi değilsin, oyun geçerli olmaz denildi.

Ağır engelli çocukların bu şekilde yorumlanma boyutu insanlık ayıbı olarak görülmektedir: *Uygulama olarak gebelik takibinde embriyonik olarak 10 Gebelik Haftasına göre bunlar saptanabilir ve listede olan hastalıklar ise sonlanabilir*. Bu açıdan bunların doğması eğer tıbbi bakım, gebelik kontrolü olmadan ise, sonradan da öldürülmesi, ötenazinin bir anlamı, toplumun suçunu örtmesi anlamında olmamalıdır. Yaşatılması bir eziyet değildir, bir anlamı vardır. Sevgisiz büyümesi de bir eziyet kapsamında olduğu için, bu çocukların sevilmesi ile elde edilen oksijenlenme, oksijen dozunu, oranını arttırmaktan daha ileri olmaktadır, yapan bilir ve gözlemler.

Bitkisel hayatın devamlılığını sağlamanın ne yararı olabilir sorusu gelmektedir. Bunun aksi öldürme girişimidir ki kim yapıyorsa cellat işi yapmaktadır. Zaten beyin ölmüş ise bir haftadan fazla yaşayamaz, yaşıyorsa tanı hatalıdır: *Uygulama olarak yaşama boyutu yaratılış üzere ise, neden yaşadığının bilimsel sorgulanması daha anlamlı olacaktır*.

SON SÖZ: Haksız yaşam demek, yaratılışa karşı çıkmaktır. Bir kişi an-ensefalili doğabilir ama bunların incelenmesi ile akciğer maturasyona doğru ilerleme gözlenir ve surfaktan bulunarak uygulanıyorsa, yaratılışta boşa olan yoktur denilmelidir.

Medical Orders for Life-Sustaining Treatment, Wikipedia[3]

MOLST is an acronym for Medical Orders for Life-Sustaining Treatment. The MOLST Program is an initiative to facilitate end-of-life medical decision-making in New York State, Connecticut, Massachusetts, Rhode Island, Ohio and Maryland, that involves use of the MOLST form. Most other U.S. states have similar initiatives, such as Physician Orders for Life-Sustaining Treatment. In New York state, the MOLST form is a New York State Department of Health form (DOH-5003). MOLST is for patients such as a terminally ill patient, whether or not treatment is provided.[1] For this example, assume the patient retains medical decision-making capacity and wants to die naturally in a residential setting, not in the intensive-care unit of a hospital on a ventilator with a feeding tube. Using MOLST, with the informed consent of the patient, the patient's doctor could issue medical orders for life-sustaining treatment, including any or all of the following medical orders: provide comfort measures (palliative care) only; do not attempt resuscitation (allow natural death); do not intubate; do not hospitalize; no feeding tube; no IV fluids; do not use antibiotics; no dialysis; no transfusions. The orders should be honored by all health care providers in any setting, including emergency responders who are summoned by a 9-1-1 telephone call after the patient loses medical decision-making capacity.[2][3]

MOLST Program in New York State

The MOLST Program is a New York State initiative that facilitates end-of-life medical decision-making. One goal of the MOLST Program is to ensure that decisions to withhold or withdraw life-sustaining treatment are made in accordance with the patient's wishes, or, if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests.[1]

Patricia "Pat" Bomba, MD, has spearheaded the MOLST Program since its inception. Dr. Bomba is a Vice President at Excellus BlueCross BlueShield.[4]

Information about the MOLST Program can be found on the website that Dr. Bomba runs called www.compassionandsupport.org.

Legal basis in New York State

Under New York common law, health care providers may withhold or withdraw life-sustaining treatment from a patient who is dying and currently lacks the capacity to make his or her own medical decisions if doing so is based upon clear and convincing evidence of the patient's wishes.[5]

Since 1987, New York has had a Do Not Resuscitate (DNR) law allowing surrogates to make decisions regarding cardiopulmonary resuscitation on behalf of an adult patient who lacks medical decision-making capacity.[6] In 1991, the law was amended to authorize non-hospital orders not to resuscitate.[7] Based upon this law, the New York State Department of Health created a "standard form" to issue a non-hospital order not to resuscitate (DOH-3474), which is still in use today.

In 2005, the law was amended to give the New York State Department of Health authority to issue "alternative forms" for issuing non-hospital orders not to resuscitate in Monroe and Onondaga Counties.[8] This established MOLST as a pilot program. In 2006, the law was amended to allow such "alternative forms" to be used to issue non-hospital Do Not Intubate (DNI) orders.[9] This was necessary because in New York State, emergency medical services personnel may only honor a DNR order in the event of a cardiac or respiratory arrest and would still intubate a patient with a DNR order unless the patient's heart or breathing has completely stopped.[10]

In 2008, MOLST ceased to be a pilot program when the law was amended to authorize use of the MOLST form as a non-hospital DNR and DNI order statewide.[11] In 2010, along with passage of the Family Health Care Decisions Act, the legal authority for MOLST was moved from N.Y. Public Health Law Article 29-B to a new N.Y. Public Health Law Article 29-CCC.[12]

Under current law, the MOLST form can be used to issue a non-hospital DNR and DNI order in New York State, and those orders must be honored by emergency medical services personnel, home care services personnel, hospice personnel and hospital emergency services personnel.[13] Physicians may also use the form for any patient in any setting to issue any orders for life-sustaining treatment.[2][14][15]

Coverage for an initial preventive physical examination under Medicare Part B includes verbal or written information regarding a patient's ability to prepare a MOLST form and the physician's willingness to issue orders on a MOLST form.[16]

New York Public Health Law section 2997-c requires the "attending health care practitioner" to offer to provide patients with a terminal illness with information and counseling regarding palliative care and end-of-life options appropriate to the patient.[17]

Yorum

Kurullar toplanıyor ve aileye senin çocuğunu/bebeğini yaşam desteğini kapatıp, ölüme erk edeceğiz deniliyor ve form uzatılıyor. Burada ekonomik olmadığı için Devlet desteği, sigorta karşılamayacağı belirtilerek imza isteniyor, yoksa kendisi ödeyeceği ifade ediliyor: *Uygulama olarak bir prematüre artık sekeli yaşamasın diyen bir ünitede olmak istemem, bu bir acımasızlıktır. Yapılacak olan bir daha sonraki olmasın diyerek neler yapalım olmasıdır.*

Canlandırma Yapmayın ve diğer ötenazi yaklaşımı olan toplumda mahkemeler de kurul kararına uymaktadırlar. Başkan Reagan daha önce bu kararı hekim verdiği için, sorumluluk genişlemesi için Hastane Etik Kurulları vermesini oluşturmuştur.

Physician Orders for Life-Sustaining Treatment, Wikipedia[4]

POLST (**Physician Orders for Life-Sustaining Treatment**) is an approach to improving end-of-life care in the United States, encouraging providers to speak with the severely ill and create specific medical orders to be honored by health care workers during a medical crisis.[1] POLST began in Oregon in 1991 and currently exists in 46 states; some of the 46 states have the program in development.[2] The POLST document is a standardized, portable, brightly colored single page medical order that documents a conversation between a provider and an individual with a serious illness or frailty towards the end of life. A POLST form allows emergency medical services to provide treatment that the individual prefers before possibly transporting to an emergency facility.

The POLST form is a medical order which means that the POLST form is always signed by a medical professional and, depending upon the state, the person stated on the form can sign as well. A pragmatic rule for initiating a POLST can be if the clinician would not be surprised if the individual were to die within one year.[3] One difference between a POLST form and an advance directive is that the POLST form is designed to be actionable throughout an entire community.[4] It is immediately recognizable and can be used by doctors and first responders (including paramedics, fire departments, police, emergency rooms, hospitals and nursing homes). Comparing to documents like DNI (Do Not Intubate), DNR (Do Not Resuscitate) and advance directive, the POLST form provides more information on the types of end-of-life treatment or intervention that the severely ill wishes to receive.[5]

Organizations that have passed formal resolutions in support of POLST include the American Bar Association[6] and the Society for Post-Acute and Long-Term Care Medicine[7] (AMDA). Other organizations that support POLST include the American Nurses Association[8] (ANA); the Institute of Medicine;[9] National Association of Social Workers[10] (NASW); AARP;[11] the American Academy of Hospice and Palliative Medicine[12] (AAHPM); Pew Charitable Trusts;[13] and the Catholic Health Association of the United States [14](CHA).

POLST orders are also known by other names in some states: Medical Orders for Life-Sustaining Treatment (MOLST), Medical Orders on Scope of Treatment (MOST), Physician's Orders on Scope of Treatment (POST) or Transportable Physician Orders for Patient Preferences (TPOPP).[15]

What is POLST?

POLST represents a significant paradigm change in advance care policy by standardizing provider communications through a plan of care in a portable way, rather than focusing solely on standardizing individuals' communications via advance directives.[3]

The POLST paradigm requires people, their surrogates, and their providers to accomplish three core tasks:

- First, POLST begins with a conversation between a health care professional and the individual (or the individual's authorized surrogate) about treatment options in light of the individual's current condition.[3]
- Second, the individual's preferences for treatments are incorporated into medical orders, which are recorded on a highly visible, standardized form that is kept at the front of the medical record or with the individual if they lives in the community.[3]

POLST forms record several treatment decisions common to seriously ill individuals, for example: cardiopulmonary resuscitation; the level of medical intervention desired in the event of an emergency (comfort only, limited treatment, or full treatment); and the use of artificial nutrition and hydration. As technology and treatment options change, POLST forms will also continue to evolve.[3]

- Third, providers encourage that the POLST form travels with the individual whenever he or she moves from one setting to another, thereby promoting the continuity of care throughout a community.[3]

The POLST form is designed to transfer across treatment settings, so it is readily available to medical personal, including EMTs, emergency physicians and nursing staff.[16] The POLST program relies upon teamwork and coordinated systems to ensure preferences are honored throughout the health care system. Research suggests the POLST form accurately represents individual's treatment preferences the majority of the time[17] and that the treatments provided at the end of life match the orders on the form.[18] An established POLST program can help reduce unwanted hospitalizations and honor the person's end-of-life wishes.[1]

To determine whether a POLST form should be completed, clinicians should ask themselves, "Would I be surprised if this person died in the next year?" If the answer is that the patient's prognosis is one year or less, then a POLST form is appropriate.[19]

In a 2006 consensus report, the National Quality Form observed that "compared with other advance directive programs, POLST more accurately conveys end-of-life preferences and yields higher adherence by medical professionals." The National Quality Forum and other experts have recommended nationwide implementation of the POLST paradigm [20] Implementation of POLST was also recently recommended by the National Academy of Sciences Institute of Medicine in its report, "Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life." The report was released September 17, 2014.

What is on the POLST Form?

The POLST form is usually on brightly colored paper that contains options for the individual depending on their health status. The POLST form generally has sections for the individual to decide whether or not they would want cardiopulmonary resuscitation (CPR), the preferred level of medical interventions, or whether they would want artificially administered nutrition. Depending on the state, there could be another section on whether to provide antibiotics or not to the individual being treated.[21]

Cardiopulmonary Resuscitation (CPR)

The first section in most forms across the country is Section A indicating the option between performing cardiopulmonary resuscitation (CPR) or no CPR or do not attempt to resuscitate. The national form indicates mechanical ventilators, defibrillation and cardioversion under the CPR specifications.[22] A study showed that there was a high rate of providers respecting the individual's decisions regarding CPR, which means that the providers respected their wishes according to the POLST forms.[23]

Preferred Medical Interventions

The level of medical intervention is on section B on the POLST form with options of "comfort measures", "limited additional treatment", or "full treatment".[21] This section only comes into play if the individual still has a pulse and/or if they are still breathing.[21] The "comfort measures" allow for natural death and only helps the individual relieve any pain. By checking this box, the individual also prefers to not be transferred within the hospital.[21] The "limited additional treatment" includes the comfort measures in addition to basic medical treatment.[21] “Full treatment” authorizes the medical team to try their best to save the individual and increases their life expectancy with all methods.[21] This option also allows people to choose whether they would like a trial period. A study on nursing home residents has shown the high rate that the medical teams respected peoples’ wishes and gave the treatments according to the orders on section B.[23]

Artificially Administered Nutrition

This section comes with options of “no artificial nutrition by tube”, “defined trial period of artificial nutrition by tube” and “long-term artificial nutrition by tube”.[21] If the person is able to chew and swallow, the food will be taken by mouth. Studies have found that orders to withhold artificial nutrition such as feeding tubes are usually executed by the providers.[23]

Antibiotics

For most versions of POLST, orders on antibiotics have three aspects: antibiotic use to enhance comfort, the use of intravenous/intramuscular (IV/IM) antibiotics, and the use of antibiotics at time of disease or infection.[23] Studies have found orders on the use of antibiotics for comfort measures tend to have high rates of execution.[23] However, one study has shown that providers do not always obey the individual's wish to not use antibiotics.[23] Because certain types of infection have other means to alleviate symptoms of infections, so physicians' use of antibiotics seem to be generally unaffected by POLST.[23]

How is the Form Used?

Before executing the orders on the POLST form, the provider should talk with individuals with decision-making capacity to obtain the most updated wishes.[5] This process or conversation could involve families and relevant care providers as well to ensure people are well-informed while making the decisions.[5] If the individual has made changes to the POLST form, the provider is responsible for explaining how the updates will likely impact future treatment plans.[5] However, if the individual is not able to make decisions because of his or her disease state, the clinicians have to follow orders on preexisting POLST forms.[5]

Differences between an advance directive and a POLST Form

Advance Directive

An advance directive is a legal document that allows individuals to share their wishes with their health care team during a future medical emergency.[4] The document does so by designating a guardian that the user wants their medical team to work with (also known as a "surrogate").[24][4] Competent individuals above 18 years of age can fill out an advance directive.[4] An advance directive allows an individual to state what treatments he or she would want in a medical crisis, but it is not a medical order.[4] Advance directives are not portable in a sense that it is not accessible across medical systems, so it is the individual's responsibility to have the form on them at all times.[4] This can bring up challenges as it can be difficult to locate and may need to be interpreted when it is needed.[4] Because advanced directives are filled out by healthy individuals, the form is considered to be a "living will".[24]

POLST Form

Unlike advance directives, a POLST should only be used when the individual is at the end of life.[15] Typically, if a provider believes that a person's condition will increasingly worsen and make it hard for the individual to survive another year, then a POLST Form is used.[24] A POLST form turns a person's treatment wishes outlined in an advance directive into medical orders.[25] The POLST Form provides explicit guidance to healthcare professionals under predictable future circumstances based on the individual's current medical condition.[1] The POLST form is reviewed more frequently compared to an advance directive to make sure that the form complies with the individual's wishes in treatments as the disease progresses.[24]

Compared to the advanced directive, there is no designated surrogate when using a POLST Form.[24] To designate a health care surrogate, people must use an advance directive.[24] Once a surrogate is established and if the individual does not have the mental capacity to make decisions, the surrogate has the authority to make decisions on the POLST Form; the amount of authority for the surrogate, however, varies per state.[24] An individual does not need to have an advance directive to have a POLST form although health care professionals recommend that all competent adults have advance directives in place; this will help healthcare providers shape a more concise medical decision that better reflects the individual's wishes.[24]

Lastly, the POLST form is very portable unlike the advance directive. It is the physicians' responsibility to make it accessible across different medical facilities.[4]

POLST History

- 1991: Oregon POLST task force was created. The first prototype was known as the Medical Treatment Cover Sheet (MTC).[26][27] This was created to have a standard to regulate medical orders for people with chronic illnesses. The list of treatments that were included on this form would include resuscitation, nutrition, intubation, antibiotics, and other preferred medical interventions.[28] Focus groups and studies were executed to evaluate the use of this form and significant modifications were made. This later resulted in the renaming of the form.[23]
- 1993: The name "Physician Orders for Life-Sustaining Treatment or POLST was adopted.[28]
- 1995: First POLST form was used in Oregon. Many other states wanted to implement this in their own settings so there was a need for execution at a national level.[27]
- 2004:
    - National POLST Paradigm Task Forced was developed. The task force included Oregon, New York, Pennsylvania, Washington, West Virginia, and Wisconsin. The focus of the task force was to create an organized standard and help other states who wanted to develop a POLST program.
    - Georgia, Idaho, Maryland, Nevada, Utah, and Vermont were all under development for POLST by this time.[27]
- 2005: The National Task Force created a clearer description and outline of the program including the contents of the form and developments of endorsement for the program. This was established as the National POLST Paradigm.[27]
- 2006: West Virginia and Wisconsin adopt POLST. Iowa forms a focus group of health care providers to address the current fragmentation of end-of-life communication.
- 2007: A formal in-person meeting was held for education on the POLST paradigm at the National Hospice and Palliative Care Organization conference in New Orleans.[27]
- 2008: POLST becomes law in California and MOLST becomes law in New York. Iowa pilot project conducted (continues until 2011).

- 2009:
  - A second in-person formal meeting was held with the American Academy of Hospice and Palliative Medicine national conference in Austin, Texas. A major goal at this point was to have a structure similar in all states so it can be used and honored in all states and provide education about the program for efficient care. The program gives people the power to make the decision about their care and provides a guidance for decision-making about life-sustaining treatments.[27]
  - Massachusetts MOLST Demonstration Project was implemented in Massachusetts pursuant to a mandate in the Commonwealth Acts of 2008. MA MOLST form http://molst-ma.org/sites/molst-ma.org/files/MOLST%20Form%20and%20Instructions%208.10.13%20FINAL.pdf
  - Oregon developed a way to allow electronic access of POLST statewide to steer away from paper forms and accessing medical records.[28]
- 2010: Illinois forms the POLST Taskforce with support from more than 60 health care organizations; the Catholic Health Association formally supports POLST.[14]
- 2011: POLST is signed into law in New Jersey [29] after Governor Chris Christie conditionally vetoes S-2197 for provisions allowing doctors to override people's wishes[*citation needed*]. Vermont requires all out-of-hospital DNR/COLST orders to be documented on the Vermont DNR/COLST form.
- 2012:
  - First National POLST Conference held in San Diego, California.[30] Iowa passes legislation to implement the current IPOST form; Illinois passes POLST legislation (Illinois introduces a POLST form in March 2013).
  - Wisconsin Catholic bishops warn against POLST.[31]
  - Anti-abortion groups react to Wisconsin bishops' statement.[32]
  - Anti-abortion leaders find parallels between POLST ramifications and similar political expedients in history.[33]
  - The Catholic Health Association specifies how the POLST form is consistent with the Catholic Directives.[34]
- 2013: POLST becomes law in Indiana and Nevada; 20 states have POLST statutes.[35] 27 states was under development for this program. Only 7 states at this point did not have POLST in some form of development.[28]
- 2015:
  - California allows a nurse practitioner or physician assistant under a supervision of a physician to sign a POLST form.[36]
  - 46 out of 50 states have the program established or under development.[2]

Public Opinions

Support

Supporters suggests that POLST protects individuals' right to make their own medical decisions and prevents the miscommunications among individuals, their family members and healthcare providers.[21] Most healthcare providers have a positive attitude towards POLST, saying that the form presents peoples' wishes and they can provide better care at individual's end of life with the form as guidance.[23] This also prevents undesirable interventions as well as unnecessary expense on hospice care in healthcare facilities.[21] For example, the medical teams would not give resuscitation or other medical interventions unless individuals indicate on the form. According to Gundersen Lutheran Health System, after they have adopted POLST, about $3000 to $6000 is reduced at the cost for each person because the hospital does not need to use medical devices or interventions to support their lives after they select "comfort measures" on the form.[21] In addition, the formal document is a standard medical order signed by physicians and it is legal and effective in various healthcare settings and states.[21] In other words, if individuals travel to another state with POLST, hospitals in that state may accept the form as a plan of care and fulfill their wishes at the end of life. POLST can be also an implement to examine any discrepancies between the actual treatments and individuals' preferences, and to make sure that healthcare providers would respect and obey their preferences,[37] which avoids the situations that may go against their wills.

POLST covers the limitations that advance directives and Do Not Resuscitate or Do Not Intubate orders (DNR/DNI) have.[5] For example, illnesses are unsteady as the conditions may change in severity every day. Individuals that are 18 years old and above can fill out the form when they are healthy and competent, but they are not able to foresee what may happen and they may change their mind in treatments;[4] however, advance directives does not take the changes into consideration.[5] The form can be filled out by surrogates who may express individual's preferences differently or mistakenly.[5] Also, DNR/DNI only considers the situations that are related to CPR or intubation instead of recording individuals' preferences in various situations at the end of their lives.[5] Some studies have shown that the providers were less likely to give aggressive treatments to individuals with DNR/DNI even if they are not critically ill. A study on nursing home residents has found that most residents with DNR order marked on POLST forms that they would like to have treatments, which indicates that DNR orders do not convey individual's ideas and POLST is a better tool in communication.[5][17] Therefore, advance directives and DNR/DNI may not be truly proposed to improve individuals care at the end of life.[5]

Opposition

Conservative groups like the Media Research Center and the Catholic Medical Association argue that there will be unintended consequences or potential abuses fostered by POLST adoption.[38][32][39] In some cases, this results from the way the enabling laws are written. Any document determining an individual's quality of care or life-ending choices carries moral and ethical dilemmas, and POLST instruments (or the protocols and circumstances through which they are explained to people) have been criticized for this by the Catholic Medical Association. The Catholic Health Association answered criticisms in a white paper entitled "The POLST Paradigm and Form: Facts and Analysis." POLST is viewed to be conflicted with Catholic ideas on "rightful and wrongful refusal decisions" especially on the last section about nutrition and antibiotics, and the Catholic providers feel being forced to follow the order since it seems to violate their beliefs.[21]

Healthcare providers also mention some challenges that have met when introducing POLST to individual's and their families.[23] They may not feel comfortable discussing the content of the form or they have trouble understanding it.[23] People and their family members may also have different opinions when completing the form.[23] In addition, the physicians may not support POLST and refuse to sign because they are worried that they may need to take the blame or have some responsibilities by signing it even if using the form is a part of standard care.[5]

Some people suggested that some of the questions on POLST forms do not apply to actual situations.[40] For example, in the first section on the form is asking if individuals would like to have resuscitation when they do not have pulses.[23] But some individuals may not be hospitalized or they may be living at home and cannot get access to the interventions mentioned on the form; and thus, the question is not suitable for their situations.[40] Some people also doubt whether POLST truly delivers individuals' wills as they may change their minds in different contexts.[21] Studies have shown that up to 45% of individuals were unsure of their choices when they first filled out the form and up to 70% of individuals had inconsistent answers when the questions were phrased differently.[21]

POLST research

Several studies have supported the use of POLST as a tool to ensure people's wishes are complied with:

- In a 1998 study, charts of 180 residents at eight Oregon nursing facilities were evaluated over a one-year period. Where the POLST forms of residents included "do not resuscitate" and "comfort measures only" orders, none of the residents received unwanted cardiopulmonary resuscitation (CPR), intensive care, or ventilator support.[41]
- In 2000, a study was done in the community setting showed that CPR use was 91% consistent with the use of POLST forms and about 45% of medical interventions were consistent with section B of the form.[23]
- In 2004, a survey of selected sites revealed that the POLST program was widely used in Oregon nursing facilities. Care matched POLST instructions to a high degree regarding CPR (91%), antibiotics (86%), intravenous fluids (84%), and feeding tubes (94%). Level-of-care instructions (from comfort care to full medical intervention) were followed less often (46%).[17]
- A 2004 survey of 572 EMTs in Oregon found that a large majority of EMTs felt that the POLST form provides clear instructions about people's preferences and is useful when deciding which treatments to provide.[3]

- In 2009, researchers assessed the penetration of POLST in hospice programs in Oregon, Wisconsin, and West Virginia.[42] A pilot study indicated that POLST was used widely in hospices in Oregon (100%) and West Virginia (85%) but only regionally in Wisconsin (6%). A majority of hospice staff believed POLST was useful in preventing unwanted resuscitation and initiating conversations about treatment preferences.[3]
- In 2010, an observational retrospective cohort study compared the use of the POLST forms with the use of "traditional" orders in 1711 residents of nursing facility.[43] The results of the study showed that individuals are much more likely to include end-of-life treatment preferences "beyond CPR status" when using the POLST form (98%) than "traditional practices or orders" (16%).[43]
- In 2011, a survey with a sample size of 169 was done in the state of New York found that the about half of the providers and healthcare workers including physicians, nurses, social workers and nurse practitioners felt the need to have a conversation about the POLST form with the individual they are providing service to.[23] The major reason for this preference is these healthcare workers believe the use of the POLST form can lead to better management of disease symptoms such as pain.[44]
- In 2014, state death records containing cause and location of death were matched with POLST orders for people (sample size N = 58,000) with a POLST form in the state registry.[23] Conclusion: The association with numbers of deaths in the hospital suggests that end-of-life preferences of people who wish to avoid hospitalization as documented in POLST orders are honored.[37]
- In 2014, a chart review study with a sample size of 31,294 studied POLST forms in an electronic registry in the state of Oregon.[45] The study found that POLST forms came in six different combinations: "DNR/Comfort Measures Only, DNR/Limited Interventions, DNR/Full Treatment, Attempt CPR/Comfort Measures Only, Attempt CPR/Limited Interventions, and Attempt CPR/Full Treatment."[45] The data showed that about 10% of the order combinations appeared confusing and did not make sense to providers because they seemed contradicting. The most popular combinations were "DNR/Comfort Measures and DNR/Limited Interventions."[23]
- In 2016, the study included comparison of two different state POLST programs having distinct demographics and different approaches to electronic registries. A key metric evaluated was the relationship of POLST medical intervention orders to in-hospital death, which was evaluated using POLST data linked with state death records. Conclusion: the study indicated similar patterns between the two states in which Comfort Only orders less often resulted in in-hospital deaths, compared to Full Treatment orders.[46]

Limitations of POLST Research

Most of the studies done on the POLST research were done in Oregon where there is a less diverse demographic.[23] The studies done on POLST were mainly done in nursing facilities. Therefore, there is limited data about POLST in other parts of the community.[23] In addition, the training for the physicians for implementing POLST program may not be consistent throughout different healthcare facilities.[23]

Yorum

Eve Bakım gibi, hastaların ölüme terk edilmesine karşın oluşan bir palyatif boyut olduğu anlaşılmaktadır: *Uygulama olarak eşitli formların geliştirildiği görülmektedir.*

Hastanın kendisi yaşam boyutu uyarlaması ile, canlandırma yapılması dahil kendi seçeneği olmaktadır. *Uygulama olarak Katolikler dahil, cana müdahale etme boyutu ile karşı çıkmaktadırlar*.

Wrongful abortion, Wikipedia[5]

The term **wrongful abortion** refers to an abortion that a pregnant woman undergoes as a result of negligent or malicious conduct by a physician or health care provider.[1]

Types of wrongful abortion

There are at least two archetypal cases of wrongful abortion:

Misinformation about pregnancy

In a case of the first type, a pregnant woman seeks medical counseling regarding the possible perils related to the continuance of her pregnancy. The adviser mistakenly maintains that the pregnancy is fraught with substantial risks for the woman, and she consequently decides to undergo an abortion. Later it is found that the information given by the adviser was wrong.[2][3]

Misinformation about health of fetus

In a case of the second type, the woman seeks advice concerning the health and bodily integrity of her fetus (*see* genetic counseling, prenatal diagnosis), and decides to undergo an abortion after being told that the fetus is deformed or disabled. Here, too, it is eventually realized that the information was wrong.[4][5][6]

Analogous terms

Wrongful pregnancy/conception

"Wrongful abortion" is comparable to other types of birth-related malpractice. One category of birth-related malpractice consists of cases in which negligence by the defendant resulted in the birth of a healthy yet unwanted child. The negligence may manifest itself in the manufacture, provision, or installation of contraceptives; in the performance of vasectomy or tubal ligation; or in the carrying out of an abortion. These cases are usually labeled "wrongful pregnancy" (or "wrongful conception" in appropriate cases). In a way, they represent a mirror image of wrongful abortion cases, although they are not exact reflections. In cases of wrongful pregnancy, the doctor's negligence makes the fulfillment of the parents' will impossible, while in wrongful abortion cases the doctor's negligence instigates, but does not necessitate, a decision that turns out to be inconsistent with such will.

Wrongful birth/life

Another category of birth-related malpractice,[7] more closely related to wrongful abortion, consists of cases in which a woman seeks medical advice regarding the health of her fetus, and decides to conceive or to continue her pregnancy once the adviser maintains that the fetus will not be born with congenital disabilities, a statement that is later found to be incorrect. The parents' cause of action for their resulting losses is labeled "wrongful birth," while the infant's cause of action for their own losses is termed "wrongful life." Wrongful birth is a more accurate mirror image of wrongful abortion.[8] The former deals with the non-prevention of the birth of an unwanted child, whereas the latter deals with the prevention of the birth of a wanted child. In both cases the defendant's negligence does not make the fulfillment of the parent's will physically impossible, but instigates a decision that turns out to be inconsistent with such will.

Yorum

Başlıca sorunlu durumlar: 1) Gebelikte bebeğin annede ileri derecede sorunlu olduğu söylenip, gebeliğin sonlandırılması, yanlış medikal işlem yapılmasıdır. 2) Bu sefer de bebekte ileri derecede anomali var denilirken, olmadığının anlaşılmasıdır: *Uygulama olarak her ikisi de tıbbi hatadır ve TCK göre taksirli suçtur. Dikkat ve özen eksikliğine bağlı yaşamsal hata işlenmiştir. Bebek 10 gebelik haftasından büyük ise doğrudan adam öldürmeye girer*.

Bunların önlenmesi için Perinatoloji Merkezleri ile kararların Perinatoloji/Neonatoloji Konsey kararı ile verilmesi istenilmektedir. Şüphe durumunda karar verilemez.
Burada verilerin analizi ile bilimsel gerçek ortaya konulmalıdır. Bu gebelikte yapılmalıdır.

Perinatoloji Konseyleri ile Mortalite toplantısı bilimsel açıdan bir irdelemedir. TCK 480. Maddesine göre sağlık elemanının suç durumunda sessiz kalması suç ise, bu nedenle ihbar bir mecburiyet olmaktadır.

Best interests, Wikipedia[6]

Best interests or **best interests of the child** is a child rights principle, which derives from Article 3 of the UN Convention on the Rights of the Child, which says that "in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the

best interests of the child shall be a primary consideration". Assessing the best interests of a child means to evaluate and balance "all the elements necessary to make a decision in a specific situation for a specific individual child or group of children".

Definition

According to the UN Convention on the Rights of the Child, assessing the best interests of a child means to evaluate and balance "all the elements necessary to make a decision in a specific situation for a specific individual child or group of children".[1] Due to the diversity of factors to consider, usually more than one profession or institution is involved in the assessment process, bringing together various perspectives and areas of expertise from the country of origin and destination and, in particular, the perspective of the child.

The following aspects are relevant for the best interests of the child:

- The child's views and aspirations;
- The identity of the child, including age and gender, personal history and background;
- The care, protection and safety of the child;
- The child's well-being;
- The family environment, family relations and contact;
- Social contacts of the child with peers and adults;
- Situations of vulnerability, i.e. the risks that the child is facing and the sources of protection, resiliency and empowerment;
- The child's skills and evolving capacities;
- The rights and needs with regard to health and education;
- The development of the child and her or his gradual transition into adulthood and an independent life;
- Any other specific needs of the child.[2]

Assessments

Best interests' assessments can be conducted informally and ad hoc or as formalized processes. Assessments look at everyday matters and decisions with more or less severe implications for the child. The best interests of a child may change significantly over time as children grow and their situations and capacities evolve, so their best interests' may need to be reassessed periodically.[3]

Determinations

Best interests' determinations are formal processes conducted with the involvement of public authorities and professional decision makers. The objective of the best interests' determination is to reach a decision based on national law that safeguards the rights of the child and promotes her or his well-being, safety and development. Decision-makers weigh and balance all the relevant factors of the case, giving due consideration to all the rights of the child and the obligations of public authorities and service providers towards the child. The objective of the best interests' determination process is the identification of a durable solution. Best interests' determinations are carried out when the issues at stake are expected to have significant implications on the child's present and future life.[4]

Elements of a best interests' assessment and determination process in transnational cases

Best interests' assessments aim to gather all the facts needed to arrive at a conclusion about the impact of any action, measure or decision on the child and her or his future. The central perspective is that of the girl or boy concerned. A trust-based relationship and communicating effectively in the child's main language enables the child to exercise his or her right to be heard. Comprehensive assessments involve a multi-disciplinary team of qualified professionals.[5]

A comprehensive best interests' assessment and determination process addresses all of the following:

- Establishing the child's identity and the identity of the child guardian and the quality of their relations, and any accompanying persons in transnational cases.
- Case assessment, including the following components:
    - Hearing the child;
    - Assessment of the child's situation, background and needs;
    - Social situation and family assessment;
    - Gathering evidence including through forensic examinations and interviews with the child;
    - Risk and security assessments;

    - Mapping sources of support, skills, potentials and resources for empowerment;
- Developing a life project.
- Comprehensive child impact assessment of any potential decisions.
- Identification of a durable solution in transnational cases.
- Continued assessments during the implementation of the durable solution with due follow-up, review and monitoring, and adjustments to the durable solution arrangements, if and as required, according to the best interests of the child[6]

Procedural safeguards in best interests' determinations

Procedural safeguards and documentation in best interests' determinations include:

- **The right of the child to express her or his views and to have them taken into account:** In a judicial or administrative procedure, children have the right to be heard and to have their views taken into account.
    - The process of hearing the child needs to be documented, with a clear description of how the child's views are balanced against other views and other information sources. The communication with the child has to be effective and child-sensitive and might require quality interpretation and cultural mediation. In cases of unaccompanied or separated children, the role of the guardian or representative is essential to facilitate the communication between the child and the authorities.[7]
    - The child has a right to a hearing when the decision-making body is a court. The hearing should be held without delay in a child-sensitive way and prevent secondary victimisation of child victims and witnesses in judicial proceedings.[8]
    - The child's age, gender and background, the child's level of development and evolving capacities should be considered.
    - Child-friendly information in a language that the child understands, enabling the child to form an opinion and to express her or his views should be provided.[9]
    - In transnational cases, children who do not speak the language of the country of destination have a right to translation and interpretation. Interpretation should be made available free of charge and with a neutral bearing when interpreters are directly involved.[10]
- **Guardianship and representation**: children have a right to an independent representative or guardian who is competent and equipped to represent and promote the best interests of the child.[11]
- **Legal representation:** When the best interests of a child are formally decided by a court or other competent body, the child is entitled to legal representation, legal information and defence, including for children applying for asylum or special protection as victims of crime.[12][13]
- **Legal reasoning:** Decisions need to be documented, motivated in detail, justified and explained, including how the decision is considered to relate to the best interests of the child and how the underlying considerations have been balanced to arrive at the decision.[14]
- **Mechanisms to review or revise decisions:** Formal mechanisms have to be in place to reopen or review decisions on the best interests of a child. Children need access to support in accessing and using these mechanisms. It has to be clearly established when a case or decision can be reopened or reviewed, as for instance when there is new evidence or when the authorities have not been able to implement the first decision.[15][16]
- **Right to appeal:** Best interests' determinations are subject to legal remedies. Children need to have access and support, such as legal assistance and representation, to appeal a decision. During the appeal procedure the implementation is suspended.[17] For decisions concerning transfer or return of a child to another county, sufficient time must be available between the decision and the execution of the decision, to enable the child to hand in an appeal or request a review of the decision.[18][19][20]

Balancing rights and interests in best interests' determinations

The different elements considered in an assessment and determination of the best interests of a child may appear to be competing or in contradiction. Potential conflicts are solved on a case-by-case basis. The right of the child to have her or his best interests taken as a primary consideration means that the child's interests have

high priority and are not just one of several considerations.[21] A larger weight is attached to what serves the child best:

- The possibility of harm outweighs other factors;
- The child's right to be brought up by her or his parents is a fundamental principle;
- A child's best interests can generally best be met with her or his family, except where there are safety concerns;
- The survival and development of the child are generally ensured best by remaining in or maintaining close contacts with the family and the child's social and cultural networks;
- Matters related to health, education and vulnerability are important factors; and
- Continuity and stability of the child's situation are important.[22][23][24]

Criticism

The definition of the *Best Interests of the Child* is not straightforward in either legal practice or when formulating laws and conventions. Its implementation has received considerable criticism by some child psychologists, epidemiologists and the family law reform movement, particularly with regard to how it often marginalizes children from one of their parents after divorce or separation, even though a child benefit from close contact with both parents. It has been argued that the current standard should be replaced with a *best interest of the child from the perspective of the child* approach that takes child-focused epidemiological and psychological research into account regarding children's physical, mental and social well-being after divorce or separation.

European Union

Reference to the best interests of the child has been introduced into relevant EU laws and policies, including in the context of migration, asylum, trafficking and potential return. The wording attached to the best interests' principle ranges between the imperative "must" and "shall" to the less prescriptive "should".[25][26][27][28][29]

Finland

The Finnish Child Welfare Act provides that the best interests of the child need to be a primary consideration in the determination of welfare measures in response to the child's needs. The Act defines the key elements that need to be taken into consideration for a best interests' determination:

1. Balanced development and well-being, close and continuing human relationships;
2. The opportunity to be given understanding and affection, as well as supervision and care in line with the child's age and level of development;
3. An education consistent with the child's abilities and wishes;
4. A safe environment in which to grow up, and physical and emotional freedom;
5. A sense of responsibility in becoming independent and growing up;
6. The opportunity to become involved in matters affecting the child and to influence them; and
7. The need to take account of the child's linguistic, cultural and religious background.[30]

This provision offers legally binding guidance to professionals on how the concept of the best interests of the child should be understood. It raises awareness of the complexity of the issues under consideration and makes reference to important rights of the child such as the right to education and development, safety and well-being, respect for the child's views and the child's cultural and other backgrounds.

United States

Since the US has not yet ratified the UN Convention on the Rights of the Child, which is the central instrument defining and providing the right of the best interests of the child for much of the world, a different set of laws, precedents, and applications apply.

History

The use of the best interest's doctrine represented a 20th-century shift in public policy. The best interests doctrine is an aspect of *parens patriae,* and in the United States it has replaced the Tender Years Doctrine, which rested on the basis that children are not resilient, and almost any change in a child's living situation would be detrimental to their well-being.

Until the early 1900s, fathers were given custody of the children in case of divorce. Many U.S. states then shifted from this standard to one that completely favored the mother as the primary caregiver. In the 1970s, the Tender Years Doctrine was replaced by the best interests of the child as determined by family courts. Because many family courts continued to give great weight to the traditional role of the mother as the primary caregiver, application of this standard in custody historically tended to favor the mother of the children.

The "best interests of the child" doctrine is sometimes used in cases where non-parents, such as grandparents, ask a court to order non-parent visitation with a child. Some parents, usually those who are not awarded custody, say that using the "best interests of the child" doctrine in non-parent visitation cases fails to protect a fit parent's fundamental right to raise their child in the manner they see fit. Troxel v Granville, 530 US 57; 120 S Ct 2054; 147 LEd2d 49 (2000).

Child welfare laws

The "best interest of the child" doctrine is largely seen in child welfare laws and the paramount consideration of the court when making decisions with regards to abused and neglected children.[31] The Adoption Assistance and Child Welfare Act of 1980 requires that, "…each child has a case plan designed to achieve placement in the least restrictive (most family like) setting available and in close proximity to the parents' home, consistent with the best interest and special needs of the child."[32] Although the statute does not define the "best interest of the child", best interest is referenced in two other sections. Moreover, several states have chosen to statutorily define or reference the "best interest of the child", and require the courts within those jurisdictions to consider specific factors.[33]

Family law

The term is used as doctrine used by courts to determine a wide range of issues relating to the well-being of children. In the application of family law, one of the most common of these issues concern questions that arise upon the divorce or separation of the children's parents. Examples include:

- With whom will the children live?
- How much contact (previously termed "access" or, in some jurisdictions, "visitation") will the parents, legal guardian, or other parties be allowed (or required) to have?
- To whom and by whom will child support be paid and in what amount?

In proceedings involving divorce or the dissolution of a common-law marriage or a civil union, family courts are directed to assess the best interests of any children of these unions. However, this doctrine is not used to settle custody matters involving urban and minority residents in cities such as Philadelphia, PA for example where the tender years doctrine is still in effect.

The determination is also used in proceedings which determine legal obligations and entitlements, such as when a child is born outside of marriage, when grandparents assert rights with respect to their grandchildren, and when biological parents assert rights with respect to a child who was given up for adoption.

It is the doctrine usually employed in cases regarding the potential emancipation of minors. Courts will use this doctrine when called upon to determine who should make medical decisions for a child where the parents disagree with healthcare providers or other authorities.

In determining the best interests of the child or children in the context of a separation of the parents, the court may order various investigations to be undertaken by social workers, Family Court Advisors from CAFCASS, psychologists and other forensic experts, to determine the living conditions of the child and his custodial and non-custodial parents. Such issues as the stability of the child's life, links with the community, and stability of the home environment provided by each parent may be considered by a court in deciding the child's residency in custody and visitation proceedings. In English law, section 1(1) Children Act 1989 makes the interests of any child the paramount concern of the court in all proceedings and, having indicated in s1(2) that delay is likely to prejudice the interests of any child, it requires the court to consider the "welfare checklist", i.e. the court must consider:

1. The ascertainable wishes and feelings of each child concerned (considered in light of their age and understanding)
2. Physical, emotional and/or educational needs now and in the future
3. The likely effect on any change in the circumstances now and in the future
4. Age, sex, background and any other characteristics the court considers relevant
5. Any harm suffered or at risk of suffering now and in the future
6. How capable each parent, and other person in relation to whom the court considers the question to be relevant, is of meeting the child's needs
7. The range of powers available to the court under the Children Act 1989 in the proceedings in question

The welfare checklist considers the needs, wishes and feelings of the child and young person and this analysis is vital to ensure that the human rights of children are always in the forefront of all consideration. The welfare

checklist provides a comprehensive list of issues that need to be considered to ensure that young people who come into court proceedings are safeguarded fully and their rights as citizens are promoted.

Immigration law

To a much lesser degree the principal of the "best interest of the child" has been utilized in immigration law as it relates to child migrants.[34]

Yorum

İdeal daima iyinin karşıtı olabilmektedir. Daha iyisi denirken fırsat kaçırılabilir: *Uygulama olarak, etkin, verimli ve kullanılabilir boyut öne alınmalıdır, daha iyisi, daha iyisi denilince elden kaçırılabilir*. Bir bebeğin içine konulan inkübatör daha iyisi daima teknolojik olarak olabilir ama serviste o bebeğe uygun olan seçilmelidir. Teknoloji değiştiği için 6 ayda bir tüm cihazların değişimi imkânsız olacağı, personelin eğitimi de olanaksız olacağı da dikkate alınmalıdır. Bu nedenle, sevk zincirlerinde bebeğin tanısı ve durumuna göre serviste imkân varsa alınmaktadır. Hekim, eğer bebeğin daha iyi imkanlarda bakılacağı bir yer varsa, sevk etmesi gerekir, yoksa hukuki açıdan da sorumlu olur.

Burada yaklaşım sadece tıbbi tanı ötesinde, yenidoğanları ailesi, çevre ve sosyal boyutları da öne alınmalıdır: *Uygulama olarak elbette bebek önemli olduğu için, tepedeki seçim, karar verdirici, yol gösterici olan elbette bebeğin tıbbi bakımı olmaktadır*.

İdeal yer, bir bakıma bizim kendimizin rahat edeceği, arzulayacağı yer olmalıdır: *Uygulama olarak gerekenler ortaya çıkarsa, zaman içinde bu gereksinimler dikkate alınmalıdır*. Bu uygulamalar elbette sağlık yapısına bağlı olarak aileden rıza alınmasını da gerekli kılmaktadır. Sosyal olan bir tercihtir, ama tıbbi açıdan olan gereksinimdir, buna göre yapılandırma yapılmalıdır.

Çocuk Koruma Kanununa göre, eğer aile bebeğin bakım ve yaklaşımına insanlık boyutu dışında ise, tedavi yapmak istemiyor ve hatta ventilatörde olmasını bir eziyet gibi görüyorsa, derhal o bebeğin velayeti Devlet üzerine alır: *Uygulama olarak prematüre bebeklere bakmak istemeyen ailelerden bu bebekler Devlet gözetimine alındığı bilinmektedir*.

Palyatif Bakım, Tedavi

Palyatif kelime anlamı olarak (www.nedirnedemek.com)[7]:

palyatif ne demek?

1. Geçici.
2. Rahatlatıcı
3. Hafifletici.
4. Hastalık belirtilerini iyileştirmeksizin geçici olarak hafifleten veya ortadan kaldıran ilaç veya yöntemler.

palyatif etki

1. İlacın hastada nedene yönelik tedavi sağlayamaması, bazı belirtileri hafifletici veya ortadan kaldırıcı etki oluşturması.

palyatif tedavi

1. İlaçlarla hastalığın nedenini ortadan kaldırmadan semptom ve belirtilerini ortadan kaldıran tedavi biçimi, semptomatik tedavi.

NOT: Tedavi edici özelliği olmasa bile, ağrının giderilmesinin önemi çok büyük yadsınamaz bir olumlu etkileşimdir.

Palliative care, Wikipedia[8]

Palliative care (derived from the Latin root *palliare*, or 'to cloak') is an interdisciplinary medical caregiving approach aimed at optimizing quality of life and mitigating suffering among people with serious, complex, and often terminal illnesses.[1] Within the published literature, many definitions of palliative care exist. The World Health Organization (WHO) describes palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual".[2] In the past, palliative care was a disease specific approach, but today the WHO takes a broader patient-centered approach that suggests that the principles of palliative care should be applied as early as possible to any chronic and ultimately fatal illness.[3] This shift was important because if a disease-oriented approach is followed, the needs and preferences of the patient are not fully met and aspects of care, such as pain, quality of life, and social support, as well as spiritual and emotional needs, fail to be addressed. Rather, a patient-centered model prioritizes relief of suffering and tailors care to increase the quality of life for terminally ill patients.[4]

Palliative care is appropriate for individuals with serious illnesses across the age spectrum and can be provided as the main goal of care or in tandem with curative treatment. It is provided by an interdisciplinary team which can include physicians, nurses, occupational and physical therapists, psychologists, social workers, chaplains, and dietitians. Palliative care can be provided in a variety of contexts, including hospitals, outpatient, skilled-nursing, and home settings. Although an important part of end-of-life care, palliative care is not limited to individuals near the end of life.[1]

Evidence supports the efficacy of a palliative care approach in improvement of a person's quality of life.[5][6] Palliative care's main focus is to improve the quality of life for those with chronic illnesses. It is commonly the case that palliative care is provided at the end of life, but it can be helpful for a person of any stage of illness that is critical or any age.[7]

Scope

Palliative care is able to improve healthcare quality in three sectors: Physical and emotional relief, strengthening of patient-physician communication and decision-making, and coordinated continuity of care across various healthcare settings, including hospital, home, and hospice.[8] The overall goal of palliative care is to improve quality of life of individuals with serious illness, any life-threatening condition which either reduces an individual's daily function or quality of life or increases caregiver burden, through pain and symptom management, identification and support of caregiver needs, and care coordination. Palliative care can be delivered at any stage of illness alongside other treatments with curative or life-prolonging intent and is not restricted to people receiving end-of-life care.[9][10] Historically, palliative care services were focused on individuals with incurable cancer, but this framework is now applied to other diseases, including severe heart failure,[11] chronic obstructive pulmonary disease, multiple sclerosis and other neurodegenerative conditions.[12]

Forty million people each year are expected to need palliative care, with approximately 78% of this population living in low and middle income countries. However, only 14% of this population is able to receive this kind of care, with a majority in high-income countries, making this an important sector to pay attention to.[13]

Palliative care can be initiated in a variety of care settings, including emergency rooms, hospitals, hospice facilities, or at home.[14] For some severe disease processes, medical specialty professional organizations recommend initiating palliative care at the time of diagnosis or when disease-directed options would not improve a patient's prognosis. For example, the American Society of Clinical Oncology recommends that patients with advanced cancer should be "referred to interdisciplinary palliative care teams that provide inpatient and outpatient care early in the course of disease, alongside active treatment of their cancer" within eight weeks of diagnosis.[9]

Appropriately engaging palliative care providers as a part of patient care improves overall symptom control, quality of life, and family satisfaction of care while reducing overall healthcare costs.[15][16]

Palliative care vis-à-vis hospice care

The distinction between palliative care and hospice differs depending on global context.

In the United States, the term *hospice* refers specifically to a benefit provided by the federal government since 1982. Hospice care services and palliative care programs share similar goals of mitigating unpleasant symptoms, controlling pain, optimizing comfort, and addressing psychological distress. Hospice care focuses on comfort and psychological support and curative therapies are not pursued.[17] Under the Medicare Hospice Benefit, individuals certified by two physicians to have less than six months to live (assuming a typical course) have access to specialized hospice services through various insurance programs (Medicare, Medicaid, and most health maintenance organizations and private insurers). An individual's hospice benefits are not revoked if that individual lives beyond a six-month period. In the United States, in order to be eligible for hospice, patients usually forego treatments aimed at cure, unless they are minors. This is to avoid what is called concurrent care, where two different clinicians are billing for the same service. In 2016 a movement began to extend the reach of concurrent care to adults who were eligible for hospice but not yet emotionally prepared to forego curative treatments.[18]

Outside the United States, the term hospice usually refers to a building or institution that specializes in palliative care. These institutions provide care to patients with end of life and palliative care needs. In the common vernacular outside the United States, hospice care and palliative care are synonymous and are not contingent on different avenues of funding.[19]

Over 40% of all dying patients in the United States currently undergo hospice care.[20] Most of the hospice care occurs at a home environment during the last weeks/months of their lives. Of those patients, 86.6% believe their care is "excellent".[20] Hospice's philosophy is that death is a part of life, so it is personal and unique. Caregivers are encouraged to discuss death with the patients and encourage spiritual exploration (if they so wish).[21]

History

The field of palliative care grew out of the hospice movement, which is commonly associated with Dame Cicely Saunders, who founded St. Christopher's Hospice for the terminally ill in 1967,[22] and Elisabeth Kübler-Ross who published her seminal work "On Death and Dying" in 1969.[*citation needed*] In 1974, Balfour Mount coined the term "palliative care".[22] and Paul Henteleff became the director of a new "terminal care" unit at Saint Boniface Hospital in Winnipeg.[23] In 1987, Declan Walsh established a palliative medicine service at the Cleveland Clinic Cancer Center in Ohio which later expanded to become the training site of the first palliative care clinical and research fellowship as well as the first acute pain and palliative care inpatient unit in the United States.[24] The program evolved into The Harry R. Horvitz Center for Palliative Medicine which was designated as an international demonstration project by the World Health Organization and accredited by the European Society for Medical Oncology as an Integrated Center of Oncology and Palliative Care.[25]

Advances in palliative care have since inspired a dramatic increase in hospital-based palliative care programs. Notable research outcomes forwarding the implementation of palliative care programs include:

- Evidence that hospital palliative care consult teams are associated with significant hospital and overall health system cost savings.[26][27]
- Evidence that palliative care services increase the likelihood of dying at home and reduce symptom burden without impacting on caregiver grief among the vast majority of Americans who prefer to die at home.[28]
- Evidence that providing palliative care in tandem with standard oncologic care among patients with advanced cancer is associated with lower rates of depression, increased quality of life, and increased length of survival compared to those receiving standard oncologic care[29][6] and may even prolong survival.[30]

Over 90% of US hospitals with more than 300 beds have palliative care teams, yet only 17% of rural hospitals with 50 or more beds have palliative care teams.[31] Hospice and palliative medicine has been a board certified sub-specialty of medicine in the United States since 2006. Additionally, in 2011, The Joint Commission began an Advanced Certification Program for Palliative Care that recognizes hospital inpatient programs demonstrating outstanding care and enhancement of the quality of life for people with serious illness.[32]

Practice

Symptom assessment

One instrument used in palliative care is the *Edmonton Symptom Assessment Scale* (ESAS), which consists of eight visual analog scales (VAS) ranging from 0–10, indicating the levels of pain,

activity, nausea, depression, anxiety, drowsiness, appetite, sensation of well-being, and sometimes shortness of breath.[33][34] A score of 0 indicates absence of the symptom, and a score of 10 indicates the worst possible severity.[33] The instrument can be completed by the patient, with or without assistance, or by nurses and relatives.[34]

Interventions

Medications used in palliative care can be common medications but used for a different indication based on established practices with varying degrees of evidence.[35] Examples include the use of antipsychotic medications, anticonvulsants, and morphine. Routes of administration may differ from acute or chronic care, as many people in palliative care lose the ability to swallow. A common alternative route of administration is subcutaneous, as it is less traumatic and less difficult to maintain than intravenous medications. Other routes of administration include sublingual, intramuscular and transdermal. Medications are often managed at home by family or nursing support.[36]

Palliative care interventions in care homes may contribute to lower discomfort for residents with dementia and to improve family members' views of the quality of care.[37] However, higher quality research is needed to support the benefits of these interventions for older people dying in these facilities.[37][38]

High-certainty evidence supports the finding that implementation of home-based end-of-life care programs may increase the number of adults who will die at home and slightly improve patient satisfaction at a one-month follow-up.[39] The impact of home-based end-of-life care on caregivers, healthcare staff, and health service costs are uncertain.[39]

Pain, distress, and anxiety

For many patients, end of life care can cause emotional and psychological distress, contributing to their total suffering.[40] An interdisciplinary palliative care team consisting of a mental health professional, social worker, counselor, as well as spiritual support such as a chaplain, can play important roles in helping people and their families cope using various methods such as counseling, visualization, cognitive methods, drug therapy and relaxation therapy to address their needs. Palliative pets can play a role in this last category.[41]

Total pain

In the 1960s, hospice pioneer Cicely Saunders first introduced the term "total pain" to describe the heterogenous nature of pain.[42] This is the idea that a patient's experience of total pain has distinctive roots in the physical, psychological, social and spiritual realm but that they are all still closely linked to one another. Identifying the cause of pain can help guide care for some patients, and impact their quality of life overall.[43]

Physical pain

Physical pain can be managed using pain medications as long as they do not put the patient at further risk for developing or increasing medical diagnoses such as heart problems or difficulty breathing.[43] Patients at the end of life can exhibit many physical symptoms that can cause extreme pain such as dyspnea[44] (or difficulty breathing), coughing, xerostomia (dry mouth), nausea and vomiting, constipation, fever, delirium, and excessive oral and pharyngeal secretions ("Death Rattle").[45] Radiation is commonly used with palliative intent to alleviate pain in patients with cancer. As an effect from radiation may take days to weeks to occur, patients dying a short time following their treatment are unlikely to receive benefit.[46]

Psychosocial pain and anxiety

Once the immediate physical pain has been dealt with, it is important to remember to be a compassionate and empathetic caregiver that is there to listen and be there for their patients. Being able to identify the distressing factors in their life other than the pain can help them be more comfortable.[47] When a patient has their needs met then they are more likely to be open to the idea of hospice or treatments outside comfort care. Having a psychosocial assessment allows the medical team to help facilitate a healthy patient-family understanding of adjustment, coping and support. This communication between the medical team and the patients and family can also help facilitate discussions on the process of maintaining and enhancing relationships, finding meaning in the dying process, and achieving a sense of control while confronting and preparing for death.[43] For adults with anxiety, medical evidence in the form of high-quality randomized trials is insufficient to determine the most effective treatment approach to reduce the symptoms of anxiety.[48]

Spirituality

Spirituality is a fundamental component of palliative care. According to the Clinical Practice Guidelines for Quality Palliative Care, spirituality is a "dynamic and intrinsic aspect of humanity" and has been associated with

"an improved quality of life for those with chronic and serious illness", especially for patients who are living with incurable and advanced illnesses of a chronic nature.[49][50][51] Spiritual beliefs and practices can influence perceptions of pain and distress, as well as quality of life among advanced cancer patients.[47] Spiritual needs are often described in literature as including loving/being loved, forgiveness, and deciphering the meaning of life.[52][53]

Most spiritual interventions are subjective and complex.[54][49] Many have not been well evaluated for their effectiveness, however tools can be used to measure and implement effective spiritual care.[49][53][55]

Nausea and vomiting

Nausea and vomiting are common in people who have advanced terminal illness and can cause distress. Several antiemetic pharmacologic options are suggested to help alleviate these symptoms. For people who do not respond to first-line medications, levomepromazine may be used, however there have been insufficient clinical trials to assess the effectiveness of this medication.[56] Haloperidol and droperidol are other medications that are sometimes prescribed to help alleviate nausea and vomiting, however further research is also required to understand how effective these medications may be.[57][58]

Hydration and nutrition

Many terminally ill people cannot consume adequate food or drink. Providing medically assisted food or drink to prolong their life and improve the quality of their life is common, however there have been few high quality studies to determine best practices and the effectiveness of these approaches.[59][60]

Pediatric palliative care

Pediatric palliative care is family-centered, specialized medical care for children with serious illnesses that focuses on mitigating the physical, emotional, psychosocial, and spiritual suffering associated with illness to ultimately optimize quality of life.

Pediatric palliative care practitioners receive specialized training in family-centered, developmental and age-appropriate skills in communication and facilitation of shared decision making; assessment and management of pain and distressing symptoms; advanced knowledge in care coordination of multidisciplinary pediatric caregiving medical teams; referral to hospital and ambulatory resources available to patients and families; and psychologically supporting children and families through illness and bereavement.[61]

Symptoms assessment and management of children

As with palliative care for adults, symptom assessment and management is a critical component of pediatric palliative care as it improves quality of life, gives children and families a sense of control, and prolongs life in some cases.[19] The general approach to assessment and management of distressing symptoms in children by a palliative care team is as follows:

- Identify and assess symptoms through history taking (focusing on location, quality, time course, as well as exacerbating and mitigating stimuli). Symptoms assessment in children is uniquely challenging due to communication barriers depending on the child's ability to identify and communicate about symptoms. Thus, both the child and caregivers should provide the clinical history. With this said, children as young as four years of age can indicate the location and severity of pain through visual mapping techniques and metaphors.[62]
- Perform a thorough exam of the child. Special attention to the child's behavioral response to exam components, particularly in regards to potentially painful stimuli. A commonly held myth is that premature and neonatal infants do not experience pain due to their immature pain pathways, but research demonstrates pain perception in these age groups is equal or greater than that of adults.[63][64] With this said, some children experiencing intolerable pain present with 'psychomotor inertia', a phenomenon where a child in severe chronic pain presents overly well behaved or depressed.[65] These patients demonstrate behavioral responses consistent with pain relief when titrated with morphine. Finally, because children behaviorally respond to pain atypically, a playing or sleeping child should not be assumed to be without pain.[19]
- Identify the place of treatment (tertiary versus local hospital, intensive care unit, home, hospice, etc.).
- Anticipate symptoms based on the typical disease course of the hypothesized diagnosis.
- Present treatment options to the family proactively, based on care options and resources available in each of the aforementioned care settings. Ensuing management should anticipate transitions of

palliative care settings to afford seamless continuity of service provision across health, education, and social care settings.

- Consider both pharmacologic and non-pharmacologic treatment modalities (education and mental health support, administration of hot and cold packs, massage, play therapy, distraction therapy, hypnotherapy, physical therapy, occupational therapy, and complementary therapies) when addressing distressing symptoms. Respite care is an additional practice that can further aid alleviating the physical and mental pain from the child and its family. By allowing the caregiving to ensue by other qualified individuals, it allows the family time to rest and renew themselves[66]
- Assess how the child perceives their symptoms (based on personal views) to create individualized care plans.
- After the implementation of therapeutic interventions, involve both the child and family in the reassessment of symptoms.[19]

The most common symptoms in children with severe chronic disease appropriate for palliative care consultation are weakness, fatigue, pain, poor appetite, weight loss, agitation, lack of mobility, shortness of breath, nausea and vomiting, constipation, sadness or depression, drowsiness, difficulty with speech, headache, excess secretions, anemia, pressure area problems, anxiety, fever, and mouth sores.[67][68] The most common end of life symptoms in children include shortness of breath, cough, fatigue, pain, nausea and vomiting, agitation and anxiety, poor concentration, skin lesions, swelling of the extremities, seizures, poor appetite, difficulty with feeding, and diarrhea.[69][70] In older children with neurologic and neuromuscular manifestations of disease, there is a high burden of anxiety and depression that correlates with disease progression, increasing disability, and greater dependence on carers.[71] From the caregiver's perspective, families find changes in behavior, reported pain, lack of appetite, changes in appearance, talking to God or angels, breathing changes, weakness, and fatigue to be the most distressing symptoms to witness in their loved ones.[72]

As discussed above, within the field of adult palliative medicine, validated symptoms assessment tools are frequently utilized by providers, but these tools lack essential aspects of children's symptom experience.[73] Within pediatrics, there is not a comprehensive symptoms assessment widely employed. A few symptoms assessment tools trialed among older children receiving palliative care include the Symptom Distress Scale, and the Memorial Symptom Assessment Scale, and Childhood Cancer Stressors Inventory.[74][75][76] Quality of life considerations within pediatrics are unique and an important component of symptoms assessment. The Pediatric Cancer Quality of Life Inventory-32 (PCQL-32) is a standardized parent-proxy report which assesses cancer treatment-related symptoms (focusing mainly on pain and nausea). But again, this tool does not comprehensively assess all palliative are symptoms issues.[77][78] Symptom assessment tools for younger age groups are rarely utilized as they have limited value, especially for infants and young children who are not at a developmental stage where they can articulate symptoms.

Communication with children and families

Within the realm of pediatric medical care, the palliative care team is tasked with facilitating family-centered communication with children and their families, as well as multidisciplinary pediatric caregiving medical teams to forward coordinated medical management and the child's quality of life.[79] Strategies for communication are complex as the pediatric palliative care practitioners must facilitate a shared understanding of and consensus for goals of care and therapies available to the sick child amongst multiple medical teams who often have different areas of expertise. Additionally, pediatric palliative care practitioners must assess both the sick child and their family's understanding of complex illness and options for care, and provide accessible, thoughtful education to address knowledge gaps and allow for informed decision making. Finally, practitioners are supporting children and families in the queries, emotional distress, and decision making that ensues from the child's illness.

Many frameworks for communication have been established within the medical literature, but the field of pediatric palliative care is still in relative infancy. Communication considerations and strategies employed in a palliative setting include:

- **Developing supportive relationships with patients and families.** An essential component of a provider's ability to provide individualized palliative care is their ability to obtain an intimate understanding of the child and family's preferences and overall character. On initial consultation, palliative care providers often focus on affirming a caring relationship with the pediatric patient and

their family by first asking the child how they would describe themself and what is important to them, communicating in an age and developmentally cognizant fashion. The provider may then gather similar information from the child's caregivers. Questions practitioners may ask include 'What does the child enjoy doing? What do they most dislike doing? What does a typical day look like for the child?' Other topics potentially addressed by the palliative care provider may also include familial rituals as well as spiritual and religious beliefs, life goals for the child, and the meaning of illness within the broader context of the child and their family's life.[61]

- **Developing a shared understanding of the child's condition with the patient and their family.** The establishment of shared knowledge between medical providers, patients, and families is essential when determining palliative goals of care for pediatric patients. Initially, practitioners often elicit information from the patient *and* child to ascertain these parties' baseline understanding of the child's situation.[80] Assessing for baseline knowledge allows the palliative care provider to identify knowledge gaps and provide education on those topics. Through this process, families can pursue informed, shared medical decision making regarding their child's care. A framework often employed by pediatric palliative care providers is 'ask, tell, ask' where the provider asks the patient and their family for a question to identify their level of comprehension of the situation, and then subsequently supplements the family's knowledge with additional expert knowledge.[80][81] This information is often conveyed without jargon or euphemism to maintain trust and ensure understanding. Providers iteratively check for comprehension of this knowledge supplementation by asking questions related to previous explanations, as information retention can be challenging when undergoing a stressful experience.[80]
- **Establishing meaning and dignity regarding the child's illness.** As part of developing a shared understanding of a child's illness and character, palliative providers will assess both the child and their family's symbolic and emotional relationship to disease. As both the somatic and psychologic implications of illness can be distressing to children, palliative care practitioners look for opportunities to establish meaning and dignity regarding the child's illness by contextualizing disease within a broader framework of the child's life.[82][83] Derived from the fields of dignity therapy and meaning-centered psychotherapy, the palliative care provider may explore the following questions with the sick child and their family:
    - What gives your life meaning, worth, or purpose?
    - Where do you find strength and support?
    - What inspires you?
    - How do you like to be thought of?
    - What are you most proud of?
    - What are the particular things you would like your family to know or remember about you?
    - When was the last time you laughed really hard?
    - Are you frightened by all of this? What, in particular, are you most frightened of?
    - What is the meaning of this (illness) experience for you? Do you ever think about why this happened to you?[82][83]
- **Assessing preferences for decision making.** Medical decision making in a pediatric setting is unique in that it is often the child's legal guardians, not the patient, who ultimately consent for most medical treatments. Yet within a palliative care setting, it is particularly consequential to incorporate the child's preferences within the ultimate goals of care. Equally important to consider, families may vary in the level of responsibility they want in this decision-making process.[84] Their preference may range from wanting to be the child's sole decision makers, to partnering with the medical team in a shared decision making model, to advocating for full deferral of decision-making responsibility to the clinician.[84] Palliative care providers clarify a family's preferences and support needs for medical decision making by providing context, information, and options for treatment and medical palliation. In the case of critically ill babies, parents are able to participate more in decision making if they are presented with options to be discussed rather than recommendations by the doctor. Utilizing this style of communication also leads to less conflict with doctors and might help the parents cope better with the eventual outcomes.[85][86]

- **Optimizing the environment for effective conversations around prognosis and goals of care.** Essential to facilitating supportive, clear communication around potentially distressing topics such as prognosis and goals of care for seriously ill pediatric patients is optimizing the setting where this communication will take place and developing informed consensus among the child's caregiving team regarding goals and options for care. Often, these conversations occur within the context of family meetings, which are formal meetings between families and the child's multidisciplinary medical team. Prior to the family meeting, providers often meet to discuss the child's overall case, reasonably expected prognosis, and options for care, in addition to clarifying specific roles each provider will take on during the family meeting. During this meeting, the multidisciplinary medical team may also discuss any legal or ethical considerations related to the case. Palliative care providers often facilitate this meeting and help synthesize its outcome for children and their families. Experts in optimized communication, palliative care providers may opt to hold the family meeting in a quiet space where the providers and family can sit and address concerns during a time when all parties are not constrained. Additionally, parents' preferences regarding information exchange with the sick child present should be clarified.[87][88] If the child's guardians are resistant to disclosing information in front of their child, the child's provider may explore parental concerns on the topic. When excluded from family meetings and moments of challenging information exchange, adolescents, in particular, may have challenges with trusting their medical providers if they feel critical information is being withheld. It is important to follow the child's lead when deciding whether to disclose difficult information. Additionally, including them in these conversations can help the child fully participate in their care and medical decision making.[79][84][89] Finally, it is important to prioritize the family's agenda while additionally considering any urgent medical decisions needed to advance the child's care.
- **Supporting emotional distress.** A significant role of the pediatric palliative care provider is to help support children, their families, and their caregiving teams through the emotional stress of illness. Communication strategies the palliative care provider may employ in this role are asking for permission when engaging with potentially distressing conversations, naming emotions witnessed to create opportunities to discuss complex emotional responses to illness, actively listening, and allowing for invitational silence.[90] The palliative care provider may iteratively assess the child and family's emotional responses and needs during challenging conversations. At times, the medical team may be hesitant to discuss a child's prognosis out of fear of increasing distress. This sentiment is not supported by the literature; among adults, end of life discussions are not associated with increased rates of anxiety or depression.[91] Though this topic is not well studied in pediatric populations, conversations about prognosis have the potential to increase in parental hope and peace of mind.[92]
- **SPIKE framework.** This is a framework that is designed to assist healthcare workers deliver bad news.[81] The acronym stands for: setting, perception, invitation, knowledge, empathy, and summarize/strategy. When giving bad news it is important to consider the setting, which considers the environment in which the healthcare provider is delivering the news including privacy, sitting, time, and the inclusion of family members. What to say should also be considered, as well as rehearsed. It is important to understand how a patient is receiving the information by asking open ended questions and asking them to repeat what they learned in their own words, which is perception aspect of the framework. The healthcare provider should seek an invitation from the patient to disclose additional information before doing so in order to prevent overwhelming or distressing the patient further. In order to ensure the patient understands what is being told, knowledge must be used. This includes speaking in a way that the patient will understand, using simple words, not being excessively blunt, giving information in small chunks and checking in with the patient to confirm that they understand, and not providing poor information that may not be completely true. In order to alleviate some of a patient's distress it is crucial to be empathetic in the sense of understanding how a patient is feeling and the reactions they are having. This can allow one to change how they are delivering information, allow the patient to have time to process the information, or console them if needed. Connecting with patients is an important step in delivering bad news; maintaining eye contact proves that the healthcare provider is present and the patient and family has their full attention. Furthermore, the provider may make a connection by touching the patients shoulder or hand, giving them a physical

connection to know that they are not alone.[93][94] Finally, it is important to summarize all the information given in order to ensure the patient fully understands and takes away the major points. Additionally, patients who have a clear plan for the future are less likely to feel anxious and uncertain, but it is important to ask people if they are ready for that information before providing them with it.[95][96]

Geriatric palliative care

With the transition in the population toward lower child mortality and lower death rates, countries around the world are seeing larger elderly populations. In some countries, this means a growing burden on national resources in the shape of social security and health care payments. As aging populations put increasing pressure on existing resources, long-term palliative care for patients' non-communicable, chronic conditions has emerged as a necessary approach to increase these patient's quality of life, through prevention and relief by identifying, assessing, and treating the source of pain and other psychosocial and spiritual problems.[97]

Society

Costs and funding

Funding for hospice and palliative care services varies. In Great Britain and many other countries all palliative care is offered free, either through the National Health Service or through charities working in partnership with the local health services. Palliative care services in the United States are paid by philanthropy, fee-for-service mechanisms, or from direct hospital support while hospice care is provided as a Medicare benefit; similar hospice benefits are offered by Medicaid and most private health insurers. Under the Medicare Hospice Benefit (MHB), a person signs off their Medicare Part B (acute hospital payment) and enrolls in the MHB through Medicare Part B with direct care provided by a Medicare certified hospice agency. Under terms of the MHB, the hospice agency is responsible for the care plan and may not bill the person for services. The hospice agency, together with the person's primary physician, is responsible for determining the care plan. All costs related to the terminal illness are paid from a per diem rate (~US $126/day) that the hospice agency receives from Medicare – this includes all drugs and equipment, nursing, social service, chaplain visits, and other services deemed appropriate by the hospice agency; Medicare does not pay for custodial care. People may elect to withdraw from the MHB and return to Medicare Part A and later re-enroll in hospice.[*citation needed*]

Certification and training for services

In most countries, hospice care and palliative care is provided by an interdisciplinary team consisting of physicians, pharmacists, nurses, nursing assistants, social workers, chaplains, and caregivers. In some countries, additional members of the team may include certified nursing assistants and home healthcare aides, as well as volunteers from the community (largely untrained but some being skilled medical personnel), and housekeepers.

In the United Kingdom, Palliative Medicine specialist training is delivered alongside Internal Medicine stage two training over an indicative four years. Entry into Palliative medicine training is possible following successful completion of both a foundation programme and a core training programme. There are two core training programmes for Palliative Medicine training:[98]

- Internal Medical Training (IMT)
- Acute Care Common Stem - Internal Medicine (ACCS-IM)

In the United States, the physician sub-specialty of hospice and palliative medicine was established in 2006[99] to provide expertise in the care of people with life-limiting, advanced disease, and catastrophic injury; the relief of distressing symptoms; the coordination of interdisciplinary care in diverse settings; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end of life care.[100]

Caregivers, both family and volunteers, are crucial to the palliative care system. Caregivers and people being treated often form lasting friendships over the course of care. As a consequence caregivers may find themselves under severe emotional and physical strain. Opportunities for caregiver respite are some of the services hospices provide to promote caregiver well-being. Respite may last a few hours up to several days (the latter being done by placing the primary person being cared for in a nursing home or inpatient hospice unit for several days).[101]

In the US, board certification for physicians in palliative care was through the American Board of Hospice and Palliative Medicine; recently this was changed to be done through any of 11 different speciality boards through

an American Board of Medical Specialties-approved procedure. Additionally, board certification is available to osteopathic physicians (D.O.) in the United States through four medical specialty boards through an American Osteopathic Association Bureau of Osteopathic Specialists-approved procedure.[102] More than 50 fellowship programs provide one to two years of specialty training following a primary residency. In the United Kingdom palliative care has been a full specialty of medicine since 1989 and training is governed by the same regulations through the Royal College of Physicians as with any other medical speciality.[103] Nurses, in the United States and internationally, can receive continuing education credits through Palliative Care specific trainings, such as those offered by End-of-Life Nursing Education Consortium (ELNEC).[104]

The Tata Memorial Centre in Mumbai has offered a physician's course in palliative medicine since 2012, the first one of its kind in the country.

Regional variation in services

In the United States, hospice and palliative care represent two different aspects of care with similar philosophies, but with different payment systems and location of services. Palliative care services are most often provided in acute care hospitals organized around an interdisciplinary consultation service, with or without an acute inpatient palliative care unit. Palliative care may also be provided in the dying person's home as a "bridge" program between traditional US home care services and hospice care or provided in long-term care facilities.[105] In contrast over 80% of hospice care in the US is provided at home with the remainder provided to people in long-term care facilities or in free standing hospice residential facilities. In the UK hospice is seen as one part of the speciality of palliative care and no differentiation is made between 'hospice' and 'palliative care'. In the UK palliative care services offer inpatient care, home care, day care and outpatient services, and work in close partnership with mainstream services. Hospices often house a full range of services and professionals for children and adults. In 2015 the UK's palliative care was ranked as the best in the world "due to comprehensive national policies, the extensive integration of palliative care into the *National Health Service*, a strong hospice movement, and deep community engagement on the issue".[106]

In 2021 the UK's National Palliative and End of Life Care Partnership published their six ambitions for 2021–26. These include fair access to end of life care for everyone regardless of who they are, where they live or their circumstances, and the need to maximise comfort and wellbeing. Informed and timely conversations are also highlighted.[107]

Acceptance and access

The focus on a person's quality of life has increased greatly since the 1990s. In the United States today, 55% of hospitals with more than 100 beds offer a palliative-care program,[108] and nearly one-fifth of community hospitals have palliative-care programs.[109] A relatively recent development is the palliative-care team, a dedicated health care team that is entirely geared toward palliative treatment.

Physicians practicing palliative care do not always receive support from the people they are treating, family members, healthcare professionals or their social peers. More than half of physicians in one survey reported that they have had at least one experience where a patient's family members, another physician or another health care professional had characterized their work as being "euthanasia, murder or killing" during the last five years. A quarter of them had received similar comments from their own friends or family member, or from a patient.[110]

Despite significant progress that has been made to increase access to palliative care within the United States and other countries, many countries have not yet considered palliative care as a public health problem, and therefore do not include it in their public health agenda.[3] Resources and cultural attitudes both play significant roles in the acceptance and implementation of palliative care in the health care agenda. A study identified the current gaps in palliative care for people with severe mental illness (SMI's). They found that due to the lack of resources within both mental health and end of life services people with SMI's faced a number of barriers to accessing timely and appropriate palliative care. They called for a multidisciplinary team approach, including advocacy, with a point of contact co-ordinating the appropriate support for the individual. They also state that end of life and mental health care needs to be included in the training for professionals.[111][112]

A review states that by restricting referrals to palliative care only when patients have a definitive time line for death, something that the study found to often be inaccurate, can have negative implications for the patient both when accessing end of life care, or being unable to access services due to not receiving a time line from

medical professionals. The authors call for a less rigid approach to referrals to palliative care services in order to better support the individual, improve quality of life remaining and provide more holistic care.[113][114]
Many people with chronic pain are stigmatized and treated as opioid addicts. Patients can build a tolerance to drugs and have to take more and more to manage their pain. The symptoms of chronic pain patients do not show up on scans, so the doctor must go off trust alone. This is the reason that some wait to consult their doctor and endure sometimes years of pain before seeking help.[115]

Popular media

Palliative care was the subject of the 2018 Netflix short documentary, *End Game* by directors Rob Epstein and Jeffrey Friedman[116] about terminally ill patients in a San Francisco hospital and features the work of palliative care physician, BJ Miller. The film's executive producers were Steven Ungerleider, David C. Ulich and Shoshana R. Ungerleider.[117]
In 2016, an open letter[118] to the singer David Bowie written by a palliative care doctor, Professor Mark Taubert, talked about the importance of good palliative care, being able to express wishes about the last months of life, and good tuition (nutrition?) and education about end of life care generally. The letter went viral after David Bowie's son Duncan Jones shared it.[119] The letter was subsequently read out by the actor Benedict Cumberbatch and the singer Jarvis Cocker at public events.[120]

Research

Research funded by the UK's National Institute for Health and Care Research (NIHR) has addressed these areas of need.[121] Examples highlight inequalities faced by several groups and offers recommendations. These include the need for close partnership between services caring for people with severe mental illness,[122][123] improved understanding of barriers faced by Gypsy, Traveller and Roma communities,[124][125] the provision of flexible palliative care services for children from ethnic minorities or deprived areas.[126][127]
Other research suggests that giving nurses and pharmacists easier access to electronic patient records about prescribing could help people manage their symptoms at home.[128][129] A named professional to support and guide patients and carers through the healthcare system could also improve the experience of care at home at the end of life.[130][131] A synthesised review looking at palliative care in the UK created a resource showing which services were available and grouped them according to their intended purpose and benefit to the patient. They also stated that currently in the UK palliative services are only available to patients with a timeline to death, usually 12 months or less. They found these timelines to often be inaccurate and created barriers to patients accessing appropriate services. They call for a more holistic approach to end of life care which is not restricted by arbitrary timelines.[132][133]

Yorum

Bir bireyin yaşamının sonuna gelmiş olsa bile, onun toplum ile bir bakıma helalleşmesi, dost ve hatta düşmanları ile bir ortak noktada bulunması önemlidir.

Genel bilinen Celal Bayar ve İnönü, rakip ama çok yakın dost olduklarını bizzat Bayar söylemiş, Erdal İnönü de teyit etmiştir. Nitekim, medya ile kardeşliğin simgesini göstermek amacı ile Pembe Köşk (İnönü evi) balkonda kol kola görüntü vermişlerdir. Görüş farklılığı, birisinin halk, diğerinin devletçi olması, farklı açıdan eylemlerine katkı sağlamıştır.
İnandırıcı bulmayanlar, Anıtkabirde 22 Kasım 1938 tarihli İnönü'nün yazısı vardır, Bayar hemen *seni sevmek ibadettir* sözünü koymamıştır.

Hasta hemen ölmek isteyebilir, ama ilk dozu aldıktan sonra elde edilen neticeye göre tam kararını vermelidir. Kendi kararını vermeyenler için ise Yaşam Hakkı temeldir, kimse karışamaz. Aile ölmesini isterse, hemen Çocuk Koruma Kanunu gereğince aileden alınıp, Devlet bakımına alınır. Aile bebeğini öldükten sonra bile uğurlayamaz.

Hekim yaşam garantisi vermez, kimse geleceği bilemez, ama hürmet ve saygı gösterme çabası için söz verebilir, bu onun Etik ilkesidir.

Ülkemizde ölmeye yakın kişileri son ziyaret ile hem miras hem de son olarak bir helallik isterler. Bu toplumu ölümden sonraki varlığı, kısaca geride kalanlar ile oluşacak ilişkileri de düzenleyen, yoluna koyan bir boyut olmaktadır.

Prematüre için bile, aile nereye gömülecek ötesi, bir ölmüş olsa bile, bebeğinin olmasından dolayı bir mutluluk hissetmekte, bizlere de yaşatma çabası olarak, insanlığın boyutu ile teşekkür etmektedirler.

Her bir hastalığın, tedavi ve imkanları açısından medya kanalı ile internetten sorgulanmakta ve bu hekimlere sorulmaktadır. Bu verileri okuyup, inceledikten sonra karar verilmeli, buna öre bilgi sunmalı, hastayı aydınlatmalıyız.
Burada sıklıkla olan ümit vermeyen bilgiler olduğu da gözden kaçmamalıdır.

Palyatif olsa bile, damardan tedavi, sekonder infeksiyonun önlenmesi, ağrının kesilmesi ile bir mucize gibi durum yaratıldığı, yaratılacağı da unutulmamalıdır.

Çocuklarda palyatif tedavi aile temelinde, merkezli yapılır ama sık hekim ve hemşire ziyaretlerine gereksinim olacaktır.
Başlıca yaklaşımları: Vizitelerde hastanın durumu, bakımı ve muayenesini yaparak, ayaktan veya hastanede bakım gerektiğine karar vermelidir. Kısaca yatakta kötüleşmesi ve bakımsız kalmasına onay vermemeli, gerekirse doğrudan Yoğun Bakıma yatırmalıdırlar. Bu açıdan bu hizmeti Devlet kuruluşları, hastane ve belirli merkezler ile birlikte yürütmelidirler.
Aileden yaşam hakkı kararı istenmez, ailenin herhangi bir reddetme boyutu da gündeme gelemez. Sadece alternatifler konusunda söz söyleme hakkı olur, hekim onaylarsa yapılabilir.

Yaşlı hastalarda da Sosyal Yardımlaşma ve Hükümet Tabipliğine bağlı oluşumlar belirli bir ev ziyareti yapmaktadırlar.
Tedavi ayarlaması da buna göre olmakta, gerekirse yatırılmaktadır.

Ücretler ülkemizde Devlet tarafından karşılanmaktadır, bu açıdan diğer Ülkelerden ayrılmaktayız. Özel sigorta boyutu konfor için kullanılmaktadır.

Bebeklerin/Çocukların Vesayeti

Yenidoğan dönemi için aile sadece bilgi alınır, müsaade istenmez, yaşam hakkı temeldir. Aile eziyet yapıyorlar yapmayın derse, Savcılık bebeği aileden alıp Devlet gözetimine vermektedir

Child custody, Wikipedia[9]

Child custody is a legal term regarding *guardianship* which is used to describe the legal and practical relationship between a parent or guardian and a child in that person's care. Child custody consists of *legal custody*, which is the right to make decisions about the child, and *physical custody*, which is the right and duty to house, provide and care for the child.[1] Married parents normally have joint legal and physical custody of their children. Decisions about child custody typically arise in proceedings involving divorce, annulment, separation, adoption or parental death. In most jurisdictions child custody is determined in accordance with the best interests of the child standard.[2]
Following ratification of the United Nations Convention on the Rights of the Child in most countries, terms such as parental responsibility, "residence" and "contact" (also known as "visitation", "conservatorship" or "parenting time" in the United States) have superseded the concepts of "custody" and "access" in some member nations. Instead of a parent having "custody" of or "access" to a child, a child is now said to "reside" or have "contact" with a parent.[3]

Legal custody

Legal custody involves the division of rights between the parents to make important life decisions relating to their minor children. Such decisions may include choice of a child's school, physician, medical treatments, orthodontic treatment, counseling, psychotherapy and religion.[4]

Legal custody may be joint, in which case both parents share decision-making rights, or sole, in which case one parent has the rights to make key decisions without regard to the wishes of the other parent.

Physical custody

Physical custody establishes where a child lives and who decides day-to-day issues regarding the child. If a parent has physical custody of a child, that parent's home will normally be the child's legal residence (domicile). The times during which parents provide lodging and care for the child is defined by a court-ordered custody *parenting schedule*, also known as a *parenting plan*.

Forms

The different forms of physical custody include:

- **Sole custody**, an arrangement whereby only one parent has physical custody of the child. The other non-custodial parent would typically have regular visitation rights.[5]
- **Joint physical custody**, a shared parenting arrangement where both parents have the child for approximately equal amounts of time, and where both are custodial parents.[5]
- **Bird's nest custody**, a type of *joint physical custody* whereby the parents go back and forth from a residence in which the child always reside, placing the burden of upheaval and movement on the parents rather than the child.[6]
- **Split custody**, an arrangement whereby one parent has sole custody over some children, and the other parent has sole custody over the remaining children.[7]
- **Alternating custody**, an arrangement whereby the child lives for an extended period of time with one parent and an alternate amount of time with the other parent. This type of arrangement is also referred to as Divided custody.[8]
- **Third-party custody**, an arrangement whereby the children do not remain with either biological parent, and are placed under the custody of a third person.

Joint physical custody

Joint physical custody, or *shared parenting*, means that the child lives with both parents for equal or approximately equal amounts of time. In joint custody, both parents are *custodial parents* and neither parent is a non-custodial parent.[9] With joint physical custody, terms such as "primary custodial parent" and "primary residence" have no legal meaning other than for determining tax status.[10] The term "visitation" is not used in joint physical custody cases, but only for sole custody orders. In joint physical custody, the actual lodging and care of the child is shared according to a court-ordered custody schedule, also known as a *parenting plan* or *parenting schedule*.[11]

Sole custody

Sole physical custody means that a child resides with only one parent, while the other parent may have visitation rights with their child. The former parent is the *custodial parent* while the latter is the *non-custodial parent*.[9][12][13][14]

Prevalence

Comparing 36 western countries in 2005/06, Thoroddur Bjarnason studied the proportion of 11-15-year-old children living in different child custody arrangements. The percent of children living in intact families with both their mother and father were highest in Macedonia (93%), Turkey (89%), Croatia (89%) and Italy (89%), while it was lowest in the United States (60%), Romania (60%), Estonia (66%) and Latvia (67%). In the other anglophone countries, it was 70% in the United Kingdom, 71% in Canada and 82% in Ireland. Among the children who did not live with both their parents, the percent in a shared parenting versus sole custody arrangement was highest in Sweden (17%), Iceland (11%), Belgium (11%), Denmark (10%), Italy (9%) and Norway (9%). At 2% or less, it was lowest in Ukraine, Poland, Croatia, Turkey, the Netherlands and Romania. It was 5% in Ireland and the United States and 7% in Canada and the United Kingdom.[15] Shared parenting is increasing in popularity, and by 2016/17, the percentage in Sweden had increased to 34% among the 6-12 year old age group and 23% among 13-18-year-old children.[16]

Jurisdiction

A child custody case must be filed in a court that has jurisdiction over the child custody disputes. Jurisdiction normally arises from the presence of the children as legal residents of the nation or state where a custody case is filed.[17] However, some nations may recognize jurisdiction based upon a child's citizenship even though the child resides in another country, or may allow a court to take jurisdiction over a child custody case either on a temporary or permanent basis based upon other factors.[18]

Forum shopping may occur both between nations and, where laws and practices differ between areas, within a nation. If a plaintiff files a legal jurisdiction that the plaintiff believes to have more favorable laws than other possible jurisdictions, that plaintiff may be accused of forum shopping.

The Hague Convention seeks to avoid this,[19] also in the United States of America, the Uniform Child Custody Jurisdiction and Enforcement Act was adopted by all 50 states, family law courts were forced to defer jurisdiction to the home state.[20]

The "best interest" rule

In the context of cases regarding custody, the "best interest" rule suggests that all legal decisions made to accommodate the child are made with the goal of ensuring a child's happiness, security and overall wellbeing. There are many different factors that go into the decision that is made in a child's best interest, which include: the child's health, environment and social interests,[2] the relationship each parent has with the child, and the ability of each parent to address the needs of the child.

Problems with the "best interest" rule

The "best interest" rule has been considered to be a standard in determining child custody for the most recent 40 years in history. Although it has been so widely favored amongst legal systems, there are some deficiencies to the concept. Robert Mnookin, an American lawyer, author, and a Professor of Law at Harvard Law School, claimed that the best interest rule is indeterminate. It is considered to be a broad and vague set of guidelines that only leads to increased conflict amongst the parents instead of promoting cooperation that would actually lead to the best interest of the child being met.[21] Some of these problems specifically include:

- The current test for best interest generates high costs, which can impose on both the court and opposing parties.[21]
- The verifiability of the best interest standard is hard to achieve. The privacy of family life makes assessing the evidence provided difficult. The best interests standard only worsens the problem, in which both parties are encouraged to introduce evidence of the quality of their parenting (which also promotes trying to disprove the opposing party's capabilities of taking the child into custody).[21]
- In an example of divorce, both parties are experiencing high levels of stress, which could make for a poor basis for assessing family behaviors and relationships.[21]

In order to better analyze the "best interest" of children, several experiments were conducted to observe the opinions of children themselves. Children of divorce were found to want equal time with both of their parents. Studies conducted by Wallerstein, Lewis and Blakeslee (2002) show that children from all age ranges indicate that equal or shared parenting is of their best interest 93 percent of the time.[22] Several other studies were able to produce similar results, including Smart (2002), Fabricus and Hall (2003), Parkinson, and Cashmore and Single (2003).[23] As a result, there has been a push to allow for joint custody of children in the most recent years, which strives to best meet the interests of the children and most evidently favors a gender neutral stance on the custody issue. However, the decision is highly situational, for joint custody can only be achieved in the absence of certain exceptions. For example, history of domestic violence found from either parent can most certainly trump the possibility of joint custody for a child.[21]

Economics

In an economic analysis, Imran Rasul has concluded that if one parent values child quality more than the other, the spouses prefer that parent to have sole custody, while joint custody is optimal for parents with relatively equal valuation of child quality. He has further concluded that "joint custody is more likely to be optimal when divorce costs fall, so that children retain contact with both parents" and that "this may improve child welfare".[24]

Gender issues

As the roles of children have changed over the past couple of centuries from economic assets to individuals, so has the role of mothers and fathers in who would provide the best care for the child. Many courts and judges lean more towards the maternal figure when there is a trial for custody of a child. According to Family Change and Time Allocation in American Families study done at UCLA, women allocate about 13.9 hours a week to child

care while men allocate about 7 hours a week.[25] Additionally, according to the Current Population Survey, in 2013, custodial mothers were more likely to have child support agreements (52.3 percent) comparative to custodial fathers (31.4 percent).[26].

Women's and father's rights activists often become involved in matters of child custody since the issue of equal parenting is controversial, most of the time combining the interests of the child with those of the mothers or fathers. Women's rights activists are concerned about "family violence, recognizing primary caregiving, and inequities associated with awarding legal joint custody without a corresponding responsibility for child care involvement".[27] Father's rights activists are more concerned about their "disenfranchisement from children's lives, the importance of parent-child attachment, combating parental alienation, and access enforcement".[27] Courts cannot determine an individual child's best interests with certainty, and judges are "forced to rely on their own interpretations of children's interests, and idiosyncratic biases and subjective value-based judgments, including gender bias".[27] Judges are currently using the 'best interest of the child' standard that was made to consider the interests of the child before the mothers and fathers, including the child's mental, emotional, physical, religious, and social needs.[28]

Child poverty, lack of resources, and women's economic dependence on men all remain pressing issues that are not effectively noted during the custody trials.[27]

Australia

Each parent has a responsibility under the Australian *Family Law Act 1975* for their children. The parental responsibility does not change in cases of separation or dysfunction between the two parents.

In the case of divorce or separation of parents many hurdles can fall in the way regarding the custody of their children, deciding who will be the custodial parent and so forth. In Australia when parents cannot come to an agreement which meets both of their needs when it comes to the custody of their child/ren cases are taken to the Family Court of Australia, which happens in more scenarios than expected. When parents cannot agree on these arrangements and take matters to court, the court makes orders about parental responsibilities, and have the power to approve and make consent orders.[29]

Czech Republic

In the Czech Republic, both parents are entrusted with child's custody until a court decides otherwise.

A divorce is possible only after a court decision on custody was rendered. A decision should be made within six months, however when parents fail to reach agreement the cases typically take much longer. The court decides with the child's best interest in mind. In case of children 12 years and older, the child's preference becomes key to the court ruling. Court may also refer parents to mediation, try "test modes" of various custody arrangements or request psychological and psychiatrical evaluation of children and parents. In exigent circumstances, a parent can file for preliminary injunction for custody or child support payments. The court must decide on whether to grant the injunction within seven days.[30]

India

In India, child custody laws primarily fall under personal laws specific to different religions and the secular Guardians and Wards Act, 1890. Here's an overview:

Hindu Law: For Hindus, the Hindu Marriage Act, 1955 and the Hindu Minority and Guardianship Act, 1956, govern child custody. The custody of a child under the age of five is usually granted to the mother, and for children above five, the court considers the child's welfare as the paramount factor.[31][32]

Muslim Law: For Muslims, custody is governed by the personal laws of the parties involved. Generally, the mother gets custody of children until a certain age (Hizanat), after which the father gets custody.

Christian Law: For Christians, the Divorce Act, 1869, govern child custody. It is usually decided based on the welfare principle, considering the best interests of the child.[33]

Parsi Law: Child custody for Parsis is governed by the Parsi Marriage and Divorce Act, 1936, where the court considers the welfare of the child as the main criterion.[34]

Secular Law: The Guardians and Wards Act, 1890, is applicable to all communities and provides provisions for the appointment of guardians for minors and custody issues.[35]

In custody matters, the courts in India focus on the best interests and welfare of the child. They consider factors such as the child's age, education, health, and emotional well-being while deciding custody. It is common for courts to grant joint custody or visitation rights to the non-custodial parent to ensure both parents maintain an active role in the child's life.

Pakistan

In Pakistan, the Guardians and Wards Act, 1890 is the principal law that governs child custody. Pursuant to that statute and case law, the governing principle in child custody determinations, whether to a parent or third party, is the welfare of the minor.[36]

United States

Looking at the history of child custody demonstrates how the views of children and the relationship between husbands and wives have changed over time. The view of children has changed from economic assets to individuals with their own interests. Fathers were also once seen as the head of the household compared to today, when fathers and mothers have more equal standing in the care of their children.[37]

The colonial era and early republic: 1630-1830

During this time period, custodial issues arose with occasions other than divorce such as the death of the father or both parents, inability of parents to care for the children, or with situations involving illegitimate children. Children at the time were seen as economic assets with labor value. In addition to this, the only other important consideration in determining custody was the ability of the adults to supervise and raise the child. Widows would lose their children because they would not be able to support them. These children would be taken from the mother and given to another family that would support the child in return for the child's labor services. Otherwise, fathers were seen as the head of the household and had complete custody rights to children.[38]

The nineteenth century

The view of children as servants to their fathers and economic assets began to change in the nineteenth century. Children were seen to have interests of their own that were often associated with the care of a nurturing mother. The women's movement of the time also fought for women's right to child custody in their campaign.[38] Judges eventually began to favor the "best interests of the child," which, especially for young and female children, was associated with mothers. Maternal presumption was judicially developed through legislature such as the "Tender Years Doctrine" that presumed that children should be placed with their mothers in custody debates.[39] Granting custody to the father was seen "to hold nature in contempt, and snatch helpless, puling infancy from the bosom of an affectionate mother, and place it in the coarse hands of the father" when the mother was "the softest and safest nurse of infancy".[40] This maternal presumption continued for over a hundred years. The only exception to maternal presumption was if the mother was considered to be "unfit." Most often, this occurred when women had committed adultery or left their husband.[38]

The early twentieth century

By the early twentieth century, divorce cases became more common, and custody disputed simultaneously became an issue that affected many families. With the changing attitudes of the Roaring 20's, a woman's sexual conduct no longer prevented her from receiving custody for her children. The double standard on sexual conduct of fathers and mothers was removed. The new rule according to Keezer on the Law of Marriage and Divorce stated that "Where the children are of tender years, other things being equal, the mother is preferred as their custodian, and this more especially in the case of female children, and this though she may have been guilty of delinquencies in the past but there is no evidence that she was delinquent at the time of determining the matter by the court."[38]

The late twentieth and early twenty-first centuries

In the late twentieth and early twenty-first centuries, divorce rates increased dramatically. Due to the nature of divorce, the rules governing child custody became increasingly difficult to determine. It was at this time that the idea of mothers being favored to gain custody of children in the event of a divorce was challenged. "The simple fact of being a mother does not, by itself, indicate a capacity or willingness to render a quality of care different from that which the father can provide", a New York court stated in 1973.[38] It was at this time that the basis of the "best interest rule" was changed to address many aspects of the child's care in order to promote gender neutrality in decisions regarding custody. These aspects include the child's mental, emotional, physical, religious, and social needs. All children have the right to services that prevent them from physical or psychological harm. This means that when assessing the best interest of the child, it is not only important to assess the parents who are fighting for custody, but also the environments in which the child would be placed under the custody of either parent. In a situation where neither parent would be deemed an appropriate caretaker for a child, custody would be given to a foster care center.[41]

In some states joint physical custody creates a presumption of equal shared parenting, however in most states, joint physical custody creates an obligation to provide each of the parents with "significant periods" of physical custody so as to assure the child of "frequent and continuing contact" with both parents.[9] For example, U.S. states such as Alabama, California, and Texas do not necessarily require joint custody orders to result in substantially equal parenting time, whereas states such as Arizona, Georgia, and Louisiana do require joint custody orders to result in substantially equal parenting time where feasible.[42] Courts have not clearly defined what "significant periods" and "frequent and continuous contact" mean, which requires parents to litigate to find out.

Yorum

Çocuk Koruma Kanununa göre eğer bebeğin bakım ve gözetiminde en ufak bir sorun saptanırsa, Sosyal Yardımlaşma Kurumunda psikologların olması ile derhal müdahale edilerek çocuk ellerinden alınır.

Komşular iki çocukları olmasına karşın, üçüncü olarak bir çocuk koruyucu aile olarak almak istemişler. Bir telefon ile bana *sizin bu konudaki hassasiyetinizi biliyoruz, daha önceki yaklaşımlardan da teyit ettiniz, eğer bir sorun görürseniz, doğrudan bize haber verin* dediler. *Çocuk yeni alışmaya çalışıyor, sabah ağlıyor, ama izliyorum, iki tarafta memnun, elbette bir durum olursa iletirim* dedim. Bu durumu aileye de ilettim, bana danışabilirsiniz diye de ekledim.

Health (Regulation of Termination of Pregnancy) Act 2018, Wikipedia[10]

The **Health (Regulation of Termination of Pregnancy) Act 2018** (Act No. 31 of 2018; previously Bill No. 105 of 2018) is an Act of the Oireachtas (Irish parliament) which defines the circumstances and processes within which abortion may be legally performed in Ireland. It permits termination under medical supervision, generally up to 12 weeks' pregnancy,[*clarification needed*] and later if pregnancy poses a serious health risk or there is a fatal foetal abnormality.[1]

Prior to 2018, abortion was legal only where pregnancy presented "a real and substantial risk to the life" of the woman, as mandated by the 1983 Eighth Amendment of the Constitution and regulated by the Protection of Life During Pregnancy Act 2013. A referendum on 25 May 2018 approved the Thirty-sixth Amendment of the Constitution, which in effect repealed the Eighth Amendment and empowered the Oireachtas to legislate for abortion. The health (Regulation of Termination of Pregnancy) Bill was published on 27 September 2018 and signed into law on 20 December 2018. The act came into force on 1 January 2019.[2]

Key provisions

The law allows for a termination:

- under section 9, where there is a serious risk to the life or of serious harm to the health of a pregnant woman, after examination by 2 medical practitioners;
- under section 10, in cases of emergency, where there is an immediate serious risk to the life or of serious harm to the health of a pregnant woman, after an examination by one medical practitioner;
- under section 11, where two medical practitioners are of the opinion formed in good faith that there is present a condition affecting the foetus that is likely to lead to the death of the foetus either before, or within 28 days of, birth; and
- under section 12, where there has been a certification that the pregnancy has not exceeded 12 weeks, and after a period of 3 days after this certification.

Under section 23, it is an offence punishable by a fine or imprisonment of up to 14 years to intentionally end the life of a foetus outside the provisions of the Act. This offence does not apply in the case of a woman ending her own pregnancy.

Background

Prior to 2018, abortion was legal only where pregnancy presented "a real and substantial risk to the life" of the woman, as mandated by the 1983 Eighth Amendment of the Constitution and regulated by the Protection of Life During Pregnancy Act 2013. After the 2016 general election, a Citizen's Assembly was established by

Oireachtas resolution and tasked with reporting on several issues, the first being "the Eighth Amendment of the Constitution". It began discussion in November 2016 and finally voted in April 2017 on a range of questions. Its first recommendation was to replace the constitutional prohibition with a mandate for the Oireachtas to legislate on abortion. It then provided a range of recommendations for circumstances in which the Oireachtas might legislate to allow abortion. The assembly's formal report was laid before the Oireachtas on 29 June 2017[3] and referred to a special Oireachtas Joint Committee for consideration. The committee met from September to December 2017 and produced its own report, recommending the same constitutional amendment as the assembly but a slightly more liberal statutory regime. The assembly had recommended allowing termination on grounds of rape or incest, but the committee felt it would be impossible to provide adequate proof for such cases and instead opted for an unrestricted provision of termination within 12 weeks' gestation.[4] Their report was debated in the Dáil between 17 and 25 January 2018[5] and again on 21 February.[6] Simon Harris, the Minister for Health, began by saying:

I want to recognise that the recommendations contained in the Committee's report represent the views of the majority of members, but that there was not unanimous agreement on them. I respect the views of those who dissent from the recommendations but I do believe they are the basis on which we must proceed on this issue.

A referendum on 25 May 2018 approved the Thirty-sixth Amendment of the Constitution, which in effect repealed the Eighth Amendment and empowered the Oireachtas to legislate for abortion. Legal challenges delayed enactment of the amendment until 18 September 2018.

Legislative history

A General Scheme of a Bill to Regulate Termination of Pregnancy was published by the Department of Health in March 2018, prior to the passage of the Thirty-sixth Amendment.[7] A second general scheme for the bill was published by the Department of Health in July 2018.[8]

The Health (Regulation of Termination of Pregnancy) Bill was introduced into the Dáil Éireann on 27 September 2018 by the Minister for Health Simon Harris. It passed final stages in the Dáil on 5 December, where it was approved by 90 votes to 15, with 12 registered abstentions.[9] Peadar Tóibín was suspended from Sinn Féin for defying the party whip to vote against the bill. He left the party to found Aontú.

On 13 December 2018, the bill passed final stage in Seanad Éireann by 27 votes to 5.[1]

On 20 December 2018, the bill was signed into law by President Michael D. Higgins. On 21 December 2018, the Minister for Health issued the statutory instruments specifying the act's commencement date,[10] and the regulations for certifications,[11] notifications,[12] and reviews of decisions.[13] On 1 January 2019, the act commenced.[10]

Implementation

The first annual report on the Act's operation, covering the calendar year 2019, was laid before the Houses of the Oireachtas on 30 June 2020 by the Minister for Health. The report revealed that in 2019 there had been 6,666 terminations in the State under the Act's provisions, of which 21 were on grounds of risk to life or health.[14]

Annual Reports of notifications in accordance with the health (Regulation of Termination of Pregnancy) Act 2018

For year	Report date	Number of terminations by risk			Number of terminations at early pregnancy	Total	Refs
		Health	Emergency	Foetus			
2019	30 June 2020	21	3	100	6,542	6,666	[15]
2020	29 June 2021	20	5	97	6,455	6,577	[16]
2021	13 July 2022	9	2	53	4,513	4,577	[17]
2022	22 June 2023	22	4	88	8,042	8,156	[18]

Yorum

Gebeliğin sonlanması için yasal düzenlemeler: *Uygulama olarak bazı hususlara dikkat edilmelidir. Bunlar:*

- Annede gebeliğin devamlılığı üzerinde yaşamsal bir tehlike söz konusu olduğu zaman termine edilebilir. Ülkemizde o bebek daima canlandırma ve yaşatılmaya da çalışılmalıdır. Kendisi yaşamaz ve ölmesi ile tıbbi işlem sonlanabilir.
- Gebelik değil, anne sağlığının tehlikeye düşmesi, kalp hastası durumları gibi yaklaşımlarda termine edilebilir.
- Bebeğin yaşamama durumu varsa, 40 Gebelik Haftasını dolduramıyorsa yapılır. Makalede doğumdan sonrası içinde vurgu vardır, bizde ise engellilerin de yaşama hakkı vardır.
- Eğer 12 haftayı geçmemiş ise, bu Ülkemizde 10 Gebelik haftasıdır, aradaki 2 hafta son adet tarihi ile fertilize olma arasındaki süreçtir. Uygulama açısından 10 Gebelik Hafa, embriyonik dönem açısından daha uygundur. Anne ve Bebek Hakkı bütünleşiştir, fetusta ise bebeğin hakkı ayrı ve gerçektir.

Burada oluşan boyut doğrudan gelişimsel olmaktadır. Diyanetin belirttiği ek bir vurgu da ekonomik, bakamayacağız gerekçesi ile termine edilmemesidir. Devlet bakmaktadır.

Medical abortion, Wikipedia[11]

A **medical abortion**, also known as **medication abortion**, occurs when drugs (medication) are used to bring about an abortion. Medical abortions are an alternative to surgical abortions such as vacuum aspiration or dilation and curettage.[5] Medical abortions are more common than surgical abortions in most places around the world.[6][7]

Medical abortions are most commonly performed by administering a two-drug combination: mifepristone followed by misoprostol. Although these medications can be used separately, evidence suggests the two-drug combination is the most effective at producing a complete abortion up to 65 days after menstrual bleeding has stopped. When mifepristone is not available, misoprostol alone may be used in some situations.[8] Methotrexate and letrozole are other medications that may be used in various combinations, often including mifepristone and/or misoprostol, to bring about an abortion.[5]

Medical abortion is both safe and effective throughout a range of gestational ages, including the second and third trimester.[9] In the United States, the mortality rate for medical abortion is 14 times lower than the mortality rate for childbirth, and the rate of serious complications requiring hospitalization or blood transfusion is less than 0.4%.[10][11][12][13] Medical abortion can be administered safely by the patient at home, without assistance, in the first trimester.[14] In the second trimester and beyond, it is recommended to take the second drug in a clinic or provider's office.[14]

Medical abortion should not be confused with emergency contraception, which typically involves drugs (such as levonorgestrel or "Plan B") taken soon after intercourse to prevent a pregnancy from beginning.

Drug regimens

Less than 12 weeks' gestation

For medical abortion up to 12 weeks' gestation, the recommended drug dosages are 200 milligrams of mifepristone by mouth, followed one to two days later by 800 micrograms of misoprostol inside the cheek, vaginally, or under the tongue.[15] The success rate of this drug combination is 96.6% through 10 weeks' pregnancy.[16]

Misoprostol should be administered 24 to 48 hours after the mifepristone; taking the misoprostol before 24 hours have elapsed reduces the probability of success.[12] However, one study showed that the two drugs may be taken simultaneously with nearly the same efficacy.[17]

For pregnancies after 9 weeks, two doses of misoprostol (the second drug) makes the treatment more effective.[18] From 10 to 11 weeks of pregnancy, the National Abortion Federation suggests second dose of misoprostol (800 micrograms) four hours after the first dose.[19]

After the patient takes mifepristone, they must also administer the misoprostol. Failure to take the misoprostol may result in any of these outcomes: the fetus may be terminated, but not fully expelled from the uterus

(possibly accompanied by hemorrhaging) and may require surgical intervention to remove the fetus; or the pregnancy may be successfully aborted and expelled; or the pregnancy may continue with a healthy fetus. For those reasons, misoprostol should always be taken after the mifepristone.[20]
If the pregnancy involves twins, a higher dosage of mifepristone may be recommended.[21]

Self-administered medical abortion

In the first trimester, self-administered medical abortion is available for patients who prefer to take the abortion drugs at home without direct medical supervision (in contrast to provider-administered medical abortion where the patient takes the second abortion drug in the presence of a trained healthcare provider).[14] Evidence from clinical trials indicates self-administered medical abortion is as effective as provider-administered abortion; however additional research is required to confirm that safety is equivalent.[22][23]
The procedure used to administer the two drugs depends on specific drugs prescribed. A typical procedure, for 200 mg mifepristone tablets, is:[24][25][26]

1. Take the mifepristone tablet(s) by mouth
2. Take the misoprostol between 24 hours and 48 hours after the mifepristone (patients should follow the medication packaging directions for route specifications, i.e. between the gums and the inner lining of the mouth cheek, under the tongue, or in the vagina by vaginal suppository)
3. The pregnancy (embryo and placenta) will be expelled through the vagina within 2 to 24 hours after taking misoprostol, so the patient should remain near toilet facilities at that time. Cramps, nausea and bleeding may be experienced while the pregnancy is being expelled, and afterwards
4. To avoid infection, the patient should not use tampons or engage in intercourse for 2 to 3 weeks[27]
5. The patient should contact their provider 7 to 14 days after the administration of mifepristone to confirm that complete termination of pregnancy has occurred and to evaluate the degree of bleeding

After 12 weeks' gestation

Medical abortion is safe and effective in the second and third trimesters.[9][28][29][30] The WHO recommends that medical abortions performed after 12 weeks' gestation be supervised by a generalist medical practitioner or specialist medical practitioner (in contrast to first trimester, where the patient may safely take the drugs at home without supervision).[14][15]
For medical abortion after 12 weeks' gestation, the WHO recommends 200 mg of mifepristone by mouth followed one to two days later by repeat doses of 400 µg misoprostol under the tongue, inside the cheek, or in the vagina.[15] Misoprostol should be taken every 3 hours until successful abortion is achieved, the mean time to abortion after starting misoprostol is 6–8 hours, and approximately 94% will abort within 24 hours after starting misoprostol.[31] When mifepristone is not available, misoprostol may still be used though the mean time to abortion after starting misoprostol will be extended compared to regimens using mifepristone followed by misoprostol.[32]

Alternative drug combinations

The mifepristone-misoprostol combination is, by far, the most recommended drug regimen for medical abortions, but other drug combinations are available.
Misoprostol alone, without mifepristone, may be used in some circumstances for medical abortion, and has even been demonstrated to be successful in the second trimester. Misoprostol is more commonly available than mifepristone, and is easier to store and administer, so misoprostol without mifepristone may be suggested by the provider if mifepristone is not available.[8] If misoprostol is used without mifepristone, the WHO recommends 800 µg of misoprostol inside the cheek, under the tongue, or in the vagina.[15] The success rate of misoprostol alone for terminating pregnancy (93%) is nearly the same as the mifepristone-misoprostol combination (96%). However, 15% of the women using misoprostol alone required a surgical follow-up procedure, which is significantly more than the mifepristone-misoprostol combination.[33]
A rarely used drug combination for uterine pregnancies is methotrexate-misoprostol, which is typically reserved for ectopic pregnancies.[34] Methotrexate is given either orally or intramuscularly, followed by vaginal misoprostol 3–5 days later.[19] The methotrexate combination is available through 63 days. The WHO authorizes the methotrexate-misoprostol combination[35] but recommends the mifepristone combination because methotrexate may be teratogenic to the embryo in cases of incomplete abortion. The methotrexate-misoprostol combination is considered more effective than misoprostol alone.[36]

Access to medical abortion

Both drugs – mifepristone and misoprostol – are no longer covered by drug patents, and hence are available as generic drugs.

Over-the-counter availability

The requirements for a prescription vary widely between countries.[37] Many countries make the medical abortion drugs available over the counter, without a prescription, such as China, India, and others.[38] Other countries require a prescription (Canada, most of Western Europe, the United States, and others).[38] Some countries require a prescription but are lax about enforcing that requirement (Russia, Brazil, and others).[38]

Telehealth access

Telehealth includes access to medical services that the person can perform at home, without in-person visits to clinic or provider offices. People who have used telehealth report being satisfied with the access it provides to abortion services.[39][40] However, those who might need the service the most (those who are incarcerated, unhoused, or live on low income) are often inhibited from accessing it.[41]

Telehealth options for people in the U.S. seeking medical abortion include: Aid Access, Plan C, Hey Jane, Choix, Just the Pill, carafem, and Abortion on Demand.[42]

Clinic-to-clinic access

In this model, a provider communicates with a patient located at another site using clinic-to-clinic videoconferencing to provide medication abortion. This was introduced by Planned Parenthood of the Heartland in Iowa to allow a patient at one health facility to communicate via secure video with a health provider at another facility.[43] This model has expanded to other Planned Parenthoods in multiple states as well other clinics providing abortion care.[43]

Direct-to-patient access

The direct-to-patient model allows for medication abortion to be provided without an in-person clinic visit. Instead of an in-person clinic visit, the patient receives counseling and instruction from the abortion provider via videoconference. The patient can be at any location, including their home. The medications necessary for the abortion are mailed directly to the patient. This is a model, called TelAbortion or no-test medication abortion (formerly no-touch medication abortion), being piloted and studied by Gynuity Health Projects, with special approval from the U.S. Food and Drug Administration (FDA).[44] This model has been shown to be safe, effective, efficient, and satisfactory.[45][46][47] Complete abortion can be confirmed via telephone-based assessment.[48]

In the United States

In the U.S., prescriptions for mifepristone may be filled by any pharmacy - online or brick-and-mortar - that has obtained a special certification.[49] This regulation was provisionally implemented in Dec 2021, and was finalized by the FDA in January 2023.[50]

From 2011 until 2021, a patient was required to visit a healthcare provider in-person (at a clinic or office) and receive mifepristone directly from the provider.[51] The requirement to visit a clinic to receive the drug was removed by the FDA in December 2021, during the COVID-19 pandemic. Under the new rules, the prescription may be obtained via telehealth (phone calls or video conferencing with a healthcare provider), and then filled at any certified pharmacy.[52][26][45][53] At the same time the FDA removed the requirement for an in-person visit, they added a requirement that dispensing pharmacies be "certified", which requires the pharmacy to have special permission to dispense the drugs – a requirement the FDA imposes on only 40 drugs out of more than 19,000 it manages.[54]

The second drug used in medical abortion, misoprostol, is most commonly used for treating ulcers, and was never subject to the in-person dispensing constraints of mifepristone, and was always available from pharmacies with a prescription.

The FDA does not authorize the use of mifepristone for medical abortion after 70 days, unlike most other countries, which authorize medical abortion into the second trimester and even the third trimester.[52]

Some states have passed laws that prohibit providers from examining the patient via phone or video conferencing, and instead require the patient to make an in-person visit to the provider to get the prescription.[55][56]

In most states, abortion drugs may be sent from a pharmacy to the patient via mail, but certain states have passed laws making that illegal, and requiring the drugs to be obtained from a pharmacy or provider in-person.[55][57]

Interest in abortion medications in the United States reached record highs in 2022, after the Supreme Court of the United States draft *Dobbs v. Jackson Women's Health Organization* ruling that would overturn 1973's *Roe v. Wade* decision was leaked online.[58] Interest was higher in states with more restrictions on access to abortion.[58] Pro-choice activists in the U.S. were exploring ways to make medical abortion more available, particularly in states where it is subject to limitations, with social media resources being utilized for this purpose.[59][60][61][62]

In March 2023, Governor Mark Gordon of Wyoming signed a bill outlawing the use of abortion pills in the state, making it the first US state to do so. The new legislation, which will go into effect on July 1, 2023, criminalizes the "prescription, dispensation, distribution, sale, or use of any drug" for the purpose of obtaining or performing an abortion. Those who violate the law, excluding the pregnant individual, may be charged with a misdemeanor and could face a $9,000 fine and up to six months in jail. Abortion providers are expected to challenge the new law in court.[63]

Contraindications

Contraindications to mifepristone are inherited porphyria, chronic adrenal failure, and ectopic pregnancy.[64][65] Some consider an intrauterine device in place to be a contraindication as well.[65] A previous allergic reaction to mifepristone or misoprostol is also a contraindication.[64]

Many studies excluded women with severe medical problems such as heart and liver disease or severe anemia.[65] Caution is required in a range of circumstances including:[64]

- long-term corticosteroid use;
- bleeding disorder;
- severe anemia

In some cases, it may be appropriate to refer people with preexisting medical conditions to a hospital-based abortion provider.[66]

Adverse effects

Most women will have cramping and bleeding heavier than a menstrual period.[65] Other adverse effects include nausea, vomiting, fever, chills, diarrhea, and headache.[27] Misoprostol taken vaginally tends to have fewer gastrointestinal side effects. Nonsteroidal antiinflammatory medications such as ibuprofen reduce pain with medication abortion.

Complications

Symptoms that require immediate medical attention:[67]

- Heavy bleeding (enough blood to soak through four sanitary pads in 2 hours)
- Abdominal pain, nausea, vomiting, diarrhea, fever for more than 24 hours after taking mifepristone
- Fever of 38 °C (100.4 °F) or higher for more than 4 hours

Complications under 10 weeks' pregnancy are rare; according to two large reviews, bleeding requiring a blood transfusion occurred in 0.03–0.6% of women and serious infection in 0.01–0.5%.[16][12] Because infection is rare after medication abortion, the American College of Obstetricians and Gynecologists, The Society of Family Planning, and the NAF do not recommend use of routine antibiotics.[68][19] A few rare cases of deaths from clostridial toxic shock syndrome have occurred following medical abortions.[69]

A 2013 systematic review which included 45,000 women who used the 200 mg mifeprestone followed by misoprostol combination found that less than 0.4% had serious complications requiring hospitalization (0.3%) and/or blood transfusion (0.1%).[12][13]

Management of bleeding

Vaginal bleeding generally diminishes gradually over about two weeks after a medical abortion, but in individual cases spotting can last up to 45 days.[64] If the woman is well, neither prolonged bleeding nor the presence of tissue in the uterus (as detected by obstetric ultrasonography) is an indication for surgical intervention (that is, vacuum aspiration or dilation and curettage). Remaining products of conception will be expelled during subsequent vaginal bleeding. Still, surgical intervention may be carried out on the woman's request, if the bleeding is heavy or prolonged, or causes anemia, or if there is evidence of endometritis.

Although medical abortion is associated with more bleeding than surgical abortion, overall bleeding for the two methods is minimal and not clinically different. In a large-scale prospective trial published in 1992 of more than 16,000 women undergoing medical abortion using mifepristone with varying doses of gemeprost or sulprostone, only 0.1% had hemorrhage requiring a blood transfusion. It is often advised to

contact a health care provider if there is bleeding to such degree that more than two pads are soaked per hour for two consecutive hours.

Safety

Medical abortion is safe even into the second and third trimesters.[9][28][29][30]

In the United States, an FDA report states that of the 3.7 million women who have had a medication abortion between 2000 and 2018, 24 died afterward, with 11 of those deaths likely unrelated to the abortion, including drug overdoses, homicides, and a suicide.[10][11] If the deaths likely unrelated to the abortion are not included, then the mortality rate for medication abortion is half the mortality rate of abortion overall.[10]:1 Including all 24 deaths, the data shows that (in the US) the mortality rate for medication abortion is equivalent to abortion overall, which is 14 times lower than the mortality rate for childbirth, and also lower than the mortality rate for Penicillin and Viagra.[10][11]

Pharmacology

Mifepristone blocks the hormone progesterone,[70][71] causing the lining of the uterus to thin and preventing the embryo from staying implanted and growing. Methotrexate, which is sometimes used instead of mifepristone, stops the cytotrophoblastic tissue from growing and becoming a functional placenta.[72] Misoprostol, a synthetic prostaglandin, causes the uterus to contract and expel the embryo through the vagina.[73]

Prevalence

Medical abortions as a percentage of all abortions

Country	Percentage
Spain	25% in 2021[74]
Netherlands	34% in 2021[75]
Italy	35% in 2020[76]
Canada	37% in 2021[77]
Belgium	38% in 2021[78]
Germany	39% in 2022[79]
New Zealand	46% in 2021[80]
United States	53% in 2020[7]
Portugal	68% in 2021[81]
Slovenia	72% in 2019[82]

Medical abortions as a percentage of all abortions

Country	Percentage
France	76% in 2021[83]
Switzerland	80% in 2021[84]
Denmark	83% in 2021[85]
England and Wales	87% in 2021[86]
Iceland	87% in 2021[87]
Estonia	91% in 2021[88]
Norway	95% in 2022[89]
Sweden	96% in 2021[90]
Finland	98% in 2021[91]
Scotland	99% in 2021[92]

A Guttmacher Institute survey of all known abortion providers in the U.S. found that medical abortions accounted for 53% of all abortions in 2020.[7] This count did not include self-induced abortions.[7]

At Planned Parenthood clinics in the U.S., medical abortions accounted for 32% of first trimester abortions in 2008,[93] 35% of all abortions in 2010 and 43% of all abortions in 2014.[94]

In 2009, medical abortion regimens using mifepristone in combination with a prostaglandin analog were the most common methods used to induce second-trimester abortions in Canada, most of Europe, China and India;[6] in contrast to the U.S., where 96% of second-trimester abortions were performed surgically by dilation and evacuation.[95]

History

Swedish researchers began testing potential abortifacients in 1965. In 1968, the Swedish physician Lars Engström published a paper on a clinical trial, conducted at the women's clinic of Karolinska Hospital in Stockholm, of the compound F6103 on pregnant Swedish women with the aim of inducing abortion. It was the first clinical trial of an abortion pill to be conducted in Sweden.[96] The paper, originally titled *The Swedish Abortion Pill*, was renamed to *The Swedish Postconception Pill*, due to the small number of induced abortions that occurred in the trial population. After these efforts were largely unsuccessful with F6103, the same researchers attempted to find an abortion pill with prostaglandins, capitalizing on the number of well-established prostaglandin scientists working in Sweden at the time; they were eventually awarded the 1982 Nobel Prize in Physiology for their work.[97]

Medical abortion became a successful alternative method of abortion with the availability of prostaglandin analogs in the 1970s and the antiprogestogen mifepristone (also known as RU-486)[98] in the 1980s.[6][36][99] Mifepristone was first approved for use in China and France in 1988, in Great Britain in 1991, in Sweden in 1992, in Austria, Belgium, Denmark, Finland, Georgia, Germany, Greece, Iceland, Israel, Lichtenstein, Luxembourg, Netherlands, Russia, Spain, and Switzerland in 1999, in Norway, Taiwan, Tunisia, and the United States in 2000, and in 70 additional countries from 2001 to 2023.[100]
In 2000, mifepristone was approved by the U.S. FDA for abortions through 49 days gestation.[101] In 2016, the U.S. FDA updated mifepristone's label to support usage through 70 days gestation.[102]

Society and culture

The WHO affirms that laws and policies should support people's access to evidence-based medically approved care, including medical abortion.[103][104]

"Reversal" controversy

Some anti-abortion groups claim that patients who change their mind about the abortion after taking mifepristone can "reverse" the abortion by administering progesterone (and not administering misoprostol).[105][106] As of 2022, there is no scientifically rigorous evidence that the effects of mifepristone can be reversed this way.[107][108] Even so, several states in the U.S. require providers of non-surgical abortion who use mifepristone to tell patients that reversal is an option.[109] In 2019, researchers initiated a small trial of the so-called "reversal" regimen using mifepristone followed by progesterone or placebo.[110][111] The study was halted after 12 women enrolled and three experienced severe vaginal bleeding. The results raise serious safety concerns about using mifepristone without follow-up misoprostol.[108]

Cost

In the U.S. in 2009, the typical price charged for a medical abortion up to 9 weeks' gestation was $490, four percent higher than the $470 typical price charged for a surgical abortion at 10 weeks' gestation.[112] In the U.S. in 2008, 57% of women who had abortions paid for them out of pocket.[113]
In April 2013, the Australian government commenced an evaluation process to decide whether to list mifepristone (RU486) and misoprostol on the country's Pharmaceutical Benefits Scheme (PBS). If the listing is approved by the Health Minister Tanya Plibersek and the federal government, the drugs will become more accessible due to a dramatic reduction in retail price—the cost would be reduced from between AU$300 and AU$800, to AU$12 (subsidised rate for concession card holders) or AU$35.[114] On 30 June 2013, the Australian Minister for Health, the Hon. Tanya Plibersek MP, announced that the Australian Government had approved the listing of mifepristone and misoprostol on the PBS for medical termination in early pregnancy consistent with the recommendation of the Pharmaceutical Benefits Advisory Committee.[115] These listings on the PBS commenced on 1 August 2013.[116][117]

Yorum

Bebeğin gebelikte düşürülmesi, tedavi amaçlı anneye uygulanan olduğu gibi bebeğin yaşamının bir nedenle sonlandırılması da olmaktadır: *Uygulama olarak çeşitli tıbbi yaklaşımlar uygulanmaktadır, ancak plasenta kalıntısı kalmamalıdır.*

Düşük yapmak için anne sağlık kuruluşlarına başvurdukları gibi kendileri de uygulamaktadırlar: *Uygulama olarak 10-12 Gebelik Haftasından sonra yapılması tehlikelidir.*

Sorun olduğunda telefon ile yardım değil 112 acil yaklaşım istenmelidir: *Uygulama olarak anne ve hastaların çekinmesi, yaşamsal tehlikeye davetiye çıkarmak demektir*. Burada ırza geçme ile olan gebeliklerin tahliyesi için 20 Gebelik Haftası öngörülmekte, ancak mutlaka hekim nezaretinde, bebeğin de genetik kimliğinin tespiti zorunluluk taşımaktadır.

İşlemlerin yapılabilmesi için annenin sağlıklı olması gerekir: *Uygulama olarak annenin pıhtılaşma sorunu, kanama diyatezinin olması, kansızlık gibi durumlarda yaşamı tehlikeye girebileceği öngörülmelidir.*

Ücretlendirmede medikal olanlar, Devlet tarafından karşılanmaktadır: *Uygulama olarak hekim nezaretinde olması ile ücret ödenemez.*

Abortion law, Wikipedia[12]

Abortion laws vary widely among countries and territories, and have changed over time. Such laws range from abortion being freely available on request, to regulation or restrictions of various kinds, to outright prohibition in all circumstances. Many countries and territories that allow abortion have gestational limits for the procedure depending on the reason; with the majority being up to 12 weeks for abortion on request, up to 24 weeks for rape, incest, or socioeconomic reasons, and more for fetal impairment or risk to the woman's health or life. As of 2022, countries that legally allow abortion on request or for socioeconomic reasons comprise about 60% of the world's population.

Abortion continues to be a controversial subject in many societies on religious, moral, ethical, practical, and political grounds. Though it has been banned and otherwise limited by law in many jurisdictions, abortions continue to be common in many areas, even where they are illegal. According to a 2007 study conducted by the Guttmacher Institute and the World Health Organization, abortion rates are similar in countries where the procedure is legal and in countries where it is not,[1][2] due to unavailability of modern contraceptives in areas where abortion is illegal.[3] Also according to the study, the number of abortions worldwide is declining due to increased access to contraception.[1][2]

History

Abortion has existed since ancient times, with natural abortifacients being found amongst a wide variety of tribal people and in most written sources. The earliest known records of abortion techniques and general reproductive regulation date as far back as 2700 BC in China, and 1550 BC in Egypt.[4] Early texts contain little mention of abortion or abortion law. When it does appear, it is entailed in concerns about male property rights, preservation of social order, and the duty to produce fit citizens for the state or community. The harshest penalties were generally reserved for a woman who procured an abortion against her husband's wishes, and for slaves who produced abortion in a woman of high status. Religious texts often contained severe condemnations of abortion, recommending penance but seldom enforcing secular punishment. As a matter of common law in England and the United States, abortion was illegal any time after quickening—when the movements of the fetus could first be felt by the woman. Under the born alive rule, the fetus was not considered a "reasonable being" *in rerum natura*; and abortion was not treated as murder in English law.

In the 19th century, many Western countries began to codify abortion laws or place further restrictions on the practice. Anti-abortion movements were led by a combination of groups opposed to abortion on moral grounds, and by medical professionals who were concerned about the danger presented by the procedure and the regular involvement of non-medical personnel in performing abortions. Nevertheless, it became clear that illegal abortions continued to take place in large numbers even where abortions were rigorously restricted. It was difficult to obtain sufficient evidence to prosecute the women and abortion doctors, and judges and juries were often reluctant to convict. For example, Henry Morgentaler, a Canadian pro-choice advocate, was never convicted by a jury. He was acquitted by a jury in the 1973 court case, but the acquittal was overturned by five judges on the Quebec Court of Appeal in 1974. He went to prison, appealed, and was again acquitted. In total, he served 10 months, suffering a heart attack while in solitary confinement. Many were also outraged at the invasion of privacy and the medical problems resulting from abortions taking place illegally in medically dangerous circumstances. Political movements soon coalesced around the legalization of abortion and liberalization of existing laws.

By the first half of the 20th century, many countries had begun to liberalize abortion laws, at least when performed to protect the woman's life and in some cases on the woman's request. Under Vladimir Lenin, the Soviet Union became the first modern state in legalizing abortions on request—the law was first introduced in the Russian SFSR in 1920, in the Ukrainian SSR in July 1921, and then in the whole country.[5][6] The Bolsheviks saw abortion as a social evil created by the capitalist system, which left women without the economic means to raise children, forcing them to perform abortions. The Soviet state initially preserved the tsarist ban on abortion, which treated the practice as premeditated murder. However, abortion

had been practiced by Russian women for decades and its incidence skyrocketed further as a result of the Russian Civil War, which had left the country economically devastated and made it extremely difficult for many people to have children. The Soviet state recognized that banning abortion would not stop the practice because women would continue using the services of private abortionists. In rural areas, these were often old women who had no medical training, which made their services very dangerous to women's health. In November 1920 the Soviet government legalized abortion in state hospitals. The state considered abortion as a temporary necessary evil, which would disappear in the future communist society, which would be able to provide for all the children conceived.[7][page needed] In 1936, Joseph Stalin placed prohibitions on abortions, which restricted them to medically recommended cases only, in order to increase population growth after the enormous loss of life in World War I and the Russian Civil War.[8][9][6] In the 1930s, several countries (Poland, Turkey, Denmark, Sweden, Iceland, Mexico) legalized abortion in some special cases (pregnancy from rape, threat to mother's health, fetal malformation). In Japan, abortion was legalized in 1948 by the Eugenic Protection Law,[10] amended in May 1949 to allow abortions for economic reasons.[11] Abortion was legalized in 1952 in Yugoslavia (on a limited basis[which?]), and again in 1955 in the Soviet Union on request. Some Soviet allies (Poland, Hungary, Bulgaria, Czechoslovakia, Romania) legalized abortion in the late 1950s under pressure from the Soviets.[how?][12][additional citation(s) needed]

In the United Kingdom, the Abortion Act of 1967 clarified and prescribed abortions as legal up to 28 weeks (later reduced to 24 weeks). Other countries soon followed, including Canada (1969), the United States (1973 in most states, pursuant to *Roe v. Wade*—the U.S. Supreme Court decision which legalized abortion nationwide), Tunisia and Denmark (1973), Austria (1974), France and Sweden (1975), New Zealand (1977), Italy (1978), the Netherlands (1984), and Belgium (1990). However, these countries vary greatly in the circumstances under which abortion was to be permitted. In 1975, the West German Supreme Court struck down a law legalizing abortion, holding that they contradict the constitution's human rights guarantees. In 1976, a law was adopted which enabled abortions up to 12 weeks. After Germany's reunification, despite the legal status of abortion in former East Germany, a compromise was reached which deemed most abortions up to 12 weeks legal, but this law was struck down by the Federal Constitutional Court and amended to only remove the punishment in such cases, without any statement to legality. In jurisdictions governed under sharia law, abortion after the 120th day from conception (19 weeks from LMP) is illegal, especially for those who follow the recommendations of the Hanafi legal school, while most jurists of the Maliki legal school "believe that ensoulment occurs at the moment of conception, and they tend to forbid abortion at any point [similar to the Roman Catholic Church]. The other schools hold intermediate positions. [...] The penalty prescribed for an illegal abortion varies according to particular circumstances involved. According to sharia, it should be limited to a fine that is paid to the father or heirs of the fetus."[13]

Timeline of abortion on request

See also: Timeline of reproductive rights legislation

The table below lists in chronological order the United Nations member states that have legalized abortion on request in at least some initial part of the pregnancy, or that have fully decriminalized abortion. As of 2023, 67 countries have legalized or decriminalized abortion on request.

Notes

Where a country has legalized abortion on request, prohibited it, and legalized it again (e.g., former Soviet Union, Romania), only the later year is included. Countries that result from the merger of states where abortion on request was legal at the moment of unification show the year when it became legal across the whole national territory (e.g., Germany, Vietnam). Similarly, countries where not all subnational jurisdictions have legalized abortion on request are not included (e.g., leading to the exclusion of Australia, Mexico, the United Kingdom, and the United States). Countries are counted even if they were not yet independent at the time. The year refers to when the relevant law or judicial decision came into force, which may be different from the year when it was approved.

Year legalized	Countries	CpY	CC
1955	(Armenia Azerbaijan Belarus Estonia Georgia Kazakhstan	15	15

Year legalized	Countries	CpY	CC
	Kyrgyzstan Latvia Lithuania Moldova Russia Tajikistan Turkmenistan Ukraine Uzbekistan as part of the Soviet Union)		
1957	China[14][a][b] (Czech Republic Slovakia as part of Czechoslovakia)[c]	3	18
1965	Cuba	1	19
1973	Denmark Tunisia[20]	2	21
1974	Singapore Sweden	2	23
1975	Austria France[d] Vietnam[e]	3	26
1977	(Bosnia and Herzegovina Croatia Montenegro North Macedonia Serbia Slovenia as part of Yugoslavia)	6	32
1978	Italy Luxembourg	2	34
1979	Norway[f][g]	1	35
1983	Turkey	1	36
1984	Netherlands[h]	1	37
1986	Cape Verde Greece	2	39
1988	Canada	1	40
1989	Mongolia[27]	1	41
1990	Belgium Bulgaria Romania	3	44
1992	Germany[i]	1	45
1993	Guinea-Bissau[28][29]	1	46
1995	Guyana	1	47
1996	Albania[j]	1	48
1997	Cambodia South Africa	2	50
2002	Nepal Switzerland	2	52
2007	Portugal	1	53
2010	Spain	1	54
2012	São Tomé and Príncipe[31] Uruguay	2	56
2015	Mozambique[k]	1	57
2018	Cyprus	1	58
2019	Iceland Ireland[l]	2	60
2020	New Zealand	1	61
2021	Argentina[m] South Korea Thailand	3	64
2022	Colombia San Marino	2	66
2023	Finland[n]	1	67

International law

There are no international or multinational treaties that deal directly with abortion but human rights law and International criminal law touch on the issues.
The Nuremberg Military Tribunal decided the case of *United States v Greifelt and Others* (1948) on the basis that abortion was a crime within its jurisdiction according to the law defining crimes against humanity and thus within its definition of murder and extermination.[35]
The Catholic Church remains highly influential in Latin America, and opposes the legalisation of abortion.[36] The American Convention on Human Rights, which in 2013 had 23 Latin American parties, declares human life as commencing with conception. In Latin America, abortion on request is only legal in Cuba (1965), Uruguay (2012),[37] Argentina (2021),[34] Colombia (2022)[38] and in parts of Mexico.[39][40] Abortions are completely banned in the Dominican Republic, El Salvador, Honduras and Nicaragua, and only allowed in certain restricted circumstances in most other Latin American nations.[36]
In the 2010 case of *A, B and C v Ireland*, the European Court of Human Rights found that the European Convention on Human Rights did not include a right to an abortion.
In 2005, the United Nations Human Rights Committee (UN HRC) ordered Peru to compensate a woman (known as K.L.) for denying her a medically indicated abortion; this was the first time a United Nations Committee had held any country accountable for not ensuring access to safe, legal abortion, and the first time the committee affirmed that abortion is a human right.[41] K.L. received the compensation in 2016.[41] In the 2016 case of *Mellet v Ireland*, the UN HRC found Ireland's abortion laws violated International Covenant on Civil and Political Rights because Irish law banned abortion in cases of fatal fetal abnormalities.
National laws
While abortions are legal at least under certain conditions in almost all countries, these conditions vary widely. According to a United Nations (UN) report with data gathered up to 2019,[42] abortion is allowed in 98% of countries in order to save a woman's life. Other commonly-accepted reasons are preserving physical (72%) or mental health (69%), in cases of rape or incest (61%), and in cases of fetal impairment (61%). Performing an abortion because of economic or social reasons is accepted in 37% of countries. Performing abortion only on the basis of a woman's request is allowed in 34% of countries, including in Canada, most European countries and China.[42]
The exact scope of each legal ground also varies. For example, the laws of some countries cite health risks and fetal impairment as general grounds for abortion and allow a broad interpretation of such terms in practice, while other countries restrict them to a specific list of medical conditions or subcategories. Many countries that allow abortion have gestational limits for the procedure depending on the reason; with the majority being up to 12 weeks for abortion on request, up to 24 weeks for social, economic, rape, or incest reasons, and more for fetal impairment or threats to the woman's health or life.[42]:26
In some countries, additional procedures must be followed before the abortion can be carried out even if the basic grounds for it are met. How strictly all of the procedures dictated in the legislation are followed in practice is another matter. For example, in the United Kingdom, a Care Quality Commission's report in 2012 found that several NHS clinics were circumventing the law, using forms pre-signed by one doctor, thus allowing abortions to patients who only met with one doctor.[43]
Roe V. Wade has been established in the US for almost 50 years, put into motion in 1973, before its overturn in 2022 due to Dobbs v. Jackson. This ruling made abortion access not a constitutional right. The decision, most of which was leaked in early May, means that abortion rights will be rolled back in nearly half of the states immediately, with more restrictions likely to follow. For all practical purposes, abortion will not be available in large swaths of the country.[1] 13 States, Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Utah, and Wyoming enacted a trigger law which placed an immediate but varying statewide abortion ban immediately following the overturning. These trigger laws were designed specifically to take effect immediately upon the fall of the *Roe* precedent. Other states, were bans are in effect after 6 weeks gestation, including Idaho, Tennessee, and Texas – have similar laws, which would take effect after 30 days of the overturning.[2][44]
Pill abortion access is legal in 36 states. However, a lawsuit in Texas is currently against the production and distribution of this Abortion pill, misoprostol. The ban would affect millions of women in the US who cannot access a medical procedural abortion due to a state ban. The group suing the FDA has asked for a preliminary

injunction to take one of the two drugs used in a medication abortion, mifepristone, off the market while the case plays out.[3] This will effectively cause a nationwide ban of pill abortion if granted.[45]

Summary tables

Legend hides	
permitted	In many cases, abortion is permitted only up to a certain gestational age. If this limit is known and does not vary by subdivision, it is shown instead of "permitted".
permitted, with complex legality or practice	
varies by subdivision	
prohibited, with complex legality or practice	
prohibited	
unknown or unclear	

Countries

The table below summarizes the legal grounds for abortion in all United Nations member states and United Nations General Assembly observer states and some countries with limited recognition. This table is mostly based on data compiled by the United Nations up to 2019,[46] with some updates, additions and clarifications citing other sources.

Legal grounds on which abortion is permitted in independent countries hide

Country	Risk to life	Risk to health	Rape	Fetal impairment	Economic or social	On request
Abkhazia[47]	prohibited	prohibited	prohibited	prohibited	prohibited	prohibited
Afghanistan	permitted[o]	prohibited	prohibited	prohibited[o]	prohibited[o]	prohibited
Albania[30]	22 weeks	22 weeks	22 weeks	no limit	22 weeks	12 weeks
Algeria[54]	permitted	permitted	prohibited	prohibited	prohibited	prohibited
Andorra	prohibited[p]	prohibited	prohibited	prohibited	prohibited	prohibited
Angola[q]	permitted	permitted	16 weeks	permitted	prohibited	prohibited
Antigua and Barbuda[59]	permitted[r]	prohibited[s]	prohibited	prohibited	prohibited	prohibited
Argentina[34]	no limit	no limit	no limit	14 weeks	14 weeks	14 weeks
Armenia[62]	permitted	permitted	permitted	permitted	22 weeks	12 weeks
Australia [subdivisions]	no limit	no limit	permitted	no limit	permitted	varies[t]
Austria[81]	no limit	no limit	3 months[aa]	no limit	3 months[aa]	3 months[aa]
Azerbaijan[82]	no limit	no limit	permitted	permitted	22 weeks	12 weeks
Bahamas[83]	permitted	permitted[ab]	prohibited	prohibited	prohibited	prohibited
Bahrain	permitted	prohibited[ac]	prohibited[ac]	prohibited[ac]	prohibited[ac]	prohibited[ac]
Bangladesh	no limit	prohibited[ad]	prohibited[ad]	prohibited[ad]	prohibited[ad]	prohibited[ad]
Barbados[86]	no limit	no limit	12 weeks	no limit	12 weeks	prohibited
Belarus[ae]	no limit	no limit	22 weeks	no limit	22 weeks	12 weeks
Belgium[90]	no limit	no limit	14 weeks[af]	no limit	14 weeks[af]	14 weeks[af]
Belize	no limit	no limit	prohibited	no limit	permitted	prohibited
Country	**Risk to life**	**Risk to health**	**Rape**	**Fetal impairment**	**Economic or social**	**On request**

Legal grounds on which abortion is permitted in independent countries hide

Country	Risk to life	Risk to health	Rape	Fetal impairment	Economic or social	On request
Benin[92]	permitted	permitted	permitted	permitted	12 weeks	prohibited
Bhutan[ag]	180 days	180 days[ah]	180 days	180 days[ah]	prohibited	prohibited
Bolivia	22 weeks	22 weeks	22 weeks	22 weeks[ai]	prohibited	prohibited
Bosnia and Herzegovina [subdivisions]	no limit	no limit	permitted	permitted	permitted	10 weeks
Botswana[99]	16 weeks	16 weeks	16 weeks	16 weeks	prohibited	prohibited
Brazil	22 weeks[ak]	prohibited	22 weeks[ak]	prohibited[ak]	prohibited	prohibited
Brunei[104]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Bulgaria[105]	no limit	20 weeks	permitted	no limit	12 weeks	12 weeks
Burkina Faso[106]	no limit	no limit	14 weeks	no limit	prohibited	prohibited
Burundi	permitted	permitted	prohibited	prohibited	prohibited[al]	prohibited
Cambodia[108]	no limit	12 weeks	no limit	no limit	12 weeks	12 weeks
Cameroon[109]	permitted	28 weeks	28 weeks	prohibited	prohibited	prohibited
Canada[am] [subdivisions]	permitted	permitted	permitted	permitted	permitted	permitted
Cape Verde[112]	no limit	no limit	12 weeks	permitted	12 weeks	12 weeks
Central African Republic	8 weeks	prohibited[an]	8 weeks	8 weeks	prohibited	prohibited
Chad	permitted	permitted	permitted	permitted	prohibited	prohibited
Chile[114]	no limit	prohibited	12 weeks[ao]	permitted	prohibited	prohibited
China[a][115][116][b]	permitted	permitted	permitted	permitted	permitted	permitted
Colombia	no limit[ap]	no limit[ap]	no limit[ap]	no limit[ap]	24 weeks[ap]	24 weeks[ap]
Comoros[119]	permitted	permitted	prohibited	prohibited	prohibited	prohibited
Country	**Risk to life**	**Risk to health**	**Rape**	**Fetal impairment**	**Economic or social**	**On request**
Congo	permitted[aq]	prohibited[aq]	prohibited	prohibited	prohibited	prohibited
Costa Rica	permitted	permitted	prohibited[ar]	prohibited	prohibited	prohibited
Croatia[123]	no limit	no limit	no limit	no limit	10 weeks	10 weeks
Cuba[124][125]	no limit	22 weeks	no limit	35 weeks	22 weeks	12 weeks
Cyprus[126]	permitted	permitted	19 weeks	permitted	12 weeks	12 weeks
Czech Republic[127][128]	no limit	permitted[as]	12 weeks	no limit	12 weeks	12 weeks
Democratic Republic of the Congo	permitted[at]	permitted[au]	permitted[au]	permitted[au]	prohibited	prohibited
Denmark[132]	no limit	no limit	no limit	no limit	no limit	12 weeks[av]
Djibouti[133][134][135]	permitted	permitted[ab]	prohibited	prohibited	prohibited	prohibited
Dominica[136]	permitted	prohibited[aw]	prohibited	prohibited	prohibited	prohibited

Legal grounds on which abortion is permitted in independent countries hide

Country	Risk to life	Risk to health	Rape	Fetal impairment	Economic or social	On request
Dominican Republic[138]	prohibited[ax]	prohibited	prohibited	prohibited	prohibited	prohibited
East Timor[ay]	no limit	prohibited	prohibited	prohibited	prohibited	prohibited
Ecuador	permitted	permitted	permitted[az]	prohibited	prohibited	prohibited
Egypt[146][147]	permitted	permitted	prohibited	prohibited	prohibited	prohibited
El Salvador[148]	prohibited	prohibited	prohibited	prohibited	prohibited	prohibited
Equatorial Guinea[149]	12 weeks	12 weeks	12 weeks	12 weeks	prohibited	prohibited
Eritrea[150]	permitted	permitted	permitted	prohibited[ba]	prohibited[ba]	prohibited[ba]
Estonia[151]	22 weeks	22 weeks	12 weeks[bb]	22 weeks	12 weeks[bb]	12 weeks[bb]
Eswatini[152]	permitted	permitted	permitted	permitted	prohibited	prohibited
Ethiopia[153][154][155]	28 weeks	28 weeks	28 weeks	28 weeks	prohibited[bc]	prohibited
Country	**Risk to life**	**Risk to health**	**Rape**	**Fetal impairment**	**Economic or social**	**On request**
Fiji[157]	no limit	no limit	20 weeks	no limit	prohibited	prohibited
Finland[n][159]	no limit	no limit	20 weeks	24 weeks	20 weeks	12 weeks
France[160][bd]	no limit	no limit	16 weeks[be]	no limit	16 weeks[be]	16 weeks[be]
Gabon[163]	10 weeks	prohibited[bf]	10 weeks	10 weeks	prohibited	prohibited
Gambia[164][165][166]	permitted	prohibited	prohibited	permitted	prohibited	prohibited
Georgia[167][168]	22 weeks	22 weeks	22 weeks	22 weeks	12 weeks	12 weeks
Germany	no limit	no limit	12 weeks	12 weeks[bg]	12 weeks[bg]	12 weeks[bg]
Ghana	28 weeks	28 weeks	28 weeks	28 weeks	prohibited	prohibited
Greece[171]	no limit	no limit	19 weeks	24 weeks	12 weeks[bh]	12 weeks[bh]
Grenada[172]	permitted	permitted	prohibited	prohibited	prohibited	prohibited
Guatemala[173][174]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Guinea	permitted	permitted	permitted	permitted	prohibited	prohibited
Guinea-Bissau[28][175]	permitted	permitted	permitted	permitted	permitted	permitted
Guyana[176]	no limit	no limit	16 weeks	16 weeks	8 weeks[bi]	8 weeks[bi]
Haiti[bj]	permitted[bk]	prohibited	prohibited	prohibited	prohibited	prohibited
Honduras[179]	prohibited	prohibited	prohibited	prohibited	prohibited	prohibited
Hungary	no limit	12 weeks[bl]	12 weeks[bl]	20 weeks[bm]	12 weeks[bl]	prohibited
Iceland[181]	no limit	no limit	permitted	no limit	permitted	22 weeks
India[182][183]	no limit	24 weeks	24 weeks	24 weeks[bn]	24 weeks[bo]	prohibited
Indonesia[184][185]	no limit	no limit	14 weeks	no limit	prohibited	prohibited
Country	**Risk to life**	**Risk to health**	**Rape**	**Fetal impairment**	**Economic or social**	**On request**

Legal grounds on which abortion is permitted in independent countries hide

Country	Risk to life	Risk to health	Rape	Fetal impairment	Economic or social	On request
Iran[186][187][188]	4 months	4 months	prohibited[bp]	4 months	prohibited	prohibited
Iraq	permitted[bq]	prohibited[br]	prohibited	prohibited[br]	prohibited	prohibited
Ireland[194]	viability[bs]	viability[bs]	12 weeks	permitted	12 weeks	12 weeks
Israel	permitted	permitted	permitted	permitted	permitted[bt]	prohibited[bt]
Italy[196]	no limit	viability	90 days	90 days	90 days	90 days
Ivory Coast	permitted	prohibited[bu]	permitted	prohibited[bu]	prohibited	prohibited
Jamaica	permitted[bv]	permitted[bw]	prohibited	prohibited	prohibited	prohibited
Japan[203]	22 weeks	22 weeks	22 weeks	prohibited	22 weeks	prohibited
Jordan[204]	permitted	permitted	prohibited	prohibited	prohibited	prohibited
Kazakhstan[205][206]	no limit	no limit	22 weeks	no limit	22 weeks	12 weeks
Kenya[207][208]	permitted	permitted	permitted[bx]	prohibited	prohibited	prohibited
Kiribati[211]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Kosovo[212]	no limit	no limit	22 weeks	no limit	10 weeks	10 weeks
Kuwait[213]	permitted	4 months	prohibited	4 months	prohibited	prohibited
Kyrgyzstan[214][215]	no limit	no limit	22 weeks	22 weeks	22 weeks	12 weeks
Laos	permitted[by]	28 weeks[by]	28 weeks[by]	28 weeks[by]	28 weeks[by]	prohibited[by]
Latvia[219][220]	permitted	24 weeks	12 weeks	12 weeks	12 weeks	12 weeks
Lebanon[221]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Lesotho[222]	permitted	permitted	permitted	permitted	prohibited	prohibited
Liberia[223]	24 weeks	24 weeks	24 weeks	24 weeks	prohibited	prohibited
Country	**Risk to life**	**Risk to health**	**Rape**	**Fetal impairment**	**Economic or social**	**On request**
Libya[224][225]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Liechtenstein[226]	permitted	permitted	permitted	prohibited	prohibited	prohibited
Lithuania[227]	no limit	no limit	12 weeks[bz]	no limit	12 weeks[bz]	12 weeks[bz]
Luxembourg[228]	no limit	no limit	14 weeks	no limit	14 weeks	14 weeks
Madagascar	prohibited[ca]	prohibited	prohibited	prohibited	prohibited	prohibited
Malawi[232]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Malaysia[233]	22 weeks	22 weeks	prohibited	prohibited	prohibited	prohibited
Maldives[cb]	no limit	prohibited	120 days	120 days[cc]	prohibited	prohibited
Mali[238][239]	permitted	permitted[ab]	permitted	prohibited	prohibited	prohibited
Malta	prohibited[cd]	prohibited	prohibited	prohibited	prohibited	prohibited
Marshall Islands	permitted[bk]	prohibited	prohibited	prohibited	prohibited	prohibited
Mauritania	permitted[ce]	prohibited[ce]	prohibited	prohibited	prohibited	prohibited

Legal grounds on which abortion is permitted in independent countries hide

Country	Risk to life	Risk to health	Rape	Fetal impairment	Economic or social	On request
Mauritius[246]	no limit	no limit	14 weeks	no limit	prohibited	prohibited
Mexico[247] [subdivisions]	varies[cf]	varies[cg]	permitted[ch]	varies[cg]	varies[cg]	varies[cg]
Micronesia	permitted[bk]	prohibited	prohibited	prohibited	prohibited	prohibited
Moldova[287]	21 weeks	21 weeks	21 weeks	21 weeks	21 weeks	12 weeks[ck]
Monaco	no limit	no limit	12 weeks	no limit	prohibited	prohibited
Mongolia	23 weeks	23 weeks	permitted	permitted	14 weeks	14 weeks
Montenegro[288]	32 weeks	32 weeks	20 weeks	20 weeks	10 weeks	10 weeks
Morocco[cl]	no limit	permitted	prohibited	prohibited	prohibited	prohibited
Country	**Risk to life**	**Risk to health**	**Rape**	**Fetal impairment**	**Economic or social**	**On request**
Mozambique	no limit	no limit	16 weeks	24 weeks[cm]	12 weeks	12 weeks
Myanmar[294][295]	no limit	prohibited	prohibited	prohibited	prohibited	prohibited
Namibia	permitted	permitted	permitted	permitted	prohibited	prohibited
Nauru[296]	no limit	no limit	20 weeks	20 weeks	prohibited	prohibited
Nepal[297][*needs update*]	28 weeks	28 weeks	28 weeks	28 weeks	12 weeks	12 weeks
Netherlands[cn]	no limit	no limit	24 weeks	no limit	24 weeks	24 weeks
New Zealand[298]	no limit	no limit	permitted	permitted	permitted	20 weeks
Nicaragua	prohibited	prohibited	prohibited	prohibited	prohibited	prohibited
Niger	permitted	permitted	prohibited	permitted	prohibited	prohibited
Nigeria [subdivisions]	permitted	prohibited[co]	prohibited	prohibited	prohibited	prohibited
Northern Cyprus[301]	permitted	permitted	permitted	permitted	permitted	10 weeks
North Korea	permitted[cp]	permitted[cp]	unclear[cp]	permitted[cp]	unclear[cp]	unclear[cp]
North Macedonia	no limit	no limit	22 weeks[cq]	22 weeks[cq]	22 weeks[cq]	12 weeks
Norway[f]	no limit	no limit	22 weeks	22 weeks	22 weeks	12 weeks
Oman	permitted[cr]	permitted[cr]	prohibited	120 days[cr]	prohibited	prohibited
Pakistan[312][313]	no limit	organ formation[cs]	prohibited	prohibited	prohibited	prohibited
Palau	permitted[ct]	prohibited	prohibited	prohibited	prohibited	prohibited
Palestine	permitted[cu]	prohibited[cu]	prohibited[cu]	prohibited[cu]	prohibited	prohibited
Panama[322][323]	no limit	prohibited	2 months	24 weeks	prohibited	prohibited
Papua New Guinea[324]	permitted	prohibited[cv]	prohibited	prohibited	prohibited	prohibited
Country	**Risk to life**	**Risk to health**	**Rape**	**Fetal impairment**	**Economic or social**	**On request**
Paraguay[328]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Peru[329]	22 weeks	22 weeks	prohibited	prohibited	prohibited	prohibited

Legal grounds on which abortion is permitted in independent countries hide

Country	Risk to life	Risk to health	Rape	Fetal impairment	Economic or social	On request
Philippines[330]	prohibited[cw]	prohibited	prohibited	prohibited	prohibited	prohibited
Poland[333]	no limit	no limit	13 weeks	prohibited[cx]	prohibited[cy]	prohibited
Portugal[336]	no limit	no limit	16 weeks	24 weeks	10 weeks	10 weeks
Qatar[337][338]	no limit	4 months	prohibited	4 months	prohibited	prohibited
Romania[339]	no limit	permitted	permitted	permitted	permitted	14 weeks
Russia[340][341][342]	permitted	permitted	22 weeks	no limit	12 weeks	12 weeks
Rwanda[343]	no limit	no limit	22 weeks	no limit	prohibited	prohibited
Saint Kitts and Nevis	permitted	permitted[cz]	prohibited	prohibited	prohibited	prohibited
Saint Lucia[346]	no limit	no limit	12 weeks	prohibited	prohibited	prohibited
Saint Vincent and the Grenadines[347]	permitted	permitted	permitted	permitted	permitted	prohibited
Samoa[348]	20 weeks	20 weeks	prohibited	prohibited	prohibited	prohibited
San Marino[349]	viability[da]	viability	viability	12 weeks[db]	12 weeks	12 weeks
São Tomé and Príncipe[31]	no limit	no limit	no limit	16 weeks	12 weeks	12 weeks
Saudi Arabia[350]	no limit	4 months	40 days[dc]	40 days[dc]	prohibited	prohibited
Senegal	permitted[dd]	prohibited[dd]	prohibited	prohibited	prohibited	prohibited
Serbia[357][358]	no limit	no limit	no limit	no limit	10 weeks	10 weeks
Seychelles	12 weeks[de]	12 weeks[de]	12 weeks[de]	12 weeks[de]	prohibited	prohibited
Sierra Leone	permitted[df]	permitted[df]	prohibited	prohibited	prohibited	prohibited
Country	**Risk to life**	**Risk to health**	**Rape**	**Fetal impairment**	**Economic or social**	**On request**
Singapore[368]	no limit	no limit	24 weeks	24 weeks	24 weeks	24 weeks
Slovakia[369][370]	no limit	permitted[dg]	12 weeks	no limit	12 weeks	12 weeks
Slovenia[371]	no limit	no limit	10 weeks	10 weeks	10 weeks	10 weeks
Solomon Islands[372]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Somalia[373][374][dh]	permitted[di]	prohibited	prohibited	prohibited	prohibited	prohibited
South Africa	no limit	20 weeks	20 weeks	no limit	20 weeks	12 weeks
South Korea[dj]	permitted	24 weeks	24 weeks	permitted	permitted[dk]	permitted[dk]
South Ossetia[380]	permitted	permitted	permitted	permitted	22 weeks	12 weeks
South Sudan[381]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Spain[382]	22 weeks	22 weeks	14 weeks	22 weeks[dl]	14 weeks	14 weeks
Sri Lanka[383]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Sudan[384]	no limit	prohibited	90 days[dm]	prohibited	prohibited	prohibited
Suriname	permitted[dn]	prohibited	prohibited	prohibited	prohibited	prohibited

Legal grounds on which abortion is permitted in independent countries hide

Country	Risk to life	Risk to health	Rape	Fetal impairment	Economic or social	On request
Sweden[386]	no limit	no limit	18 weeks	18 weeks	18 weeks	18 weeks
Switzerland[387]	no limit	no limit	12 weeks	12 weeks	12 weeks	12 weeks
Syria[388]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Taiwan[389][390]	no limit	no limit	24 weeks	no limit	24 weeks	prohibited
Tajikistan[391]	permitted	22 weeks	22 weeks	22 weeks	22 weeks	12 weeks
Tanzania[do]	no limit	permitted[dp]	prohibited	prohibited	prohibited	prohibited
Thailand[395][396]	no limit	no limit	no limit	no limit	20 weeks	20 weeks
Country	**Risk to life**	**Risk to health**	**Rape**	**Fetal impairment**	**Economic or social**	**On request**
Togo[397]	permitted	permitted	permitted	permitted	prohibited	prohibited
Tonga	permitted[dq]	prohibited	prohibited	prohibited	prohibited	prohibited
Transnistria[400][401]	no limit	no limit	22 weeks	no limit	22 weeks	12 weeks
Trinidad and Tobago	permitted[dr]	permitted[dr]	prohibited	prohibited	prohibited	prohibited
Tunisia[20]	no limit	no limit	3 months	no limit	3 months	3 months
Turkey[405][406][407]	no limit	10 weeks	20 weeks	no limit	10 weeks	10 weeks
Turkmenistan[408]	no limit	no limit	permitted	permitted	22 weeks	5 weeks
Tuvalu[409]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Uganda	28 weeks	28 weeks	28 weeks	28 weeks	prohibited	prohibited
Ukraine[410]	22 weeks	22 weeks	22 weeks	22 weeks	12 weeks[ds]	12 weeks[ds]
United Arab Emirates	no limit	prohibited	prohibited	prohibited[dt]	prohibited	prohibited
United Kingdom [subdivisions]	no limit	no limit	permitted[du]	no limit	24 weeks[du]	varies[dv]
United States[419] [subdivisions]	no limit	varies[dw]	varies[dw]	varies[dw]	varies[dw]	varies[dw]
Uruguay[481][482]	no limit	no limit	14 weeks[eo]	no limit	12 weeks[eo]	12 weeks
Uzbekistan[484]	permitted	22 weeks	22 weeks	22 weeks	22 weeks	12 weeks
Vanuatu[485]	permitted	permitted[ep]	prohibited	prohibited	prohibited	prohibited
Vatican City	prohibited[eq]	prohibited	prohibited	prohibited	prohibited	prohibited
Venezuela[493][494]	22 weeks	prohibited	prohibited	prohibited	prohibited	prohibited
Vietnam[495][496]	permitted	permitted	permitted	permitted	permitted	22 weeks[er]
Yemen[500]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Zambia[501]	permitted	permitted	permitted	permitted	permitted	prohibited
Zimbabwe[502][503]	22 weeks	22 weeks	22 weeks[es]	22 weeks	prohibited[et]	prohibited[et]
Country	**Risk to life**	**Risk to health**	**Rape**	**Fetal impairment**	**Economic or social**	**On request**

Autonomous jurisdictions

The table below summarizes the legal grounds for abortion in autonomous jurisdictions not included in the previous table.

Legal grounds on which abortion is permitted in other autonomous jurisdictions hide

Jurisdiction	Risk to life	Risk to health	Rape	Fetal impairment	Economic or social	On request
Akrotiri and Dhekelia[506]	permitted	permitted	permitted[eu]	permitted	permitted[eu]	prohibited
American Samoa[507]	permitted	permitted	prohibited	prohibited	prohibited	prohibited
Anguilla[508]	no limit	28 weeks	prohibited	28 weeks	prohibited	prohibited
Aruba[509]	permitted[ev]	prohibited	prohibited	prohibited	prohibited	prohibited
Bermuda[510]	permitted	permitted	permitted	permitted	prohibited	prohibited
British Virgin Islands[511]	no limit	28 weeks	prohibited	28 weeks	prohibited	prohibited
Cayman Islands[512]	permitted	prohibited	prohibited	prohibited	prohibited	prohibited
Cook Islands[513][ew]	permitted	permitted[ex]	prohibited	prohibited	prohibited	prohibited
Curaçao[517]	permitted[ev]	prohibited[ev]	prohibited[ev]	prohibited[ev]	prohibited[ev]	prohibited[ev]
Falkland Islands[519]	no limit	no limit	permitted[eu]	no limit	24 weeks[eu]	prohibited
Faroe Islands[520]	no limit	no limit	16 weeks	16 weeks	prohibited[ez]	prohibited
Gibraltar[521]	no limit	no limit	12 weeks[fa]	no limit	12 weeks[eu]	prohibited
Greenland[523]	no limit	no limit	no limit	no limit	no limit	12 weeks
Guam[524][525]	no limit	no limit[fb]	26 weeks[fb]	26 weeks[fb]	13 weeks[fb]	13 weeks[fb]
Guernsey [subdivisions]	permitted[fc]	permitted[fc]	varies[fd]	varies[fd]	varies[fd]	prohibited
Hong Kong[532]	no limit	24 weeks	24 weeks	24 weeks	24 weeks	prohibited
Isle of Man[533]	no limit	no limit	23 weeks	no limit	23 weeks	14 weeks
Jersey[534]	no limit	no limit	12 weeks	24 weeks	12 weeks	12 weeks
Macau[535]	no limit	no limit	24 weeks	24 weeks	prohibited	prohibited
Montserrat[536]	no limit	viability	prohibited	viability	prohibited	prohibited
Niue	permitted[ff]	permitted[ff]	prohibited	prohibited	prohibited	prohibited
Northern Mariana Islands[542]	prohibited[fg]	prohibited[fg]	prohibited[fg]	prohibited[fg]	prohibited[fg]	prohibited[fg]
Pitcairn Islands[fh]	no limit	no limit	permitted[du]	no limit	24 weeks[du]	prohibited
Puerto Rico[546]	no limit	no limit	no limit[fi]	no limit[fi]	no limit[fi]	prohibited[fi]
Saint Helena, Ascension and Tristan da Cunha[fj]	no limit	no limit	permitted[du]	no limit	24 weeks[du]	prohibited
Sint Maarten[551]	permitted[ev]	prohibited[fk]	prohibited[fk]	prohibited[fk]	prohibited[fk]	prohibited[fk]
Tokelau[552]	permitted[fl]	permitted[fl]	prohibited	prohibited	prohibited	prohibited
Turks and Caicos Islands[554]	permitted[fm]	permitted[fm]	prohibited	prohibited	prohibited	prohibited

Legal grounds on which abortion is permitted in other autonomous jurisdictions hide						
Jurisdiction	**Risk to life**	**Risk to health**	**Rape**	**Fetal impairment**	**Economic or social**	**On request**
U.S. Virgin Islands[555]	no limit	no limit	24 weeks	24 weeks	24 weeks	24 weeks
Jurisdiction	**Risk to life**	**Risk to health**	**Rape**	**Fetal impairment**	**Economic or social**	**On request**

Comparative limits for countries with elective abortions

Legal limits may not be directly comparable. Limits may be expressed in trimesters, months, weeks of pregnancy (implantation), weeks from fertilization, or weeks from last menstrual period (LMP).

Countries with more restrictive laws

According to a report by Women on Waves,[*better source needed*] approximately 25% of the world's population[*as of?*] lives in countries with "highly restrictive abortion laws"—that is, laws which either completely ban abortion, or allow it only to save the mother's life. This category includes several countries in Latin America, Africa, the Middle East, the Asia-Pacific region, as well as Malta in Europe.[fr][556] The Center for Reproductive Rights report that "[t]he inability to access safe and legal abortion care impacts 700 million women of reproductive age."[557]

Some of the countries of Central America, notably El Salvador, have also come to international attention due to very forceful enforcement of the laws, including the incarceration of a gang-rape victim for homicide when she gave birth to a stillborn son and was accused of attempting an illegal abortion.[558][559][560]

El Salvador has some of the strictest abortion laws of any country. Abortion under all circumstances, including rape, incest, and risk to the mother's health, is illegal. Women can be criminalized and penalized to up to 40 years in prison after being found guilty of an abortion. El Salvador's abortion laws are so severe that miscarriages and stillbirths can sometimes be enough for conviction. The Inter-American Court has already ruled that El Salvador was responsible for the death of Manuela, who was sentenced to 30 years in prison in 2008 for aggravated homicide after suffering an obstetric emergency that resulted in her losing her pregnancy.[4][561] Lack of access to abortion is recognized by Uruguay, Mexico, Argentina, and Colombia as a human rights issue. This shows progress in underdeveloped nations.

Ireland

Ireland has had a long withstanding rule of the land called the Offenses Against Persons Act of 1861, which is what first prohibited abortions. This law was enacted to prohibit abortions in Ireland in 1920 when Ireland became its own independent country. To counteract the infiltration of pro-abortion laws, Ireland's Catholic organizations formed the Pro Life Amendment Campaign. This organization was formed to create an abortion ban at a constitutional level. Ireland's 8th constitutional amendment was made in 1986, "acknowledges the right to life of the unborn and [gave] due regard to the equal right to life of the mother."[562]

In 1992, a case of a 14-year-old pregnant girl, threatening suicide to the courts if she were not allowed abortion, sparked change in Ireland's people. An appeal was made to the higher courts that suicidal thoughts were enough for endangerment of a mother's life for termination to be allowed. This case began the new wave of activism in Ireland which promoted the protection of the mother's life, and pushed for abortion rights. Activism grew into the larger public eye which prompted new laws to be made and introduced protecting the mother's life.[562]

New wave of activism in Ireland stretched until 2013 when the Protection of Life During Pregnancy Act was signed into law. This law recognized the mother's life over the fetus's and would allow pregnancy termination in cases where the mother is in danger. In 2018 Ireland's abortion ban by constitution was repealed and abortions up to the first trimester were legalized and covered by Ireland's public health service.[562]

Caribbean

The Caribbean and Latin America are the two strictest regions regarding abortion access. Only two Caribbean countries, Cuba and Guyana, is abortion legalized per request of the mother. Cuba is the most progressive of the Caribbean Islands, passing legislation in 1965 which legalized abortions in all circumstances up to 10 weeks. Guyana's legislation passed in 1995, legalized abortions up to 8 weeks in all circumstances.[563]

Abortions are prohibited under all circumstances in Aruba, Curaçao, Dominican Republic, Haiti, Jamaica and Suriname. However, different countries' laws restrict and allow abortions in

different circumstances. In Barbados, Belize, Saint Vincent and Grenadine abortions are allowed when the mother cannot financially provide for her child. This is called abortion with "broad or social economic grounds". When the mother's life is endangered abortions are allowed in Bahamas, Grenada and, in the case of Trinidad and Tobago, Saint Lucia, St Kitts and Nevis. These countries however, are often very strict with the regulations surrounding this legislation, and while it is "to preserve the women's health", in most cases it is only when the mother's life is endangered. Antigua and Barbuda and Dominica allow abortions when the mother's life is directly at risk.[563]

Beginning of pregnancy controversy

Controversy over the beginning of pregnancy occurs in different contexts, particularly in a legal context, and is particularly discussed within the abortion debate from the point of measuring the gestational age of the pregnancy. Pregnancy can be measured from a number of convenient points, including the day of last menstruation, ovulation, fertilization, implantation and chemical detection. A common medical way to calculate gestational age is to measure pregnancy from the first day of the last menstrual cycle.[fs] However, not all legal systems use this measure for the purpose of abortion law; for example countries such as Belgium, France, and Luxembourg use the term "pregnancy" in the abortion law to refer to the time elapsed from the sexual act that led to conception, which is presumed to be 2 weeks after the end of the last menstrual period.[ft]

Exceptions in abortion law

Exceptions in abortion laws occur either in countries where abortion is as a general rule illegal or in countries that have abortion on request with gestational limits. For example, if a country allows abortion on request until 12 weeks, it may create exceptions to this general gestation limit for later abortions in specific circumstances.[569]

There are a few exceptions commonly found in abortion laws. Legal domains which do not have abortion on demand will often allow it when the health of the mother is at stake. "Health of the mother" may mean something different in different areas: for example, prior to December 2018, Ireland allowed abortion only to save the mother's life, whereas abortion opponents in the United States argue health exceptions are used so broadly as to render a ban essentially meaningless.[570]

Laws allowing abortion in cases of rape or incest often differ. For example, before *Roe v. Wade*, thirteen U.S. states allowed abortion in the case of either rape or incest, but only Mississippi permitted abortion of pregnancies due to rape, and no state permitted it for just incest.[571]

Many[*vague*] countries allow abortion only through the first or second trimester, and some may allow abortion in cases of fetal defects, e.g., Down syndrome, or where the pregnancy is the result of a sexual crime.

Other related laws

Laws in some countries with liberal abortion laws protect access to abortion services. Such legislation often seeks to guard abortion clinics against obstruction, vandalism, picketing, and other actions, or to protect patients and employees of such facilities from threats and harassment. Other laws create a perimeter around a facility, known variously as a "buffer zone", "bubble zone", or "access zone", where demonstrations opposing abortion are not permitted. Protests and other displays are restricted to a certain distance from the building, which varies depending on the law. Similar zones have also been created to protect the homes of abortion providers and clinic staff. Bubble zone laws are divided into "fixed" and "floating" categories. Fixed bubble zone laws apply to the static area around the facility itself, and floating laws to objects in transit, such as people or cars.[572] Because of conflicts between anti-abortion activists on one side and women seeking abortion and medical staff who provides abortion on the other side, some laws are quite strict: in South Africa for instance, any person who prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy faces up to 10 years in prison (section 10.1 (c) of the Choice on Termination of Pregnancy Act[573]).

On 3 November 2020, an association of 20 Kenyan charities urged the government of Kenya to withdraw from the Geneva Consensus Declaration (GCD), a US-led international accord that sought to limit access to abortion for girls and women around the world. GCD was signed by 33 nations, on 22 October 2020.[574]

Judicial decisions

Year	Jurisdiction	Description	Abortion access affirmed or expanded?
1879	Canada	Abortion trial of Emily Stowe	
1938	United Kingdom	*R v Bourne* Abortion in case of risk to physical or mental health included in risk to life. The decision was also implemented by some British territories and their successors.[363]	Yes
1952	Canada	*Azoulay v R*[575]	
1969	Victoria (Australia)	*R v Davidson*[fu] Abortion allowed in case of risk to life, and physical or mental health.[576]	Yes
1971	United States	*United States v. Vuitch*	Restrictions upheld
	New South Wales (Australia)	*R v Wald* Abortion in case of socioeconomic reasons included in risk to physical or mental health.	Yes
1973	United States	*Doe v. Bolton* Abortion allowed after viability if necessary to protect her health.	
		Roe v. Wade Abortion allowed on demand in the entire country.	
1975	Germany	German Federal Constitutional Court abortion decision	Law restricted
1976	Canada	*Morgentaler v R*	Restrictions upheld
	United States	*Planned Parenthood v. Danforth*	Legalization upheld
1979		*Maher v. Roe*	
		Colautti v. Franklin	
1980	Puerto Rico	*Pueblo v. Duarte* Application of *Roe v. Wade* to Puerto Rico.[546]	Yes
	United States	*Harris v. McRae*	
1981		*H. L. v. Matheson*	Restrictions upheld
	Israel	*A. v. B.* Paternal consent not required.	Yes
1983	United States	*City of Akron v. Akron Center for Reproductive Health*	
1986		*Thornburgh v. American College of Obstetricians and Gynecologists*	
1988	Canada	*R v Morgentaler*	Yes
1989		*Borowski v Canada (AG)*	
	United States	*Webster v. Reproductive Health Services*	Restrictions upheld
	Canada	*Tremblay v Daigle*	Yes
1990	United States	*Hodgson v. Minnesota*	
1991		*Rust v. Sullivan*	
1992	Ireland	*Attorney General v. X* Abortion allowed in case of risk to life, including risk of suicide.	Yes
	United States	*Planned Parenthood v. Casey*	
1993		*Bray v. Alexandria Women's Health Clinic*	
	Germany	2 BvF 2/90[169]	
	Canada	*R v Morgentaler*	Yes

Year	Jurisdiction	Description	Abortion access affirmed or expanded?
1995	New South Wales (Australia)	*CES v. Superclinics* Physical or mental health should be considered not only during the pregnancy but also after the birth.	
1997	Poland	K 26/96 Abortion for economic or social reasons ruled unconstitutional.[335]	Law restricted
	United States	*Thornburgh v. American College of Obstetricians and Gynecologists*	
1998	South Africa	*Christian Lawyers Association v Minister of Health* Law allowing abortion on demand ruled constitutional.	Legalization upheld
2000	United States	*Hill v. Colorado*	
		Stenberg v. Carhart Supreme Court struck down Nebraska's partial-birth abortion ban.	Yes
2001	Argentina	*T., S. v. Government of Buenos Aires City*[577]	
2003	United States	*Scheidler v. National Organization for Women*	
2006		*Ayotte v. Planned Parenthood of Northern New England*	
		Scheidler v. National Organization for Women	
		Gonzales v. Carhart Supreme Court upheld the Partial-Birth Abortion Ban Act of 2003.	Restrictions upheld
	Colombia	Constitutional Court allowed abortion in case of danger to woman's life or health, rape, and fetal deformation.[118]	Yes
	Council of Europe	*D v Ireland*	
	New South Wales (Australia)	*R v Sood*[578]	
2007	Council of Europe	*Tysiąc v Poland*[579]	
	Slovakia	Constitutional Court ruled law allowing abortion on demand constitutional.[580]	Legalization upheld
2008	Nepal	*Achyut Kharel v. Government of Nepal* [581]	
2009	Council of Europe	*A, B and C v Ireland* The court rejected the argument that article 8 conferred a right to abortion, but found that Ireland had violated the European Convention on Human Rights by failing to provide an accessible and effective procedure by which a woman can have established whether she qualifies for a legal abortion.	Yes
	Nepal	*Lakshmi v. Government of Nepal* Supreme Court upheld and expanded legal abortion.[582]	
2011	United Kingdom	*British Pregnancy Advisory Service v Secretary of State for Health*[583]	
2012	Argentina	*F., A. L.* Abortion allowed in case of rape of any woman, regardless of her mental health.[584]	Yes
	Brazil	*ADPF 54* Abortion allowed in case of anencephaly.[585]	
	Council of Europe	*P. and S. v. Poland*[586]	
2013	El Salvador	Case of "Beatriz"[587]	
2014	Bolivia	Ruling 0206/2014[588]	
	Ireland	*P.P. v. Health Service Executive*	

Year	Jurisdiction	Description	Abortion access affirmed or expanded?
2015	Dominican Republic	Constitutional Court ruled law allowing abortion in certain cases unconstitutional.[589]	Law restricted
	Rwanda	RPA 0787/15/HC/KIG[590]	
2016	United States	*Whole Woman's Health v. Hellerstedt*	Yes
	United Nations	*Mellet v Ireland*	
2017	Chile	Constitutional Court ruled law allowing abortion in certain cases constitutional.[114]	Yes
	Croatia	Constitutional Court ruled law allowing abortion on demand constitutional.[591]	Legalization upheld
2018	United Kingdom	*Northern Ireland Human Rights Commission v Department of Justice*[592]	
2019	South Korea	Abortion allowed on request. Decision took effect in 2021.[378]	Yes
	Australia	*Clubb v Edwards*	
	Kenya	*FIDA-Kenya and Others v. Attorney General and Others* Abortion allowed in case of rape.[209]	Yes
2020	Poland	K 1/20 Abortion in case of fetal deformity ruled unconstitutional. The decision was implemented on 27 January 2021.[334]	Law restricted
	Thailand	Ruling No. 4/2563[593]	
	Colombia	Constitutional Court ruled law allowing abortion in certain cases constitutional rejecting both total ban and legalization.[594]	Law upheld
2021	Ecuador	Abortion allowed in case of rape of any woman, regardless of her mental health.[145]	Yes
	Mexico	Deadlines in case of pregnancy after rape ruled unconstitutional.[250][251]	
		Penalties for abortion ruled unconstitutional.[39][40]	
		[595]	
		[596][597]	
	Inter-American Court of Human Rights	*Manuela and Others v. El Salvador*[598]	
	United States	*United States v. Texas*	Restrictions upheld
		Whole Woman's Health v. Jackson	
2022	Colombia	Constitutional Court decriminalized abortion up to 24 weeks of gestation.[38]	Yes
	United States	*Dobbs v. Jackson Women's Health Organization* States may now ban or restrict abortion before viability, *Roe v. Wade* and *Planned Parenthood v. Casey* overturned.	Law restricted
	India	Abortion allowed under the same criteria regardless of marital status.[599]	Yes
2023	Mexico	Abortion allowed at federal health facilities anywhere in the country.[248][249]	Yes

Yorum

Her ülkede çıkarılan yaşa ile, bu hukuk boyutuna taşınmıştır: *Uygulama olarak Diyanet görüşü de alınarak yasa oluşturulmuştur*. Burada ekonomik nedenle, bakamam bu bebeğe gerekçe olamayacağı, engelli olsa bile Devlet bakımı altına alacaktır, almaktadır.

Ülkemizde olan yasal yaklaşım:

- 10 Gebelik haftasına kadar (son adet tarihine göre hesaplanması ile embriyonik 12 Gebelik Haftasına eş düşmektedir), anne ve bebek hakkı bütünleştiği için anne karar verir. Ülkemizde babanın onayı da gereklidir.
- 20 Gebelik haftasında da tıbbi olarak ilan edilen hastalıklar listesinde bulunanlara göre termine söz konusu edilir.
- Anne sağlığı temeldir, buna göre yaklaşım yapılmalıdır. Bebek matür olması anne durumuna göredir, beklenmesi zorunluluk taşımaz.
- Tüm yaklaşımlar tıbbi tam donanımlı yerlerde yapılmalı, bebekler canlandırma ve bakım imkânı olan, Neonatoloji Yoğun Bakım Üniteleri olan yerlerde olmalıdır.

Bildirgeler ve Hukuk Yaklaşımları[13,14]

Yayınlara bakılınca bazı yaklaşımlar olduğu görülecektir, ama buna karşın hukuk tanımlaması oluşmakta, suç da hukuki, kanuni olduğu için, buna göre yaklaşım gerekir.
Emir, amirin sözü veya belirli bir görüşü öne sürerek, bundan dolayı yaptım demek, suçu hafifletmesi değil, ağırlaştırıcı nedendir.
Başkaları yapıyor demekte bu suçu hafifletmez. Çünkü yaşam hakkını kaldırmak için söylenen her gerekçe daha da çıkmaza sokacaktır.

Bildirgeler sunulacak ce sonra onun yorumu yapılacaktır.

➢ 1948-1950 İnsan Hakları Sözleşmesi

Başlıca özet noktalar:

- **Çocuk Hakları nedeniyle çocuk özel korunmalıdır.** Çocuk, özel olarak korunur, yasalar ve başka yollarla sağlıklı ve normal biçimde, özgürlük ve saygınlık koşullarında bedensel, zihinsel, ahlak, manevi ve toplumsal olarak gelişmesine olanak sağlayacak fırsat ve kolaylıklardan yararlanır. Bu amaçla çıkarılacak yasalarda, çocuğun çıkarları önde gelir.
- **Çocuk için özel güvenlik tedbiri uygulanmalıdır.** Çocuk toplumsal güvenlik olanaklarında yararlanır. Sağlık içinde ve yetişme hakkı vardır. Bu amaçla kendisine ve annesine özel bakım ve korunma olanakları sağlanır. Bu olanaklar doğum öncesi ve doğum sonrası bakımı da içerir. Çocuğun, yeterli beslenme, barınma, eğlenme ve sağlık hizmetlerine hakkı vardır.
- **Ölüm doğum oranı ve çocuk ölümlerinin azaltılması ve çocuğun sağlıklı gelişmesi için önlemler alınması**; Çevre ve endüstri sağlığının her bakımından iyileştirilmesi; Salgın ve yöresel hastalıklarla, meslek hastalıkları ve öteki hastalıkların önlenmesi, bakımı ve denetlenmesi; Hastalık durumunda herkese tıbbi hizmet ve bakım sağlayacak koşulların yaratılması için gerekli olan önlemleri içerir.

- **Çocuğun olabilecek en iyi sağlık düzeyine kavuşma, tıbbi bakım ve rehabilitasyon hizmetlerini veren kuruluşlardan yararlanma hakkını tanırlar**. Taraf Devletler, hiçbir çocuğun bu tür tıbbi bakım hizmetlerinden yararlanması hakkında yoksun bırakılmamasını güvence altına almak için çaba gösterirler.
- **Bebek ve çocuk ölüm oranlarının düşürülmesi**; Bütün çocuklara gerekli tıbbi yardımın ve tıbbi bakımın; temel sağlık hizmetlerinin geliştirilmesini önem verilerek sağlanması;
- **Anneye doğum öncesi ve sonrası uygun bakımın sağlanması**; Bütün toplum kesimlerinin özellikle ana-babalar ve çocukların, çocuk sağlığı ve beslenmesi, anne sütü ile beslenmenin yararları, toplum ve çevre sağlığı ve kazaların önlemesi konusunda temel bilgileri elde etmeleri ve bu bilgileri kullanmalarına yardımcı olunması; Koruyucu sağlık bakımlarının, ana-babaya rehberliğini, aile planlaması eğitimi ve hizmetlerinin geliştirilmesi; amaçlarıyla uygun önlemleri alırlar.
- İnsan Hakları 1948 Bildirgesinin sağlık konusunda ayrıca vurguları vardır.

NEONATOLOJİ AÇISINDAN: 1948 İnsan Hakları Beyannamesinden alınan yaklaşımda da çocuklara özel ilgi gösterilmesi belirtilmektedir. Bebek ölümlerinin azaltılması konu açık vurgudur. Bunun ilerideki aşamalarda özgün bir Bilim Dalı olması görüşü ile Neonatoloji yapılandırılmıştır.

• 1964-2008 Helsinki

Sağlıklı olmak, yaşamın sağlıklı olması, sağlığın devamlılığı, kontrol ve tedavi gibi çoklu parametreleri kapsamaktadır: *Yaklaşım olarak Tıp Biliminin gereksinimlerini hasta açısından oluşturarak yapmalıdır*. ***Hastamın sağlığı benim ilk önceliğimdir" cümlesiyle hekimi bağlar***

Yaklaşımlarda yarar önemlidir, bu hesapta olunmalıdır: *Yaklaşım olarak yapılanların amaç ve güdüsü sorgulanır ve dayanak, gerekçe bireyin iyiliği olmalıdır*. ***Uluslararası Tıp Etiği Kodu "Tıbbi hizmetleri verirken, hekimin yalnızca hastanın yararına göre davranması gerektiğini bildirir***

NEONATOLOJİ AÇISINDAN: Yaşam hakkının sağlanması, canlandırma boyutu doğrudan herhangi bir sorgu ve dayanak olmadan, bilimsel açıdan yapılmalıdır. Gelecek bilinmez ama amaç ve güdü belirgin bellidir.

• 1972 Amerika Hastaneler Birliği

Bilgilendirme ve rıza alma boyutu ortaya getirilmekte, bunun temel olduğu vurgulanmaktadır: *Yaklaşım olarak her bireyin aydınlanma hakkı vardır, buna göre de rıza alınmalıdır*. 1972 Amerika Hastaneler Birliği Hasta Hakları Bildirgesi: Hastanın hastalığı, sağaltım yöntemleri hakkında bilgilendirilmesi ve seçim yapma hakkının sağlaması vurgulanmıştır.

NEONATOLOJİ AÇISINDAN: Yaşam hakkı söz konusu olunca rızaya gerek olmaz. Bu nedenle bebeğin yaşatılması konusunda sadece bilgi verilir, rıza alınmaz.

• 1981 Lizbon I, 1995 Lizbon II Bildirgesi

Lizbon Yaklaşımında tanımlananlar: Lizbon yaklaşımında Sağlık hizmetlerinden faydalanma, eşit hizmet alma (Dil, din, ırk, etnik köken, cinsiyet vb ayrımcılığa uğramadan hizmet alma), güvenlik, hizmet alacağı kurumu seçme, hizmet göreceği personeli seçme, değiştirme, tedaviye rıza, tedaviyi reddetme, mahremiyet, bilgi edinme, ziyaretçi, refakatçi, rahatlık, dini ibadet, başvuru, şikâyet ve dava açma haklarının tanımlandığı görülmektedir.

NEONATOLOJİ AÇISINDAN: Gebelik ve doğum eyleminin daha rahat, daha izole ve kendi aralarında, ev içi gibi olması sağlanabilir olmuştur.

- ## 1989-90 Çocuk Hakları

Başlıca özet noktalar:

- Her çocuğun temel yaşama hakkına sahip olduğunu kabul ederler.
- Çocuğun hayatta kalması ve gelişmesi için mümkün olan azami çabayı gösterirler.
- Çocukları ilgilendiren bütün faaliyetlerde, çocuğun yararı temel düşüncedir.
- Çocuğun esenliği için gerekli bakım ve bu amaçla tüm uygun yasal ve idari önlemleri alırlar
- Kurumlar, çocuklar için yetkili makamlarca konulan ölçülere uymalarını taahhüt ederler.
- Hiçbir çocuğun bu tür tıbbi bakım hizmetlerinden yararlanma hakkında yoksun bırakılmamasını güvence altına almak için çaba gösterirler
- Bebek ve çocuk ölüm oranlarının düşürülmesi, **b**ütün çocuklara gerekli tıbbi yardımının ve tıbbi bakımın; temel sağlık hizmetlerinin geliştirilmesine önem verilerek sağlanması, Anneye doğum öncesi ve sonrası uygun bakımın sağlanması, Bütün toplum kesimlerinin özellikle anne- babalar ve çocukların, çocuk sağlığı ve beslenmesi, anne sütü ile beslenmesinin yararları, koruyucu sağlık bakımlarının, anne- babaya rehberliğini aile planlaması eğitimi ve hizmetlerinin geliştirilmesi; amaçlarıyla uygun önlemleri alırlar.
- Kuruluşlar çocukların sağlığı için zararlı geleneksel uygulamalarının kaldırılması amacıyla uygun ve etkili her türlü önlemi alırlar

NEONATOLOJİ AÇISINDAN: Çocuk Hakları Sözleşmesi gebelik, doğum ve gelişimin izlenmesi konusunda her türlü, bireye özgü hak sağlanması gerekliliği üzerinde durulmaktadır.

- ## 1993 Finlandiya

Başlıca özet noktalar: Yaklaşımlar geleneksel değil, tümü tıbbi bilim çerçevesinde olmalıdır denilmektedir. Uygulayanlar da bu konuda uzman, kısaca Perinatolog ve Neonatolog olmalıdırlar.

NEONATOLOJİ AÇISINDAN: Tümü uzmanların organizasyonunda yapılanmalıdır.

- ## 1994 Amsterdam

Başlıca özet noktalar: Yaklaşımlarda belirli tıbbi bakım ve yaklaşımın tıbbi garanti olarak verilmektedir, bu tedavi garantisi değildir.

NEONATOLOJİ AÇISINDAN: Yaklaşımlar evde bile olsa, belirli tıbbi bakım yaklaşımı yapılacağı garantisi verilmektedir.

- ## 1995 Bali

Başlıca özet noktalar:

- Triyaj yapılması ile bakım boyutunda sevk edilmesi,
- Ülkemizde tedavi etmeme değil, hangi tür tedavi boyutu olduğundan daha ileri bakım için sevk öngörülmektedir.

NEONATOLOJİ AÇISINDAN: Ülkedeki tüm Yenidoğan Yoğun Bakım Yatakları Bakanlık tarafından bilindiği için, 112 telefon ile arayarak hasta gönderileceğini haber vermektedir. Gebelik üzere ayrılanlar hariç tüm olgular kabul edilmektedir.

- ## 1997 Oviedo-Biyotıp sözleşmesi

Başlıca özet noktalar:

- İnsanın Üstünlüğü: İnsanın menfaatleri ve refahı, bilim veya toplumun saf menfaatlerinin üstünde tutulacaktır.
- Tıbbi uygulamalar rıza şartına bağlanmaktadır.

NEONATOLOJİ AÇISINDAN: Birey hakkı üstündür ve Yaşam Hakkı en temel haktır.

- ## 2001 Barcelona Anne/Bebek Hakları

Başlıca özet noktalar: Bebek anomalili bile olsa, yaşam hakkı vardır, aile istemez ise Devlet bakar:

NEONATOLOJİ AÇISINDAN: Bebeğin hakları anne isteğine göre oluşmayacağını vurgulamaktadır. 10 Gebelik Haftasına kadar anne ve bebek hakkı bütünleştiği için ancak bu zamanda anne rızası yeterli olacaktır.

- ## 2002-DNRO Florida Supreme/Yargıtay Kararı

Başlıca özet noktalar: Kişi kendi rızası ile canlandırma yapılmama onayı ile sağlık elemanlarına bir matbu ve resmi metin hazırlamaktadır. Personelin buna uyması beklenmektedir.

NOT: Ülkemizde canlandırma yapmayın rızası geçersizdir.

NEONATOLOJİ AÇISINDAN: Bir kimsenin yaşayıp yaşamayacağı bilinmez, canlandırama işlevinde, bebekten sonuç alınmaz, beyin temelinde ölüm ile ancak bırakılabilir. Bebeği yaşatmak daha doğrusu bilimsel çaba harcamak hekimliğin işlevidir. Rıza erişkinde dikkate almak olası iken, bebekler için böyle bir gerekçe olmaz, ailenin rızası ve talebi de geçerli olamaz. Aile talep ederse, bebek Devlet bakımına alınabilir.

- ## 2002 ROMA Sözleşme

Başlıca özet noktalar: Civil Liberties kavramında civil vatandaşlık olarak tanımlanmakta, bizler ise birey hakkı olarak görmekteyiz. Burada insanlar arasına ayırım olmayacağı vurgusu ile, tanımladığımız birey, kişi hakları en üst gözetilmesi, sağlanması gereken olarak irdelenmelidir ve bu haklar vatandaşlığın üzerindedir.

NEONATOLOJİ AÇISINDAN: Her gebeliğin yaşatılması ve sağlıklı olması ile yaşamının sağlanması temel olmalıdır.

- **2002 AB Kadına işkence Kadınlara Karşı Ayrımcılığın Önlenmesi Bildirgesi**

Başlıca özet noktalar: Kadınlara karşı ayrımcılığın adaletsiz olduğunu ve insan onuruna karşı bir suç teşkil ettiğini ilan eder. Tüm hukuk yaklaşımı da bunun üzerine yapılanmalıdır.
NEONATOLOJİ AÇISINDAN: Gebe ve annenin özel ve özgün yeri ve ayrıca bebeğe sevgi ile bakması, emzirmesi ile sadece onun yapabileceği işler olduğu için eşit değil, pozitif destek ve yaklaşımlarda öngörülmelidir. Irza geçilme durumlarında da kadın korunmalıdır.

- **2006 BM Özürlü Hakları**

Başlıca özet noktalar: Burada özürlü değil, engelli olarak ele alınmalıdır, onlara yaşam hakkı tanımak ötesinde engellerin kaldırılması veya yönetilmesi için her türlü yardım yapılmalıdır:
NEONATOLOJİ AÇISINDAN: IDH: impairments, disabilities and handicaps: Bozukluklar, yapmamazlık/engelli olmak ve eksiklik gibi durumları olanlar için yaşam hakkı ile tüm sağlık boyutlarının temininin bir zorunlu görev olduğu vurgusu vardır.

- **2006 Avrupa Konseyi Kılavuzu/Sözleşmesi**

Başlıca özet noktalar:

- Yaşam hakkı, aynı zamanda var oluş, varlık hakkıdır, alındıktan sonra geri verilemez, tazmin edilemez, gebelikte de bu sağlanmalıdır.
- Yaşam Hakkı katı şekilde uygulanmalı, ölüm durumunda da araştırmalı, sorgulanmalıdır.
- Yaşam kavramı soyut olduğu için ne zaman başlar ne zaman sonlanır açık değildir.
- Gebeliğin sonlanması sadece anne değil, gelecek nesil boyutu ile insanlığı ilgilendirir.
- Yaşamın sonlanması aşamasında olan kişiye bile ağrıları giderilmeli ama yaşamı sürdürülmelidir.
- Yaşamın sonuna geldiği sanılanların bile eylemleri, yaşamayı sonlandırıcı olamaz, bu müsaade edilemez.
- Kolluk güçleri, polisler ve askerlerde bile yaşam tehlikeye girmedikçe öldürücü ateş edemezler
- Yaşamda destek ancak gereken, dayanağı kadardır, fazla kullanılmaz, yaşamı tehlikeye atıcı yaklaşımlar yapılamaz. Etki ve tepki, tıbbi yaklaşım orantılı olmalıdır.
- Ölüm ve tıbbi açıdan ölümden sonra da sorgulama yapılmalı, bunun için etkili uyarı sistemleri, önlemleri de alınmalıdır.

NEONATOLOJİ AÇISINDAN: Yaşam Hakkının hiçbir şekilde bahaneler ile ortadan kaldırılamayacağı açıktır. Tüm ölümler Mortalite Toplantıları ile sorgulanması gerektiği belirtilmektedir.

AVRUPA SÖZLEŞMESİ

Başlıca özet noktalar: Bu haklar vatandaşlığın üzerindedir ve kişilere aynı şekilde bağlanmaktadır. Koruyucu sağlık tedavisi hakkı ve ulusal kanun ve uygulamalar tarafından oluşan şartlar kapsamında tedaviden yararlanma hakkıdır. Garanti edilen minimum standartlar sağlanmalıdır.
Avrupa Sözleşmesine uymayanlara açılacak dava konuları: Statünün 35. maddesi sağlığı koruma hakkı vermektedir. 35.maddeye ilaveten Temel Haklar Statüsünde dolaylı veya direkt

olarak hasta hakları ile ilgili burada tekrarlamaya değer birçok şart ve koşullar mevcuttur: *İnsan haysiyetinin dokunulmazlığı (madde 1), ve yaşama hakkı (madde 2); doğruluk hakkı (madde 3); güvenlik hakkı (madde 6); kişisel verilen korunma hakkı (madde 8); ayrım gözetilmemesi hakkı (madde 21); kültürel, dini ve dil farklılığı hakkı (madde 22); çocuk hakları (madde 31); yaşlı hakları (madde 25); eşit ve adil çalışma şartları hakkı (madde 31); sosyal güvenlik ve sosyal yardım hakkı (madde 34); çevresel korunma hakkı (madde 37); tüketici koruma hakkı (madde 38); taşınma ve ikamet özgürlüğü (madde 45)* bunlar arasındadır.

NEONATOLOJİ AÇISINDAN: Yaşam Hakkı temel olunca, bu sağlanmayınca, diğer haklardan da mahrum edilme davası gündeme gelmektedir.

1)-- 2006 tanımlama ile civil vatandaşlık olarak tanımlayanlar olabilir, ancak 2002 Roma Sözleşmesi ile bunun daha üst olduğu, her bireye hak olduğu vurgusu vardır: *Yaklaşım olarak her birey, doğmamış bile eşit haklarda kabul edilerek, buna göre uygulamalar yapılmalıdır*. 1) **Birey hakları önceliklidir "*Civil liberties*"**,

2)--Burada Kamu, kurum ve kuruluşların yaptığı zorlamalar da kabul edilemez denilmektedir: *Yaklaşım olarak birey hakkı kamu hakkının da üstündedir*. 2) **Bireyin hakları her türlü zorlamalara karşın korunmalıdır: "*the right to legal recourse when their rights have been violated, even if the violator was acting in an official capacity*"**.

Ulusal Etik/Hukuk Yapılanması

➢ 1928 Tababet ve Şuabatı Sanatlarının Tarz-ı İcrasına Dair Kanun

Başlıca özet noktalar: büro hizmetleri vurgusu vardır, felsefe, etik ilkeler konusu 1960 Deontoloji Nizamnamesindedir.
NEONATOLOJİ AÇISINDAN: Burada bu konu irdelenmese bile, sağlık yapılanması söz konusu edildiği için ilgili kapsamda ele alınabilir.

➢ 1959-1960 Deontoloji Nizamname/Etik Felsefe ilkeleri

Başlıca özet noktalar:

- Tabip ve diş tabibinin başta gelen vazifesi, insan sağlığına, hayatına ve şahsiyetine ihtimam ve hürmet göstermektir.
- Hastanın cinsiyeti, ırkı, milliyeti, dini ve mezhebi, ahlaki düşünceleri, karakter ve şahsiyeti, içtimai seviyesi, mevkii ve siyasi kanaati ne olursa olsun, muayene ve tedavi hususunda azami dikkat ve ihtimamı göstermekle mükelleftir.
- Gerekli bakımın sağlanamadığı acil vakalarda, mücbir sebep olmadıkça ilk yardımda bulunur.
- Meslek ve sanatının icrası vesilesiyle muttali olduğu sırları, kanuni mecburiyet olmadıkça, ifşa edemez.
- Sağlık müesseselerinde tatbik olunan usul ve kaideler mahfuz olmak üzere, hasta; tabibini serbestçe seçer.
- Sanat ve mesleğini icra ederken, hiçbir tesir ve nüfuza kapılmaksızın, vicdani ve mesleki Kanaat'ına göre hareket eder.
- Tatbik edeceği tedaviyi tayinde serbesttir.
- Mesleğinin icrası dışında dahi olsa, meslek ahlak ve adabı ile telif edilemeyen hareketlerden kaçınır.

- 1998 Türk Tabipler Birliği ***" Hekimlik ve Meslek Etiği Kuralları***: Aynı konular daha detaylı irdelenmektedir.

NEONATOLOJİ AÇISINDAN: Doğum her boyutta olacağı için, acil yaklaşımlara için eğitilmeli ve beceri kazanmalıdır.

➢ 1980 Anayasa 17. Maddesi

Başlıca özet noktalar: Anayasa da zorunluluk ile kanun ile tanınan haller dışında kişilik hakkı tanımlanmaktadır. Emir bile olsa kanuni dayanağı yok ise, yapılmaz, sorumluluk yapan ait olur.

- Herkes, yaşama, maddi ve manevi varlığını koruma ve geliştirme hakkına sahiptir.
- Tıbbi zorunluluklar ve kanunda yazılı haller dışında, kişinin vücut bütünlüğüne dokunulamaz; rızası olmadan bilimsel ve tıbbi deneylere tabi tutulamaz.
- Yasalarda kanuni dayanağı olmayan emirler yapılamaz, ötenazi daha önce tanımlanmamasına karşın, yine de bir suç niteliğinde olmuştur

NEONATOLOJİ AÇISINDAN: Burada tanımlanmasa bile herkes denildiği için, yenidoğan, gebelikteki fetus da bu kapsamdadır.

➢ 1983 Sterilizasyon

Başlıca özet noktalar:

- Gebeliğin onuncu haftası doluncaya kadar kadının sağlığı açısından tıbbi sakınca olmadığı takdirde, istek üzerine rahim tahliye edilir.
- Gebelik süresi on haftayı geçen kadınlarda, rahim tahliyesi yapılamaz, ancak, Tüzük'e ekli (2) sayılı listede sayılan hastalıklardan birinin bulunması halinde kesin klinik ve laboratuvar bulgulara dayanan, gerekçeli raporlarla saptanması zorunludur

NEONATOLOJİ AÇISINDAN: Gebelikte 10 hafta, embriyonik dönem, terminasyon açısından önemlidir, 20 Gebelik Haftası da ırza geçmelerde önemsenmektedir.

➢ 1987 Sağlık Hizmetleri Temel Kanunu (3359 sayılı yasa)

Başlıca özet noktalar:

- Sağlık kurum ve kuruluşları yurt sathında eşit, kaliteli ve verimli hizmet sunacak şekilde Sağlık ve Sosyal Yardım Bakanlığınca, diğer ilgili bakanlıkların da görüşü alınarak planlanır, koordine edilir, mali yönden desteklenir ve geliştirilir.
- Koruyucu sağlık hizmetlerine öncelik verilmek suretiyle kamu ve özel bütün sağlık kurum ve kuruluşlarının kurulması ve işletilmesi…
- Bütün sağlık kurum ve kuruluşları ile sağlık personelinin ülke sathında dengeli dağılımı ve yaygınlaştırılması esastır.
- Herkesin sağlık durumunun takip edilebilmesi ve sağlık hizmetlerinin daha etkin ve hızlı şekilde yürütülmesi gereklidir.
- Sağlık kurum ve kuruluşları coğrafik ve fonksiyonel hizmet alanları, verecekleri hizmetler, yönetim, hizmet ilişki ve bağlantıları gibi konularda tespit edilen esaslara uymak ve verilen görevleri yapmakla yükümlüdürler. Çağdaş tıbbi bilgi ve teknolojinin ülkeye getirilmesi ve teşviki sağlanır.

- Ana çocuk sağlığı ve aile planlaması ve benzeri konularda eğitilmeleri ve takipleri bütün kamu kuruluşlarının sorumluluğu, kamu kurumu niteliğindeki meslek kuruluşları, özel ve gönüllü kuruluşların iş birliği içerisinde gerçekleştirilir.
- Engelli çocuk doğumlarının önlenmesi için, gebelik öncesi ve gebelik döneminde tıbbi ve eğitsel çalışmalar yapılır. Yeni doğan bebeklerin metabolizma hastalıkları için gerekli olan testlerden geçirilerek risk taşıyanların belirlenmesine ilişkin tedbirler alınır.

NEONATOLOJİ AÇISINDAN: Bakanlığa önemli görevler düşmektedir: Bu yasa ile Bakanlık tüm sağlık organizasyonunda, özel boyutlar dahil, gündeme gelmektedir.

➢ 1989 Çocuk Hakları

Başlıca özet noktalar:

- Çocuğun gerek bedensel gerek zihinsel bakımdan tam erginliğe ulaşmamış olması nedeniyle doğum sonrasında olduğu kadar, doğum öncesinde de uygun yasal korumayı da içeren özel güvence ve koruma gereksiniminin bulunduğu gerçeği ile haklar oluşturulmuştur

NEONATOLOJİ AÇISINDAN: Doğum öncesi, gebelikte ve doğum sonrasında da her türlü bedensel, zihinsel ve sosyal destek ile özel güvenceye alınması gerektiği vurgusu vardır.

➢ 1993 İlaç ve Klinik Araştırmaları Hakkında Yönetmelik (2008 Yeni düzenleme)

Başlıca özet noktalar:

- İnsanlar üzerinde deney yapmak kesinlikle yasaktır. Burada belirtilen FAZ IIIb ve FAZ IV boyutunu kapsamaktadır.
- Bu Yönetmelik; insanlar üzerinde yapılacak ilaç klinik araştırmaları, ilaç dışı klinik araştırmalar, tıbbi cihazlarla yapılan araştırmalar, yeni bir cerrahi yöntem kullanılarak yapılacak klinik araştırmalarına ilişkin her türlü klinik araştırmayı, araştırma yerlerini ve bu araştırmaları gerçekleştirecek gerçek veya tüzel kişiler ile biyoyararlanım ve biyoeşdeğerlik çalışmaları ile tedavi amaçlı denemeleri kapsar.
- Gözlemsel çalışmalar, insani amaçlı ilaca erken erişim programları ve ilaç dışı standart tedavi uygulamaları bu Yönetmeliğin kapsamı dışındadır.

NEONATOLOJİ AÇISINDAN: Araştırmalar ancak gönüllüler üzerine yapılabilir, bu açıdan Neonatoloji ancak genel anlamda vardır.

➢ 1998 Hasta Hakları (2003 Yönerge)

Başlıca özet noktalar: Ulaşım Web itesi ile yapılabilmektedir.

- Yaşama, maddi ve manevi varlığını koruma ve geliştirme hakkını haiz olduğu vurgusu yapılmaktadır.
- Teşhis, tedavi veya korunma maksadı olmaksızın, ölüme veya hayati tehlikeye yol açabilecek veya vücut bütünlüğünü ihlal edebilecek veya akli veya bedeni mukavemeti azaltabilecek hiçbir şey yapılamaz ve talep de edilemez.

- Ötenazi yasaktır. Tıbbi gereklerden bahisle veya her ne suretle olursa olsun, hayat hakkından vazgeçilemez. Kendisinin veya bir başkasının talebi olsa dahil, kimsenin hayatına son verilemez.
- Hasta, modern tıbbi bilgi ve teknolojinin gereklerine uygun olarak teşhisinin konulmasını, tedavisinin yapılmasını ve bakımını istemek hakkına sahiptir.

NEONATOLOJİ AÇISINDAN: Gebeliğin sonlandırılması rıza ile de olsa, ötenazi kapsamında ise suç niteliğindedir. Yaşam hakkını almaya kimsenin yetkisi yoktur.

➢ 1998 Nüfus Planlaması Hakkındaki Kanun; 2827

Başlıca özet noktalar: Bu Kanunun amacı, nüfus planlaması esaslarını, gebeliğin sona erdirilmesi ve sterilizasyon ameliyelerini, acil müdahale halleri ile gebeliği önleyici ilaç ve araçların temin, imal ve saptanmasına ilişkin hususları düzenlemektir.

- Nüfus planlaması, fertlerin istedikleri sayıda ve istedikleri zaman çocuk sahibi olmaları demektir.
- Gebeliğin onuncu haftası doluncaya kadar annenin sağlığı açısından tıbbi sakınca olmadığı takdirde istek üzerine rahim tahliye edilir.
- Gebelik süresi, on haftadan fazla ise rahim ancak gebelik, annenin hayatını tehdit ettiği veya edeceği veya doğacak çocuk ile onu takip edecek nesiller için ağır maluliyete neden olacağı hallerde doğum ve kadın hastalıkları uzmanı ve ilgili daldan bir uzmanın objektif bulgulara dayanan gerekçeli raporları ile tahliye edilir.
- Derhal müdahale edilmediği takdirde hayatı veya hayati organlardan birisini tehdit eden acil hallerde durumu tespit eden yetkili hekim tarafından gerekli müdahale yapılarak rahim tahliye edilir.

NEONATOLOJİ AÇISINDAN: Prematüre doğumlarda yaşam hakkı sağlanması gerektiği için, mutlaka Yoğun Bakım Ünitelerinin olduğu yerde yapılmalıdır.

➢ 1998 Hasta Hakları Yönetmeliği

Başlıca özet noktalar:

- Teşhis, tedavi veya korunma maksadı olmaksızın, ölüme veya hayati tehlikeye yol açabilecek veya vücut bütünlüğünü ihlal edebilecek veya akli veya bedeni mukavemeti azaltabilecek hiçbir şey yapılamaz ve talep de edilemez.
- Ötenazi yasaktır. Tıbbi gereklerden bahisle veya her ne suretle olursa olsun, hayat hakkından vazgeçilemez. Kendisinin veya bir başkasının talebi olsa dahil, kimsenin hayatına son verilemez.
- Hasta, modern tıbbi bilgi ve teknolojinin gereklerine uygun olarak teşhisinin konulmasını, tedavisinin yapılmasını ve bakımını istemek hakkına sahiptir.

NEONATOLOJİ AÇISINDAN: Anne ve babanın tedaviyi reddetme hakkı yoktur. Olursa, Mahkeme Çocuk Koruma Kanunu gereği bebeği aileden alıp Devlet Korumasına vermektedir.

➢ 2003 Sözleşmeli Sağlık Personelinin Uymakla Yükümlü Olduğu Mesleki ve Etik Kurallar

Başlıca özet noktalar:

- **Hukuk Yapısı içinde yaparlar**: Görevlerini, Türkiye Cumhuriyeti Anayasasına, kanunlara ve evrensel hukuk kurallarına bağlı olarak, dürüstlük, adalet, hakkaniyet, objektiflik, güvenirlilik, tarafsızlık, saydamlık, hesap verme sorumluluğu, karar ve işlemlerde etkinlik, göreve bağlılık ve kamu yararına uygunluk çerçevesinde yürütürler.
- **Eşitliği sağlarlar**: Dil, din, inanç, düşünce, ırk, cinsiyet ve uyrukluk ayrımı yapamazlar; hiç kimseye fırsat eşitliğini engelleyici davranışlarda ve kötü muamelede bulunamazlar.
- **Politik görüş değil bilimsel yaklaşım esas alınır**: Herhangi bir siyasi partinin veya siyasi görüşün, kişinin, şirketin, teşebbüsün, odanın, birliğin, derneğin veya vakfın yararını veya zararını hedef alan davranışlarda bulunamazlar.
- **Seçim ile, toplumun tercihi alakaları olmaz, bilimin hasta üzerindeki veriye göre yaklaşırlar**: Doğrudan veya dolaylı olarak, bir seçim kampanyasında, birinin seçilmesini sağlamak veya engellemek amacıyla görev yaptığı kurumun kaynaklarını kullanamaz, kullanılmasına yetki veremezler
- **Bütçe ve kaynaklar hizmete yönelik olmalıdır**. Kamu kaynaklarını ve kamu mallarını, görevleriyle ilgili olmayan faaliyetler için kullanamazlar.
- **Yetkiler, hizmete ve amaca uygun olmalıdır**. Yetkilerini kullanırken, alınacak tedbirlerin elde edilmek istenilen amaç ile orantılı olmasını sağlamak ve sunulan hizmetin amacıyla uygun olmayacak şekilde, kısıtlama ve yükümlülük getirmekten kaçınmak zorundadırlar.
- **Uygulamalarda kişilik hakları v hürmet boyutunda olmalıdırlar**. Hizmetten faydalananlara karşı saygılı ve nezaketli davranmakla, yazışmalara, telefonlara ve her nevi araçla yöneltilen taleplere cevap verirken hizmetten faydalananlara yardımcı olmakla ve konudan sorumlu değil ise ilgili görevliye yönlendirmekle yükümlüdürler.
- **Hizmet üretirken, yararlı olmak, zarar vermemek, güvenilir ve saygın olunma vurgusu vardır**. Kamu hizmetini talep edenlere yardımcı olmak, başkalarına zarar vermekten kaçınmak, dürüst, güvenilir ve adil olmak, özel hayata saygı duymak, insan onuruna ve vatandaş olmanın saygınlığına yaraşır şekilde hizmet vermek ve belirlenen hizmet sunum ilkelerine sadakatle uymakla yükümlüdürler.
- **Yaşam hakkı boyutu ile, yaşama, varlığı korumak, geliştirme hakkının temel olduğu vurgusu vardır**. Bedeni, ruhi ve sosyal yönden tam bir iyilik hali içinde yaşama, maddi ve manevi varlığını koruma ve geliştirme hakkının en temel insan hakkı olduğu, hiçbir merci veya kimsenin bu hakkı ortadan kaldırmak yetkisinin olmadığı hizmetin her safhasında daima göz-önünde bulundurulur.
- **Bilimsel olmayan uygulamalar tatbik edilemez**. Hastaların tanı ve tedavisinde bilimsel olmayan yöntemler uygulanamaz, gerekli bilimsel aşamalardan geçip ruhsatlandırılmamış kimyasal, farmakolojik, biyolojik maddeler ilaç olarak kullanılamaz.
- **Normlara uygunluk, kurallara uyum, bireyin hakkı ve kanun ile belirlenen olmalıdır. Görüş yeterli değildir**. Bu kurallar da yer alan tanzimlere ve genel etik ilkelere, ulusal ve uluslararası normlara uymakla yükümlüdürler.

NEONATOLOJİ AÇISINDAN: Genel vurgu yapılmış olsa da fiziksel, ruhsal ve sosyal açıdan yaşam hakkını iyilik içinde koruma ve geliştirme ifadesi ile temel ilke yapmaktadır. Bunun anlamı elbette yaşamın başlangıcı olan gebelik ve yenidoğan evresi olmalıdır.

➢ 2005 TCK (2004 CMK)

Başlıca özet noktalar:

- **Hukuk, hak olarak öncelikle kişi hak ve özgürlüğünü korumak ve suç işlenmesini önlemek olarak tanımlamaktadır:** Ceza Kanununun amacı; kişi hak ve özgürlüklerini, kamu düzen ve güvenliğini, hukuk devletini, kamu sağlığını ve çevreyi, toplum barışını korumak, suç işlenmesini önlemektir
- **Suç kanunda açık ifade ile belirtilmelidir**. Kanunun açıkça suç saymadığı bir fiil için kimseye ceza verilemez ve güvenlik tedbiri uygulanamaz. Kanunda yazılı cezalardan ve güvenlik tedbirlerinden başka bir ceza ve güvenlik tedbirine hükmolunamaz.
- **Adalet ve kanun önünde eşitlik ilkesi:** Ceza Kanununun uygulamasında kişiler arasında ırk, dil, din, mezhep, milliyet, renk, cinsiyet, siyasal veya diğer fikir yahut düşünceleri, felsefi inanç, milli veya sosyal köken, doğum, ekonomik ve diğer toplumsal konumları yönünden ayrım yapılamaz ve hiçbir kimseye ayrıcalık tanınamaz.
- **Düzen ile alakalı hususlara uymamak suç değildir**. İdarenin düzenleyici işlemleriyle suç ve ceza konulamaz.
- **Suç somut olmalı, kıyas, yorum yasaktır. Medeni Kanun'da yazmıyorsa, toplumun görüşü ve kıyas o zaman yapılabilir**. Suç işleyen kişi hakkında işlenen fiilin ağırlığıyla orantılı ceza ve güvenlik tedbirine hükmolunur.
- **Mazeret ve bilmiyordum geçerli olamaz**. Ceza kanunlarını bilmemek mazeret sayılmaz.
- **Özel kanunlarla ilişki açıktır ve TCK bağlayıcıdır.** Bu Kanunun genel hükümleri, özel ceza kanunları ve ceza içeren kanunlardaki suçlar hakkında da uygulanır.
- **Hakkını kullanan kimseye ceza verilmez. Rıza önemlidir**. Kişinin üzerinde mutlak surette tasarruf edebileceği bir hakkına ilişkin olmak üzere, açıklandığı rızası çerçevesinde işlenen fiillerden dolayı kimseye ceza verilmez,
- **Konusu suç teşkil eden emir hiçbir surette yerine getirilmez**. …yerine getiren ile emri veren sorumlu olur (Anayasa 137Md),

NEONATOLOJİ AÇISINDAN:

- **Rıza olsa bile, 10 Gebelik Haftasından sonra abortus yapılamaz**. Tıbbi zorunluluk bulunmadığı halde, rızaya dayalı olsa bile, gebelik süresi on haftadan fazla olan bir kadının çocuğunu düşürten kişi…
- **Mağdur durumda ise 20 Gebelik haftasından sonra düşük yapılamaz.** Kadının mağduru olduğu bir suç sonucu gebe kalması halinde, süresi yirmi haftadan fazla olmamak ve kadının rızası olmak koşuluyla, gebeliği sona erdirene ceza verilmez…

➢ 2005 Çocuk Hakları Kanunu

Başlıca özet noktalar:

- **Koruyucu ve desek tedbirleri alınmalıdır.** Koruyucu ve destekleyici tedbirler, çocuğun öncelikle kendi aile ortamında korunmasını sağlamaya yönelik danışmanlık, eğitim, bakım, sağlık ve barınma konularında alınacak tedbirlerdir.

NEONATOLOJİ AÇISINDAN: Çocukların aile sorunu olunca, prematüre bebeği kabul etmeyen ailelerden bebekler alınıp, Devlet bakımına alınmışlardır.

➢ 2009 Engelli Hakları Kanunu

Başlıca özet noktalar:

- **Engelli ve tüm çocukların danışmanlık ve savunuculuğu Devlet üstlenmektedir. Dava Devlet adına açılmaktadır.** Başta çocuklar ve özürlüler olmak üzere tüm hastaların danışmanlığını ve savunuculuğunu yapmak

NEONATOLOJİ AÇISINDAN: Devlet doğrudan yaşam hakkı açısından dava açmakta, tüm ölümlerin irdelenmesi de bir görev olarak üstlenmektedir.

➢ 2011 Klinik Araştırmalar Yönetmeliği (Etik)

Başlıca özet noktalar:

- **Tıbbi araştırmalar gönüllü üzere yapılabilir, rıza boyutu gebelikte mahkeme kararı ile oluşmaktadır.**

➢ 2011 Türk Ticaret Kanunu

Başlıca özet noktalar:

- **Yasaklanmış olanlar butlan olan, kabul edilmeyen, geçersiz olarak irdelenir.** Aksine bir hüküm bulunmadığı takdirde, ticari hükümlerle yasaklanmış işlemler ve şartlar batıldır**.**

➢ 2014 Hasta Hakları Yönetmeliğinde Değişiklik Yapılmasına Dair

Başlıca özet noktalar:

- **Tüm sağlık işletmeleri Bakanlık yapısında organize edilmektedir.**
- **Rıza şartı yeterlilik olan için geçerlidir, gerekirse mahkeme kararı alınmalıdır.**
- **Tıbbi müdahale bilim ve hukuka uygun olmalıdır**: Tıp mesleğini icraya yetkili kişiler tarafından uygulanan, sağlığı koruma, hastalıkların teşhis ve tedavisi için ilgili meslekî yükümlülükler ve standartlara uygun olarak tıbbın sınırları içinde gerçekleştirilen fizikî ve ruhî girişimi,
- **Bilgilendirme aydınlatma şeklinde olmalıdır, hastalık değil, hastalığın bireye yaptığı etki anlatılmalıdır**: Yapılması planlanan her türlü tıbbi müdahale öncesinde müdahaleyi gerçekleştirecek sağlık meslek mensubu tarafından kişiye gerekli bilginin verilmesini,
- **Gizlilik esastır, hastanın bilgi verilmesi istenilene bilgi verilebilir.**
- **Her tıbbi yaklaşım kayıt içinde olmalı, çıkarken de çıkış özeti/epikriz sunulmalıdır.**
- **Acil durumlarda yaşam hakkı önceliklidir.**
- **Hasta sağlık hizmeti alırken, iletme usullerine uyar.**
- **Hasta belirli aralıklarla taburcu olsa da takip edilmelidir.**

- **Sorunlarda Hasa İletişim Birimi ve Hasta Hakları Birimine başvurabilir.**

NEONATOLOJİ AÇISINDAN: Tüm yaklaşımlarda yaşan hakkı temeldir, bu çerçeveden bakılmalıdır. Hasta ailesi şikâyetinde, yaşam hakkı veya varlığını tehlikeye düşürecek, tedavi hakkını belirtmesi ile Çocuk Koruma Kanunu gereği, aileden alınıp, Devlet korumasına Mahkeme kararı ile verilebilir.

➢ 2014/32 Hasta Hakları Uygulamaları Genelgesi

Başlıca özet noktalar:

- **Hasta Hakları Kurulu oluşturulmaktadır.**

NEONATOLOJİ AÇISINDAN: Şikâyet eden kişi doğrudan kurulda ifade etmektedir, ancak Yaşam Hakkı gibi konular temel olduğu için, şikâyet eden, Çocuk Koruma Kanunu nedeniyle elinden Devlet bebeği alıp, koruyucu aileye verebilmektedir. Şikâyet hukuka uygun olmalıdır.

Etik Hukuk Açmazı

Bazı araştırmacılar toplumsal görüşleri ileri sürerek, bunların bir etik boyut olarak ele almaları ve hukuk nazarına karşı çıkardıkları görülmektedir. Hukuk suç/ceza konusunda iken, etik doğru nedir/doğru ne yapmalıyım konusundadır. Farklı yaklaşım burada oluşmakta, ancak suç bir doğrusal boyut olarak gösterilemez, kanunsuz emir yapmak da suçtur ve sorumluluğu kaldırmaz. Nitekim Groningen protokolünde Savcılık dava açmayacağı sanılmaktadır vurgusu (For the Dutch public prosecutor, the termination of a child's life (under age 1) is acceptable if four requirements were properly fulfilled) vardır.

Bir makale ele alınarak bu konuda yorumlar yapılacaktır.

Sunum: Tıp Etiği Açısından Yaşamın Sonuna İlişkin Kararlar[15]

Aslıhan AKPINAR Hacettepe Üniversitesi Tıp Fakültesi Tıp Tarihi ve Etik Anabilim Dalı Hacettepe Biyoetik Merkezi

SUNU-1) Genel anlamda tıbbın yapması gereken hastaların acılarını uzaklaştırmak, hastalıklarının şiddetini azaltmak ve hastalıkları tarafından zaptedilmiş olanları bu tür durumlarda tıbbın elinden bir şey gelmeyeceğinin farkında olarak, tedavi etmeyi reddetmektir. Hipokrat (İ.Ö. 460-370)

Yorum

Tıbbi Deontoloji Nizamnamesi "*Umumi kaide ve esaslar Madde 2 – Tabip ve diş tabibinin başta gelen vazifesi, insan sağlığına, hayatına ve şahsiyetine ihtimam ve hürmet göstermektir*" ifade etmekte, yaşam hakkı temel hak olduğuna göre, morfinin perfüzyon ile verilmesi ile giderilebilir. Tıbbin elinden bir şey gelmeyecek değil, hastadaki neticeler net bilinemez. A grubunda, kısaca en etkin olduğu kanıtlanan tedavi protokolünde bile %5-15 farklı etki elde edilebilmektedir.

Pancoast tümürü olan bir İntörn iken hastam oldu. Aileye anlattık, hiçbiri konuşan hasta ölür mü dediler. Birden arrest oldu, canlandırma yaptım, ilk planda aile reaksiyon verir gibi oldu, sonra teşekkür etti. Bu arada miras konusu halledilmiş, mezar hazırlanmış, her sülaledeki

olanlar ciddi ölecek diyerek aileden bağışlanma ve af dileyen olmuş. Huzur içinde toprağa verdik, birden ölse idi, kavga ve Karadenizli oldukları için, silahlar konuşacaktı dediler.
Komşumuz, Prof. Mühendis olan hocamızın, pankreas başı tümör tespit edildi, yaygın metastazları da vardı, en fazla 2 ay yaşayacağını literatür belirtmekte idi. Bana tedavi olmamayı, bir an önce ölmeyi düşündüğünü söyledi. Ben bir ilk küre başla dedim ve %50'den fazla küçülme oldu, bir yıldan fazla yaşadı. Esas önemli olan aile dahil, toplum ona ölüm hazırlığı yaptı, mezar hazırlandı ve helalleşti.

Ölüm oruçlarında da karışılamaz, şekerli elektrolitli sıvı verilerek, ölüm geciktirilebilir, ama bilinç kaybı olunca canlandırma yapılır, ama pek geri dönüş olmaz. Buradaki amaç bireyin ölüm orucundan vaz geçme kararı verebilmesidir. Bunun olması için toplum, kendi grubunun baskısından da hastane ortamı ile kurtarmak gerekir. 1968 olaylarında bireylerin beni kurtarın dediklerine bizzat şahit olunmuştur.

Tıbbın elinden bir şey gelmeyeceği demek, garanti vermek gibi olmakta, gelecek bilinmez, bize düşüne görev, palyatif olsa da yardım etmek olmalıdır.

SUNU-2) Ölüm artık... Bir sonuç değil, Günler bazen aylar süren bir süreç olarak Evlerimizde değil, Hastanede, hatta yoğun bakım ünitesinde Ailemiz ve yakınlarımızın değil, Yabancıların yanında ... gerçekleşmektedir.

Yorum

Ölüm sadece bir tıbbi tanım değil, dini tanımlama ötesinde de felsefe boyutu olarak da bir yaklaşım olmaktadır.
Her canlı ölümü tadacak, ancak ölüm bir yok olma değil, bir bakıma yeni nesle bir enerji, bilgi ve becerilerin aktarımı olmaktadır. Buna karşın, sevgi ve insanlık olmadığı zamanda, o insan bedensel, fiziksel canlı olsa da ölü gibi anlamı olmamaktadır. Nitekim ölüm orucunda ölenler, daha ölmeden bile poster ve diğer medya yöntemleri ile bir boyut kazandırılmaktadır.

Ölüm boyutu bu açıdan farklı ele alınabilir, Atatürk için öldü denilemez.

SUNU-3) Anglo – Amerikan Kültüründe

- 1976 – Karen Ann Quinlan vakası
- 1983 – President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions

Ne pahasına olursa olsun kurtarma amacı
Kabul edilebilir bir yaşam kalitesine dönüş için makul bir beklenti olmadığında ölüm sürecini uzatmaktan kaçınma arzusu

Yorum

Baby Doe olgusunda olduğu gibi, Down Sendromlu Trakeal atrezili çocuğun tedavisi cerrahi olası iken, onun Down Sendromunu öne çıkarıp tedavi etmemek yasal kabul edilmemiştir.
Yazar olarak 3 defa 3 ay ara ile Amerika'da Hastane Etik Kurul, Neonatoloji Ünitesinde izlemci profesör olarak çalışmam sonucunda İstanbul Deklarasyonu oluşturulmuş ve Dünya, Avrupa Perinatoloji Konseyleri Etik Esaslar olarak kabul edilmiştir. Buna göre yaşam hakkı esastır.

Ne pahasına olursa olsun, eğer yaşatma olanağı var ise niye yapılmasın?

Engelli Haklarında da Devlet korumak esasındadır, kaldı ki, engelli olanlar, canlandırmanın çoğunlukla geç başlamasından olmaktadır. Serebral Palsi gebelikten başlayan bir durumdur.

SUNU-4) Yaşam desteğini sınırlandırmak: Dünya çapında bir uzlaşı mı? (Veatch, 2004)
- Avrupa – %73 (Sprung, 2007)
- ABD – %79 (SUPPORT, 1995)
- İngiltere ve Cape Town –

Yorum

Yaşam desteğini sınırlandırmak suçtur.
Ekonomik gerekçelere dayandırmak ise tamamen bilinçli taksir, dikkat ve özen eksikliğine kasıtlı neden olmaktır. Kısaca TCK göre ağırlaştırılmış suçtur.

SUNU-5) Yaşamın sonuna ilişkin kararlar;
Hasta açısından – tedaviyi ret
Hekim açısından
- Hastanın tedavilerin esirgenmesi veya sonlandırılması talebi
- İntihara yardım talebi
- Ötanazi talebi
- Gönüllülük bildiremeyenlerde ötanazi talebi
- Hasta V vekil karşıdır
- Tedavilerin esirgenmesi veya sonlandırılması
- Hekim yardımlı intihar
- Gönüllü ötanazi
- Gönüllülük bildiremeyenlerde (nonvoluntary) ötanazi
- Gönülsüz (involuntary) ötanazi

Yorum

Ülkemizde intihar girişimlerini engellemeyen kişiler suçlanmış ve ceza almışlardır. İntihar durumlarında bile bu suçtur.
Tedavi garantisi vermeyen bir hekimlik mesleğinde, sadece yardım için olan sağlık elemanı, nasıl sonlandırma yaklaşımına destek olabilirler. Sözel destek bile suçtur.

SUNU-6) Yaşamı destekleyen tedavileri sınırlandırma kararları Withholding
Bir şeyi yapmaktan veya vermekten kaçınmak
Tedavileri esirgemek
Tedavileri sonlandırmak
Withdrawing Geri çekmek
Vazgeçmek

Yorum

Bir tedavi başlanırken, mutlaka tedavi edecek değil, yardım etmesi planlanarak yapılır. Cevap alınmaz ise ancak bu durumda kesilir. Tek bir veri olmalıdır, tedaviye yanıt vermedi, alerji oluştu veya ters etkileşim olduğu için kesilebilir.
Ventilatörün kapatılması demek, bunun aktif öldürmek olacağı için doğrudan suçtur.

SUNU-7) Esirgemek mi? Sonlandırmak mı?
- Yaşamı Destekleyen Tedavileri (YDT) esirgemek ve sonlandırmak farksızdır

• YDT esirgemek sonlandırmaktan daha uygundur
• YDT sonlandırmak esirgemekten daha uygundur

Yorum

Yaşayan bir kişi, kesin ölmemişse, buna Yaşam Desteği verilmelidir. Verilmemesi suçtur, yapılamıyorsa da sevk edilmelidir.
Covid-19 Hastalığı nedeniyle Avrupa'da tedavi kesilmesi istenen yüz binden fazla hasta, uçak ile ambulansla Türkiye'ye gelmiş ve uygulamalara devam edilmiştir. Ne kadarı yaşadığı bilinmemekte, ama yaşayanlar olduğu da belirgindir.

Amerika'da Hastane Etik Kurulda bir olgu sunumunda 7 yaşındaki çocuk, bisiklet kazası geçirmiş, bir hafta toparlanmadığı için ventilatörün durdurulması kararı verilecekti. Ben oğlumun ODTÜ mühendislikte okuyan sınıf arkadaşının, araba ile nehre girip, ventilatörde 2 ay kaldığı, sonra mezun olabildiğini belirttim. Süre tanımalarını söyledim. Senin oylamada yetkin yok, denilerek sonlanma kararı verilmiştir.

SUNU-8) Hasta açısından... Kendi hakkında karar verme hakkına sahip olan hasta, değerleri ve beklentileri doğrultusunda yarar / yük olarak neyi kabul edeceğini, ne tür bir yaşam kalitesini katlanabilir bulacağını belirleme hakkına sahiptir.
Bu nedenle hasta ya da vekillerinin olası tedaviyle sunulacak ne kadar yarar için ne kadar sıkıntıyı göze alabileceklerine karar verebilmelerine olanak tanınmalıdır.

Yorum

Geleceği kimse bilemez. Hele bu gibi durumlarda, Tedavi protokolünde A değil B grubunda %25 farklı sonuç alınabileceği, olgu ise çok farklı sonuçlar olduğundan, gelecek ancak bir öngörüdür, kesin olunamaz. A grubu tedavide bile %5-15 yanıt vermediği bilinmektedir.
Garanti verilemeyen bir durumda kesin konuşmak da olası olamaz. Yaygın kanseri olan bir olgunda, o sırada yeni bir ilaç yurtdışından, Amerika'dan getirildi ve hastaya uygulandı. Tedavi ettiği değil, yaşamını uzattığını söyleyebilirim.

SUNU-9) Yaşamı Destekleyen Tedavinin Reddedilmesi
• Karar verme kapasitesine sahip olan hastanın Aydınlatılmış Ret Hakkı
• 1983 Venedik Bildirgesi
• 1992 Dünya Tıp Birliği (DTB) Hekim Yardımlı İntihar İçin Tutumu
• 1998 Hasta Hakları Yönetmeliği (m.25)
• 2010 Türk Tabipleri Birliği Yaşamın Sonuna İlişkin Etik Bildirge

Yorum

Tedaviyi reddetme ile yaşamı reddetme boyutu farklıdır. Bu Bildirgeler bu Makalede sunulmakta, bunların ölüme onay vermediği de açıktır.
Tedaviyi reddetmek, varlığı reddetmekten farklıdır.
SUNU-10) Yaşayan Dilek veya Tıbbi Vasiyet
• Karar verme kapasitesini kaybeden hastada,
• 1997 İnsan Hakları ve Biyotıp Sözleşmesi "müdahale sırasında isteğini açıklayabilecek durumda bulunmayan bir hastanın, tıbbî müdahale ile ilgili olarak önceden açıklamış olduğu istekleri göz önüne alınmalıdır"
• Türk Tabipleri Birliği Yaşamın Sonuna İlişkin Etik Bildirge

Yorum

Hukuk çıkan kanun ile suçtur demekte iken, bunu Etik kabul ediyor demek olanaksızdır. Suçu övmeye girer ki o da suçtur.

Türk Ticaret Kanunundaki yaklaşım ile, bir antlaşma, bir işlem, herhangi bir boyut, ne olursa olsun, hukuk dışı, kanun ile yasaklanmış işlemler ise butlan, geçersiz ve kabul edilemez, reddedilmelidir. **2011 Türk Ticaret Kanunu Madde 1530:** *Aksine bir hüküm bulunmadığı takdirde, ticari hükümlerle yasaklanmış işlemler ve şartlar batıldır.*

SUNU-11) Hekim açısından... Tıbbi yararın tarafsızca belirlenmesi – Orantılılık İlkesi

• Günlük uygulamalarda yarar / yük oranlarını hesaba katma anlayışının yaşamı korumakla ilgili mutlak ödev anlayışının yerine geçmesi önerilmektedir

Tıbbi faydalar: Pozitif ve ölçülebilir şekilde hastalığın tedavi edilmesi, durdurulması veya hastalığın, durumun, semptomların ve acının azalması

Yaşam kalitesi: hastanın yaşamına hem hasta hem diğerleri tarafından tatmin edici bulunan günler veya aylar eklenmesi

Tıbbi yükler: Tedavinin ölçülebilir bir fayda sağlamaması ve ağrı, acı ve güçsüzlüğü sürdürmesi

Yaşam kalitesi: Hastanın yaşam kalitesini baskılaması

Yorum

Neonatoloji de rıza olmayacağına göre, 10 Gebelik Haftasına kadar anne ve bebek rızası bütünleştiği için, bu durumda embriyo iken sonlandırılabilir. Bundan sonra 20 Gebelik Haftasına kadar sürede, Tıbbi olarak kanun ile iletilen liste (2 nolu Liste) içinde ise, Perinatoloji konsey görüşü ile, anne ve hekim kesin rızası ile işlem yapılabilir.

20 Gebelik Haftasına kadar da Tıbbi Listede olan gerekçe yanında ırza geçme boyut da Savcılık talebi ile dahil edilmektedir.

Bunun dışında bir gerekçe kabul göremez, ekonomik yetersizlikte Devlet bakar, bakmaktadır.

SUNU-12) Hekim açısından... Tıbbi yararın tarafsızca belirlenmesi – Orantılılık İlkesi

• Özellikle yaşamın sonunda yetersiz bir hasta için yarar ve yükleri dengelemek zordur.

• Eğer bir tedavi orantısız şekilde fonksiyon kaybına, sakatlığa ya da ağrıya sebep olacaksa hekimin bu tedaviyi uygulama yükümlülüğü bulunmamaktadır

Yorum

Engelli Yasasında olduğu gibi, hekim tedavi yapacak ise, sorun olacak diye tedavi kesilmesi, tedavi değişikliği, palyatif yaklaşımlar verilmez denilemez. Alternatif tedavi eğer uygun ise, ana tedavi kesilmeden vermelidir. Ancak, zararlı olmayan verilir, alerji varsa, olmayan verilir. Yetersizliği olgu verisi tayin etmelidir, hasta göre uygulanır, sosyal boyutta önemlidir, hastayı ölüme terk edildiği algısı da kabul edilebilir değil, yasal açıdan suç kapsamındadır. Hekim mutlaka tedavi edecek diye bir kural da yoktur. 1968 Yıllarında öğrenci olaylarında Acilde yatan ve ölen hastaların öldü raporları jandarma güvenlik alıktan sonra verilir, çünkü ceset kaçırılma durumları olabilirdi. Ölüm zamanı daha önce, reaksiyon yok, pupil dilate diye yazılır, ama cihaz ile yaşatılıyor diye not konulurdu. Bu bize sosyal ölüm kaydı diye bir kavramı da getirmiştir.

SUNU-13) Hekim açısından... Yaşam Kalitesinin değerlendirilmesi

• Yaşamın değeri ile karıştırılmamalıdır.

• Bireyin fiziksel, sosyal ve zihinsel fonksiyonlarının yeterliliği ve hastanın yaşamını bağımsız sürdürebilmesi anlamına gelir.

Yorum

Yaşam bir varlık iken, bunun kalitesi, değeri gibi parametreleri ile karşılaştırmamak, en büyük haksızlık olmaktadır. Ensefalili bile olsa, anne oyuncak bebek gibi bakarak tatmin olmaktadır. Down sendromlu çocukların sorunları halledilirse, devamlı gülen, neşeli çocuklar olması ve onlara eğitim veren kurumlar ile iş veren Belediye Tesisleri olunca, aileler termine edilmesi yanında olmadıkları gözlenmiştir. Ayrıca nasıl olsa çocukları olmayacak, onların mutlu olması için çaba harcayan aileler bilinmektedir.
Yaşam Hakkı, hakların en üstündedir.

SUNU-14) Hekim açısından Yararsız olanı yapmama

• Kaynakları adil paylaştırma

Yorum

Deontoloji Nizamnamesinde deneyip, yararsızlığını saptanması gerekir demektedir. Yararsız olanın yapılmadığı gerekir, ama ağrıyı kesmek gereksiz denilemez.
Psikolojik tatmin için Placebo yaklaşımlarından sık psikolojik olarak yararlandığı da bilinmektedir.
Kaynakların adil kullanılması için sevk edilmelidir. Uçak ve helikopterle Neonatoloji 'de sevk sıktır.

SUNU-15) Boşuna / yararsız tedavi

Etkinlik Son 100 vakada işe yaramamış olduğu sonucuna varılan müdahaleler

Fizyolojik yararsızlık

Nicel Yaklaşım

Nitel Yaklaşım

Fayda Yalnızca kalıcı bilinçsiz durumu sürdüren ya da yoğun bakıma tamamen bağımlı olmaya son vermeyen tedaviler

Tıbbın amaçlarına ulaştırmayan tedavi

Yorum

Bilimsel olmayan yaklaşımlar zaten kabul edilemez. Kanıta Dayalı Tıp Kavramında A grubunda bile %5-15 Farklı netice alınıyorsa, olgu sunumları zaten gerekçe tutulamaz.
Prematürelere oksijenlenmeyi gidermek için oksijen vermek, akciğerin sıvı tutması ile daha kötüleştirebilir, bu nedenle PEEP dahil, surfaktan gibi diğer faktörlere dikkat etmeden, verdim netice alamadım denilemez. Fizyolojik fayda görmemesinin nedeni, Fizyo-Patolojik bir sorun gelişmesinden olmaktadır.

SUNU-16) YBÜ Triyajı

• Tedaviyle elde edilecek tıbbi fayda – geriye dönüş olasılığı
• Sağ kalım süresi- yaşam beklentisi
• Hastanın beklenen yaşam kalitesi
• Etkilenenlere yükü

Yorum

Hekim için en büyük ruhsal darbe, o kadar eğitim al ve sonra tedavi etme, ölüme bırak olmaktadır. Klinik tecrübeler ile, olguların gece, gündüz demeden, yaklaşım yapılınca mucizeler gelişebilmektedir.
Zehirlenme ile gelen bir çocukta, 1970 yıllarında bırakın diyen kıdemliye inat, 12 saat, sabah 06:00 kadar el ile ventile etmiş, çocuk 7:00 iken ortalığı koşarak dağıtması üzerine, kıdemli bu kim deyince, akşam bırakın ölsün dediğin çocuk demiştim.

SUNU-17) Yaşamı Destekleyen Tedavilerin sınırlandırılması (Esirgenmesi veya sonlandırılması) …

- Özerk ve aydınlatılmış bir hasta/uygun vekili tarafından veya ilerisi için dilek vasıtasıyla reddedilen
- Getirdiği yükler sağladığı yararlardan ağır gelen
- Katlanılmaz bir yaşam kalitesini sürdüren
- Boşuna / yararsız olduğu kararına varılan
- Uygun triyaj mekanizmasıyla daha öncelikli hastaların bulunduğu kararına varılan hastalarda Etik açıdan uygundur

Yorum

İzmir'de farklı zamanlarda iki aile, prematüre çocuklarının ventilatörde eziyet çektiği için kapatılması için Savcılığa başvurmuşlar, Savcı yazılı imzalarını aldıktan sonra tutuklanmalarını sağlamıştır.
Ayrıca Çocuk Kuruma Kanunu gereğince, çocukların vesayetlerini alarak Devlet bakımına vermiştir.

SUNU-18) Tanımlar Hekim yardımlı intihar Ötanazi

- Ölümcül dozu hasta alır veya ilacı uygulayacak aleti kendisi çalıştırır.
- Hekim- bilgi sağlayabilir- araç sağlayabilir- ilgili kuruluşlara yönlendirebilir
- Hekim ölümcül dozda bir ilaç (örn. Potasyum klorit) uygular.
- Hekim hem ölüm aracını temin eder hem de ölüme neden olacak uygulamayı başlatan ajandır.

Yorum

İntihara yardım etmek suçtur. İntiharı önlememekte suçtur, bu zor kullanılarak yapılamaz.
Yukarıdaki eylemde olanlar suç ötesinde, amirin suç emrini yapmak ve ihbar etmezlerse de suç işlemiş olurlar.

SUNU-19) Bazı ülkelerde yasal düzenlemeler Hekim yardımlı intihar Ötanazi

- Türkiye – 2004 TCK m. 84 yeterli kişiler için teşvik/yardım 10 yıla kadar; yetersizler için kasten adam öldürme
- İsviçre – 1941
- Oregon – 1997 (sınırlı uygulama)
- Hollanda – 2002
- Washington – 2008
- Lüksemburg – 2009
- İngiltere?

• Türkiye – 2004 TCK hüküm yok – 1998 HHY m. 13
• Hollanda – 2002
• Belçika – 2002
• Lüksemburg – 2009 •
• İngiltere?

Yorum

Ülkemizde kanunen kasıtlı adam öldürmeye girer.
Sessiz kalmak da suçtur.

SUNU-20) Koşullar
• Karar verme kapasitesine sahip hastanın gönüllü talebi
• Devam eden bir hekim-hasta ilişkisi
• Hasta ve hekim tarafından karşılıklı katılımla alınmış aydınlatılmış karar
• Destekleyen ancak eleştiren ve sorgulayan bir karar verme süreci
• Alternatiflerin düşünülüp tartılarak reddedilmiş olması
• Hastanın ölüm talebinin tekrarlayarak ifade edilmiş olması
• Hastanın dayanılmaz ağrı-acı içinde olması
• En az ağrı-acı veren ve rahatlama sağlayan araçların kullanılması

Yorum

Bu koşulları söyleyen de suça ortaktır.
Açlık grevinde de şekerli su verilmesi yanında, devamlı yaşam konusunda destekleyici yaklaşım yapılması, ölümün geciktirilmesi gerekmektedir.

SUNU-21) Gönüllülük bildiremeyenlerde (nonvoluntary) ötanazi Groningen protokolü, 2005
• Tanı ve prognozu kesin
• Umutsuz ve katlanılmaz ağrı-acı
• Tanı, prognozu ve katlanılmaz ağrı acı için bağımsız bir başka hekim görüşü
• Ebeveynin ortak aydınlatılmış kararı
• Kabul edilmiş tıbbi uygulamalara uygun işlemler

Yorum

Groningen Protokolünde de Savcının dava açmayacağı umut edilir demektedir. Buna karşın Yaşam Hakkı olanlar 2006 Açıklamalarında yaşama dokunmayın vurgusu vardır.
2006 Yaşam Hakkı konusu bu Makalede ayrıca irdelenmektedir.

SUNU-22) Sonuç o Ülkemizde YDT kararlarında yasal endişeler ön plandadır (Akpınar, 2005).
--Buna rağmen YDT sınırlandırma kararlarının verildiği az sayıda da olsa bazı çalışmalarla gösterilmiştir (İyilikçi ve ark, 2004; Bilgen, 2009; Özcan Şenses, 2009).
--Bu nedenle öncelikle uygulamada YDT'nin sınırlandırılması kararlarının nasıl gerçekleştiği konusunda geniş kapsamlı tanımlayıcı çalışmalara ihtiyaç vardır.

Böylece;
• İlgili uzmanlık derneklerinin konuyu hukukçular ve yasa yapıcıları da içine alan çeşitli platformlarda tartışmaya açması,
• TTB Etik Bildirgeleriyle başlayan politikaların desteklenmesi ve
• Tüm bu çabaların yasal düzenlemelerin oluşumuna kaynaklık etmesi mümkün olabilir.

Yorum

Yasal düzenlemeler yaşam hakkıdır, etik yaklaşımlar belirli kültürel yapı olup, Birey Hakkı kültürüne tamamen terstir. Hukukçular bunu tartışmış ve 2006 yılından bu yana, Türk Ceza Kanunu da 2005 yılından itibaren birey hakkını temel almıştır.
Hukuk yaklaşımı doğru boyutta olup, bu Makalede haklılık konusu işlenmektedir.
SON SÖZ: Ülkemizde Kanun ile Ötenazi yaklaşımı suç olarak tanımlanmış ise, aynı zamanda amir emri bile olsa suç unsuru yapılmaz, Anayasal bir emir ise, TCK göre sağlık personelinin sessiz kalması da suç olarak nitelendirilmiş ise, TCK 215 Maddesine göre işlenmiş olan bir suçu veya işlemiş olduğu suçtan dolayı bir kişiyi alenen öven kimsenin, bu nedenle kamu düzeni açısından açık ve yakın bir tehlikenin ortaya çıkması hâlinde cezalandırılabileceği açık olduğuna göre, letting to die dahil, tedavi etmeme, kaçınma, ölmeye yardım suçtur. Hasta kendi rızası ile ölüm orucunda oluğu gibi reddedebilir, ancak sağlık personeli bu işe olumlu bakmamalıdır.
Bir Neonatoloji Profesör arkadaş, hazırladığı yayınını incelememi rica etmişti, ben Savcılığa gider, ihbar ederim, onlarda sizden kim diye sorar, gizlilik kalkar ve suçlu duruma düşersiniz dedim ve yayınını göstermedi, sadece toplantıda ötenazinin %14 olduğunu hatırlarım, onu da unutun, dedim, çünkü bu bile suç kapsamına girer demiştim.

Kanunsuz Emir Yerine Getirilemez[16], Suçu Bildirmeme de suçtur[17]

Kanunsuz emir:
Anayasa 137. Maddesi ve buna dayanarak olan TCK aynı şekilde vurgu yapmaktadır.
J. Kanunsuz emir: MADDE 137- *Kamu hizmetlerinde herhangi bir sıfat ve suretle çalışmakta olan kimse, üstünden aldığı emri, yönetmelik, tüzük, kanun veya Anayasa hükümlerine aykırı görürse, yerine getirmez ve bu aykırılığı o emri verene bildirir. Ancak, üstü emrinde ısrar eder ve bu emrini yazı ile yenilerse, emir yerine getirilir; bu halde, emri yerine getiren sorumlu olmaz. Konusu suç teşkil eden emir, hiçbir suretle yerine getirilmez; yerine getiren kimse sorumluluktan kurtulamaz.*

- **TCK: *Kanunun hükmü ve amirin emri:* Madde 24-** (1) Kanunun hükmünü yerine getiren kimseye ceza verilmez. (2) Yetkili bir merciden verilip, yerine getirilmesi görev gereği zorunlu olan bir emri uygulayan sorumlu olmaz. (3) Konusu suç teşkil eden emir hiçbir surette yerine getirilemez. Aksi takdirde yerine getiren ile emri veren sorumlu olur. (4) Emrin, hukuka uygunluğunun denetlenmesinin kanun tarafından engellendiği hallerde, yerine getirilmesinden emri veren sorumlu olur.

Suçu Bildirmeme:

- **TCK: S*uçu bildirmeme:* Madde 278-** (1) İşlenmekte olan bir suçu yetkili makamlara bildirmeyen kişi, bir yıla kadar hapis cezası ile cezalandırılır. (2) İşlenmiş olmakla birlikte, sebebiyet verdiği neticelerin sınırlandırılması halen mümkün bulunan bir suçu yetkili makamlara bildirmeyen kişi, yukarıdaki fıkra hükmüne göre cezalandırılır. (3) Mağdurun onbeş yaşını bitirmemiş bir çocuk, bedensel veya ruhsal bakımdan özürlü olan ya da hamileliği nedeniyle kendisini savunamayacak durumda bulunan kimse olması halinde, yukarıdaki fıkralara göre verilecek ceza, yarı oranında artırılır.

- **TCK: K*amu görevlisinin suçu bildirmemesi:* Madde 279-** (1) Kamu adına soruşturma ve kovuşturmayı gerektiren bir suçun işlendiğini göreviyle bağlantılı olarak öğrenip de yetkili makamlara bildirimde bulunmayı ihmal eden veya bu hususta gecikme gösteren kamu görevlisi, altı aydan iki yıla kadar hapis cezası ile cezalandırılır. (2) Suçun, adlî kolluk görevini yapan kişi tarafından işlenmesi halinde, yukarıdaki fıkraya göre verilecek ceza yarı oranında artırılır.
- **TCK: *Sağlık mesleği mensuplarının suçu bildirmemesi:* Madde 280-** (1) Görevini yaptığı sırada bir suçun işlendiği yönünde bir belirti ile karşılaşmasına rağmen, durumu yetkili makamlara bildirmeyen veya bu hususta gecikme gösteren sağlık mesleği mensubu, bir yıla kadar hapis cezası ile cezalandırılır. . (2) Sağlık mesleği mensubu deyiminden tabip, diş tabibi, eczacı, ebe, hemşire ve sağlık hizmeti veren diğer kişiler anlaşılır.

Yaşam Hakkı temel olduğuna göre ötenazi dahil, özellikle prematüre dahil, tüm canlı doğanlara yaklaşım yapılmalıdır.

Başlıca hakları tanımlayan özet noktalar:

- **İnsan Hakları**: İnsan Haklarına Saygı Zorunluğu: Her bireyin hür ve eşit onuru ve hakları olduğu belirtilmektedir. Birbirleri ile kardeşlik bağı ile bağlı olduğu belirtilmektedir.
- **İnsan Hakları**: Her bireyin yaşam hakkı, hürriyeti/özgürlüğü ve birey olarak güvenliği olmalıdır. İşkencenin yasaklanması da bu kapsamdadır.
- **Avrupa Sözleşmesi:** Yaşam'ın ne olduğu ya da ne zaman başlayıp ne zaman sona erdiği –açıklığa kavuşturulmamıştır.
- **Avrupa Sözleşmesi:** Eğer biri yaşam hakkından keyfi olarak mahrum bırakılırsa diğer tüm haklar (32 adet İnsan Hakkı) anlamsız olacaktır.
- **Avrupa Sözleşmesi:** Devletler ölüm olaylarını araştırma "pozitif yükümlülük" olarak yapılmalıdır.
- **Avrupa Sözleşmesi:** Doğmamış yaşama kapsamında koruma yolları verildiği açıktır.
- **Avrupa Sözleşmesi:** Hamileliğin sonlanmasının sadece annenin özel hayatının bir meselesi olduğu şeklinde yorumlanamaz.
- **Tıbbi Deontoloji/Etik İlkeler**: 1) Hastayı İyileştirme Garantisi Vermeme Hakkı: 2) Hastanın hayatını kurtarmak ve sıhhatini korumak mümkün olmadığı takdirde dahi, ıstırabını azaltmaya veya dindirmeye çalışmakla mükelleftir. 3) Ananın hayatını kurtarmak için yegâne çare teşkil ettiği takdirde, avortman yapılması caizdir.

Tarihsel boyut olarak başlıca özet noktalar:

- **(Letting to die) 1982** Yılında Down Sendromlu, özefegeal atrezili, trakeo özefegeal fistülü olan olgunun, besin ve sıvı verilmesi kesilerek, ölüme terk edilmesidir.
    - Savcı, suç duyurusunda bulunuluyor: Savcı 1973 Rehabilitasyon Yasasını çocuk istismarı nedeniyle suç duyurusu yapıyor.
    - Trakeal atrezisi tedavi edilmelidir: 1984 KARAR, 1985 yürürlüğe girmiştir. 1986 yılında mahkeme: Bebek geriye dönülmez olarak komada veya "futile/gerçekten yarasız/anlamsız" tedavi denilmesine karşın ABD Yargıtay, Down Sendromu değil, sorun Trakeal atrezi olunca, Yargıtay'ın kararında Tedavisi varsa Tedavi geri çekilemez denilmektedir.
    - 1982 yılında Başkan Reagan, kendileri konuşamadığı, kendilerini ifade edemeyenler için Etik Kurulların devreye girmesini ve "*Sağlık Bakım*

Kararlarının Oluşturulmasını" etik kurullara bırakılması hukuk yaklaşımını getirmiştir.

- **Tüm canlı doğanlar koruma altına almıştır**. Çocuk İstismarı Hakkında 2002 yılında Canlı Doğan Bebeklerin Korunma Yasası çıkarılmıştır.
- 2004 yılında YASAL kuralların eşit olmadığı ve soyut kavramlar olduğunu tanımlanmıştır.
- 2007 Amerikan Pediatri Akademisi "***best interests standard–ilgiliye en iyi standardını***" koymuştur.
- Recommendations for end-of-life care in the intensive care unit: a consensus statement by the American College of Critical Care Medicine. Crit Care Med 2008
- National Consensus Project for Quality Palliative Care; 2009
- 2009 ACOG Life-limiting illnesses or conditions

ÖZET:

- **Halen ülkemizde bu durum bilerek ve kasten adam öldürme anlamındadır (TCK 80-81)**
  - **Dikkat ve Özen eksikliği düşünürse suç TAKSİR olmaktadır.**
    TCK: Madde 89- (1) Taksirle başkasının vücuduna acı veren veya sağlığının ya da algılama yeteneğinin bozulmasına neden olan kişi, üç aydan bir yıla kadar hapis veya adlî para cezası ile cezalandırılır. (2) Taksirle yaralama fiili, mağdurun; (e) Yaşamını tehlikeye sokan bir duruma, Neden olmuşsa, birinci fıkraya göre belirlenen ceza, yarısı oranında artırılır. (3) Taksirle yaralama fiili, mağdurun; a) İyileşmesi olanağı bulunmayan bir hastalığa veya bitkisel hayata girmesine, b) Duyularından veya organlarından birinin işlevinin yitirilmesine, Neden olmuşsa, birinci fıkraya göre belirlenen ceza, bir kat artırılır. (5) Bilinçli taksir hali hariç olmak üzere, bu maddenin kapsamına giren suçların soruşturulması ve kovuşturulması şikâyete bağlıdır.
- **Etik ile Yasa karşı karşıya gelmektedir.**
- **Avrupa'da Groningen Protokolü dışına olumlu bir yazı olmadığını gördüm ve bu Protokol Avrupa'da da dava açılmasını engelleyen bir durum oluşturmamaktadır, kısaca dava açılır ama kararı jüri verdiği için ceza almayabilmektedirler.**

Sonuç

Toplumların kültürel yaklaşımları belirli farklı adalet mekanizmaları içinde olabilirler. Çoğunluk değil, bireyin hakkı önemlidir ki en temel olan da yaşam hakkıdır.
Gebelik ve yenidoğan bebek tüm insanlığı var oluşun ilk basamağı ise bu konuda tıbbi bakım ve destek de kaçınılmaz beklenti olmalıdır.

Bir olgu Sunumu: 7 defa gebeliği olan ama çocuklarını ilk haftalarda düşüren yaşı da ilerlemiş bir anne, Perinatoloji destek ile gebe kaldı. Gebelik izleminde, listede olan bir durum söz konusu olduğu için, tahliye önerildi ama anne kabul etmedi. Bebek an-ensefalili idi, ama yaşadı. Çok sorunlar yaşadı bizim bakımızda iken, anne bebek 6 aylık ölünce, teşekküre geldi. Ben dedi, bebeğimi kucağıma aldım, onun kokusunu ve emzirmeye çabalamak ile bir mutluluk hazzı aldım. Anne olduğumu hissettim. Yaşatma mücadelesinde de yaptıklarım tümden onu sahip olmamdı demiştir. Hekimlerin bırakın ölsün dememeleri de beni ziyadesiyle insanlığa güvenimi arttırdı, teşekkür ederim demiştir.

Engelli annelerin mutluluğunu hissetmelidir. Down sendromlu çocuklar devamlı güler yüzlü oldukları için anneleri çok severler ve daha sonra Şehrimizde iş verme yerleri olduğu için, izlemde onların mutluluğuna şahit olmuşuzdur.

Bir örnek ile olay tarihsel süreç içinde daha net ortaya konulabilir. Pamukkale Harabelerini yürüten Jeolog bana o dönemin hukuk kitabını İngilizce'ye dönüştürmüş ve hediye etti. Her eyleme bir ceza verilir, ancak benim dikkatimi ne çekmeli diye sordum. Sosyal sınıflara göre cezalardaki değişimlere bakmamı önerdi.
OLAY Keçinin ırzına geçmek idi: a) Köylü bu suçu işlemiş ise, öldürülüyor, keçi ise ziyafet ile yeniliyor, b) Tüccar işlemiş ise, para alınıyor, ziyafetin bedelini de ödüyor ama katılmıyor, c) Komutan eğer bu suçu işlemiş ise, niye bu gereksinimi normal yolla karşılanmadığı için hizmetkarlarına ceza veriliyor, ziyafete o da çağırılıyor, keçi yeniliyor.

Toplum jüri sistematiğinde, Amerika'da zenciyi öldüren polis ceza almaması gibi, eli silaha benzettim demesi yeterli olmaktadır. Aynı şekilde bu prematürenin yaşaması ile sekelli olacaktır denilmesi ile letting to die yapılmaktadır. Hukuksal birçok olay olmasına karşın, Baby Doe davasında da olay Trakeal Atrezi değil Down sendromu olarak niteleyip, tedavisiz hastalık olarak yorumlanması ile ceza alınmamıştır. Halen birçok olay Amerika ve diğer ülkelerde sürmekte, aileye biz ödemeyeceğiz, rıza vermezsen parayı ödersin demektedirler. Zaten bu yaklaşımı alan bebekte salık personelinin dikkatli ve özenli bakılmadığı da bir gerçektir.

Sonuç, bebeğe her tülü yaşamsal destek sağlayın, bebek yaratılış gereği kendisi ölsün. Yaşaması zor olanlarla tıbbi uğraşmak, birçok beceri ve tecrübe kazandıracağını da unutmamalıdır. Hem huzurlu ve akşam rahat uyursunuz.

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