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Social, Health and Family Affairs Committee

Minutes

Hearing on "Living wills and the protection of health and human rights", held in Paris on Thursday, 19 May 2011

The Chairperson of the Social, Health and Family Affairs Committee, **Ms Maury Pasquier**, opened the hearing and gave the floor to Mr Xuclà i Costa, rapporteur, for a brief introduction.

Mr Xuclà i Costa stated that he preferred to be brief, as he believed that listening to the experts was the priority of this meeting. The topic of living wills was very important to him and he made it very clear that he did not wish to extend the topic to other related debates such as euthanasia.

Ms Erny, Head of the Rights, Ethics and Legal Support Division of the Ministry of Labour, Employment and Health (France), as well as representative of the Steering Committee on Bioethics (CDBI) of the Council of Europe, gave an overview of the legal situation in Europe based on the symposium on the decision-making process regarding medical treatment in end of life situations organised by the CDBI on 30 November - 1 December 2010 in Strasbourg. Seen as an excellent introduction to the following exchange of expertise and views and a fundamental contribution to the upcoming report, her full presentation has been added to the present document as an Appendix.

Prof. Lorda, Lecturer on Bioethics at the Andalusian School of Public Health, Granada (Spain), discussed the legal framework and use made of advanced directives (AD) in Spain. He pointed out that the consideration of "previously expressed wishes" of patients was covered by Article 9 of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (opened for signature in 1997). In Spain, so called "healthcare directives" are covered under Article 11 of the Basic Law 41/2002 of 14 November for the Regulation of Patient Autonomy, Rights and Obligations with regard to Medical Information and Documentation. According to this law, any person of legal age may state, in written form, his or her wishes with regard to healthcare and treatment and to the use of their body and organs after their death. They may also appoint a proxy who will oversee the respect of his or her wishes in relation with the medical staff. It is then up to the health department of each of the Spanish regions to regulate relevant procedures ensuring that the right of each patient is respected. Another important reference document was Recommendation CM/Rec(2009)11 of the Committee of Ministers to member states on principles concerning continuing powers of attorney and advance directives for incapacity which covered the contents, effects, forms and possible revocation of advanced directives under principles 14 – 17.

Concerning the application of ADs in Spain, **Prof. Lorda** specified that they had to be filled out either before a notary, before three witnesses (at least two of whom must not be related by kinship or estate) or by a government civil servant (normally an employee of the Living Will Registry of the Autonomous Region), and that the direct participation of health professionals was not required. This detachment of

* Declassified by the Committee on 21 June 2011.

ADs from a clinical context, where decisions in end of life situations were normally taken, constituted a serious problem in his view. Although ADs were increasingly registered for both sexes, there was clearly a higher number of women expressing their wishes in advance (61%). In accordance with the number of autonomous regions in Spain, there were 17 regional registries, where the lodging of ADs was generally voluntary but recommended (only three regions have made registration compulsory). Registries were generally computerised, thus allowing health care professionals to access ADs via computer or phone. Spain does not possess private registries such as those in the United States. A national registry is under construction and shall link up all the regional registries.

The main problem encountered in the field of ADs, according to **Prof. Lorda**, was the very low implication of the central government (Ministry of Health), of scientific and professional associations and the Medical College. Certain legal aspects still needed to be clarified, such as the validity of ADs between different regions and countries. In some cases, contradictions could be observed in the position of the Catholic Church. The implementation of ADs still required enhancement at the level of autonomous regions (limited political implication of regional governments, little active information of citizens (only passive information on request), bureaucratic registration processes, complicated documents, no links between administrative and clinical processes, only limited training for professionals, access to and consultation of the Registry. According to figures obtained through a survey in Catalonia in 2007/2008, only 42% of persons interviewed had ever heard about the law regulating ADs, only 21% had thought about filling one in, and only 5% had actually done so already. A Spanish national survey in 2009 brought to light the same low levels of knowledge about ADs and their consideration as a personal choice.

Prof. Lorda then concluded his presentation by sharing with members some of the proposals made by the region of Andalusia, which is relatively advanced in this field and where the registration of ADs through an official form is compulsory. To reinforce and facilitate the use of ADs, it is notably suggested to ask scientific and professional associations to get more strongly involved in information and training programmes as well as the development of advance care planning programmes. Existing forms should be reviewed and made easier to understand, whilst both patients and professionals should be provided with guidelines on how to fill them in. Registries should be further decentralised and should involve hospitals and primary care centres. Registered ADs should be automatically included into electronic clinical records where they exist. Information flows concerning ADs should be enhanced (use of call centres, consultation of registries by professionals, etc.).

Mr Andorno, Institute of Biomedical Ethics University of Zurich (Switzerland), explained that there were very different legal approaches to Advanced Directives among European countries, and that the European Convention on Human Rights and Biomedicine (Oviedo Convention) remained insufficient in this regard. He explained the basic understanding that both the informed consent to treatment and the refusal of consent were two different expressions of the patients' right to "self-determination", and that ADs were meant to help patients exercise this right when they had irreversibly lost their decision-making capacity. The term "AD" included two kinds of documents which can be combined: 1) living wills, written documents established to anticipate situations where decision-making may not be possible anymore, and 2) power of attorney through which individuals may appoint someone to make healthcare decisions on their behalf in the future if they lose the ability to do so. According to the expert, European countries had very different or no legal standards on ADs. This led to particular difficulties if health care decisions needed to be taken in a country other than the one where patients lived. Currently, four groups of countries could be distinguished for their legislation (categories followed by selected examples):

- Countries where specific laws have been adopted making ADs legally binding (Austria, Belgium, Finland, Germany, Hungary, the Netherlands, Spain, Switzerland, United Kingdom);
- Countries where specific laws on this matter have been adopted in recent years, though these documents are not legally binding (France);
- Countries where there is no specific legislation yet, but which are planning to introduce it in the next few years (Italy);
- Countries where there is no specific legislation yet and which do not have concrete plans to introduce it in coming years (Bulgaria, Greece, Lithuania, Norway, Portugal, Serbia, Slovakia, Turkey).

Mr Andorno referred to the European Biomedicine Convention which provided that "the previously expressed wish related to a medical intervention by a patient who is not, at the time of the intervention in a state to express his or her wishes shall be taken into account". However, the Convention remained vague on the legal effect of such documents and did not specify the extent or conditions under which patients' rights must be taken into account, which would allow health care professionals to decide arbitrarily. Although the Council of Europe Recommendation (2009)11, unlike the Oviedo Convention, also explicitly referred to powers of attorney, it remained insufficient according to the expert. At a recent workshop at the Institute of Biomedical Ethics of the University of Zurich (2008), international experts agreed that Article 9 of the Oviedo Convention was the appropriate starting point for common European rules, but that it remained too vague on living wills and even more so regarding powers of attorney. Some experts, however, considered that the dissemination of information about ADs amongst patients and the respect of such ADs by medical practitioners were even more important. Moreover, even in countries where ADs were "binding", they did not represent an absolute value, but could be disregarded for certain reasons, which meant that the difference between "binding" and "non-binding" ADs needed to be examined once again. International experts generally agreed that a common form or model of AD could be helpful in facilitating its implementation across Europe, as would a European network of registries between which information on ADs could be exchanged if need be, for example for travelling people.

In his final remarks, **Mr Andorno** noted that national approaches varied according to the degree of patient autonomy, which was given prominent value in some countries whilst others relied on more "paternalistic" decision-making structures. All countries generally agreed that ADs could play a positive role in health care practice, but Article 9 of the Oviedo Convention needed to be completed with more specific standards in order to reach a higher level of harmonisation between national legislation and practices.

Prof. Butenko, Head of the International Scientific Relations office of the National Academy of Medical Sciences, Kyiv (Ukraine), reported that national laws concerning living wills did not exist in Ukraine for the time being. The level of interest in this issue was generally very low as a majority of people were pre-occupied with access to basic services in the context of the current deficient health care system. According to him, the country did not have a tradition of openly informing patients about their actual condition, but doctors would rather inform close relatives in order to protect patients themselves from devastating psychological effects. Overall, there was still a strong belief that doctors know best what to do and when to stop life-prolonging treatments. Nevertheless, living wills may get introduced soon, given that there was a lively public debate on issue, in which the two "camps" of doctors and patients were confronting each other. However, the delegation of "power of attorney" had fewer chances of being introduced, as most people had too little confidence in the judicial system. According to the expert, Ukraine was urgently in need of common recommendations to be proposed by the Assembly and of a roadmap for introducing living wills.

Mr Barbi thanked all experts for the most interesting presentations. He referred to the example of Italy where attempts where currently being made to ban any measure allowing the patient to refuse hydration or nutrition. Italy's constitution enshrined the right to refuse treatment – but was hydration and nutrition treatment? He wondered if such discussions were also taking place in other countries. For him, living wills allowing individuals to express their own wishes, were an expression of the state of civilisation. As far as Germany was concerned, **Mr Barbi** wondered if there was a common position presented by the Catholic and Protestant churches, and if so, what effect did it have?

Mr Huss asked if it was possible to receive a copy of all presentations shown during the hearing, and noted the complexity of the issue which was closely linked to those of palliative care and euthanasia. He pointed out that an aspect not to be forgotten was the one of patients' rights whilst being with an individual medical practitioner and at home (and not only in hospital as previously mentioned). Furthermore, for him the access to ADs was not equal, given that mostly people of a certain intellectual level seemed to decide to register them. He confirmed that national legislation needed to specify to what extent medical staff needed to respect patients' wills, and that living wills needed to be precise, registered and updated – without ever leaving out one of these steps.

Mr Xuclà i Costa, after having listened to all experts' presentations, also considered that the term of Advanced Directives was more complete and appropriate, even for the title of his report. Many questions needed to be examined: What could be the degree of a patient's self-determination without the involvement of a doctor? Was a member of the family the best representative for a patient or were they generally too biased (financial interests)? How to make public registers a compulsory measure in all countries?

Ms Rupprecht reported on Germany where parliamentarians were well informed through the work and conferences of the German Ethical Council ("Deutscher Ethikrat"). Doctors were generally obliged to respect patients' rights even without a registered AD, even children were asked about their wishes. The whole issue also needed to be seen in the context of health rationing and the prioritisation of medical services provided. Finally, it was important to also think of situations where decision-making was urgent but where ADs registered by patients were not immediately accessible; a possible solution might be an electronic chip implanted into the body which carried all relevant information?

Mr Andorno, replying to Mr Barbi, confirmed that in some countries cessation of the provision of nutrition to the patient was illegal (such as in the United Kingdom through the Mental Capacity Act of 2005, or in Austria). According to his knowledge, in Italy, the provision of artificial nutrition could not be stopped either.

According to **Prof. Lorda**, three autonomous regions of Spain dispose of legislation on this point and have regulated that any treatment could be withdrawn if so wished by the patient and should not be imposed on a patient when he or she does not wish to receive it. But the question was still being debated in Spain whether artificial hydration and nutrition constituted treatment or general care. The question of self-determination was closely linked to the binding effect of living wills. A doctor needed the informed consent of a patient before he/she could be treated. If a patient refused treatment (for example, a blood transfusion), there was no informed consent, and thus the doctor had no right to treat the patient against his/her will, even if this endangered the patient's life. Of course, the opposite was also true: if a patient wanted a certain treatment which was clinically not indicated or illegal, the doctor had the right to refuse that treatment.

Prof. Butenko once again insisted on the fact that this was not the main problem in Ukraine where about 90% of the people had no health insurance and 80% of patients died at home without having access to hospices.

Mr Andorno expressed his belief that an additional protocol to the Oviedo Convention could be a useful tool in establishing clearer criteria related to ADs. In his view, the relatively advanced Swiss legislation, or the German law on legal "guardians", could serve as models for European standard-setting processes.

The Chairperson, in light of the limited time left for discussion, cut short the discussion, noted a general agreement for a change in the title (to include the term of "Advanced Directives"), and asked all experts to kindly provide in writing possible further information in reply to the questions raised by the members.

Mr Xuclà i Costa thanked the experts for the valuable contributions, but admitted that he was not in a position to draw immediate conclusions after the great amount of information received. He would therefore propose his conclusions in writing in a revised version of his text, the debate of which was only foreseen for the January 2012 part-session. He wished, however, that the issue of patients' "self-determination" be a central one of his report. This was, for him, part of the common standards of quality of life that all Council of Europe member states should support.

Appendix

Advance directives / living wills
Lessons of the symposium (30 November - 1 December 2010) on the decision-making process regarding medical treatment in end of life situations

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The question of advance directives/living wills is linked to end of life issues. It is a matter of enabling the person to state, in advance, his/her choices regarding the decisions which will have to be taken about his/her end of life medical treatments and care, should he/she no longer be able to express his/her wishes personally. Advance directives (ADs) are a means of bringing the expression of sick people's wishes back into play at a time when they can no longer express them themselves.

From the legal and human rights standpoint, ADs are one of the possible answers to the problem posed by the person's deficient willpower at the time of the end of life decision-making process. By allowing the expression of the person's will to be taken into account, they guarantee respect for his/her dignity, central to the principles of the European Convention on Human Rights. More specifically, they allow the concerns of the Convention on Human Rights and Biomedicine to be met as regards the application of the principle of consent, an essential bioethical principle.

The Parliamentary Assembly, as from its 1976 resolution, then regularly in the following recommendations on the human rights of the terminally ill, recognised the importance of advance directives in applying the principle of respect for human dignity and the principle of personal autonomy.

The symposium on "*the decision-making process regarding medical treatment in end of life situations*" organised with the CDBI at the end of 2010 devoted a whole session to the question of ADs which enabled us to take stock of (1) the ethical and legal foundations of this type of instrument, (2) the current state of existing legislation at European level and the developments proceeding in the member states, and principally (3) the state of collective thinking in the matter. At all events, the question of ADs was evidently crucial in the framework of a study on end of life situations.

I – A consensus on the principles underlying reflection on ADs

1) General principles:

On a legal plane, it is clear to all that advance directives have their foundations in the application of:

- the principle of personal **autonomy** discerned by the European Court of Human Rights for the application of **Article 8 of the European Convention on Human Rights** on the right to privacy; there can be no intervention affecting the person without his or her consent;

- **the principle of primacy of the human being and more precisely the principle of consent** enshrined in **Articles 2 and 5 of the Convention on Biomedicine**.

It follows from these principles that the patient must not be manipulated and that his/her **will**, when clearly expressed, must prevail even if it signifies refusal of treatment: **no-one can be compelled to undergo a medical treatment against their will.** Consent, the principle that underpins the sector of patients' rights and bioethics, is the prime expression of the principle of personal autonomy.

Accordingly, **in end of life situations**, as long as a patient can express his/her will, he/she must be **associated in the decisions** that determine his/her treatment and the adaptation thereof; he/she may request its limitation or even cessation; no intervention and no treatment may be administered to him/her against his/her will, even if the prospect of survival is affected by desisting. The right to withdraw consent is indeed the corollary to the principle of giving consent.

2) A more specific provision in the Convention on Biomedicine

But what is the position when a patient can no longer personally participate in the decision-making process? Which legal instruments can ease this situation and let the process incorporate a prior expression of will?

A decision "in the place" of the patient, even on an institutional basis (legal representations or agent appointed beforehand) may appear unsatisfactory and raises awkward questions, particularly where the decision concerns a limitation or cessation of treatment. The Convention on Biomedicine offers an answer; **consideration of previously expressed wishes as provided in Article 9** is thus a worthwhile avenue:

"The previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account."
This is therefore the context in which instruments such as treatment protocols settled between the patient and practitioner, living wills and advance directives are placed.

The authors of the Convention on Biomedicine, as the explanatory report points out, did not wish to give the provision binding effect. Wishes shall be "*taken into account*" by the doctor who, though under an obligation to enquire about them, is only bound by them in so far as they are consistent with the present situation and with the patient's interests. There is thus **a margin of discretion** in order that the instrument does not backfire on the patient and operates in a suitable and up-to-date manner. In the Convention on Biomedicine, "previously expressed wishes" are therefore an **indicator of the patient's will** for the doctor which he cannot disregard, although he retains the **possibility of reassessing** the patient's wishes in the light of the actual situation that presents itself, and of advances in medicine especially.

The Article 9 provision, however, raises no impediment to state arrangements for regular living wills with binding effect.

II – Situation in the member states (see R. Andorno's contribution)

III – State of thinking; content of debates,

Above and beyond agreement on the principles (respect for the dignity of the human being presupposing recognition of the principle of personal autonomy, the latter relying on the person's free and informed consent), their gradations, hence the **legal situations** in the European states **as regards taking account of wishes previously expressed by the person, are disparate.**

1- A first distinction relates to the means of expressing will, which may be direct or indirect

- **means of indirect expression of will**: those which pertain to trusted persons, authority to act, or power of attorney. These devices are themselves subject to variation; either the designated person testifies to what he or she thinks would be the will of the patient if the latter could still express it, or the designated person is instructed to represent the patient's best interests when the decision is reached;
- **means of direct expression**: those allowing the patient's will to be reconstituted without go-betweens. This is where **living wills and advance directives (or decisions) can be placed**, as also could the **treatment protocols** settled with the practitioner, whose ambit is no doubt wider but which can also anticipate the progressive stages of the disease and the decisions concerning them.

2- With specific reference to advance directives, there are several sources of disparities

The first disparity concerns the **existence or otherwise of specific legislation.**
Next, even if such legislation exists, the mechanisms may give advance directives **a greater or lesser binding effect.** Consequently, there are **a number of variants in the terms** attached to these ADs, and the variants match the questions that ADs inevitably raise:

1°) What should be the ambit and the content of ADs:

- Some participants in the symposium asserted that advance directives could only concern **"negative" decisions** such as a request to limit or terminate treatment. Advance directives would thus be distinct from **treatment protocols**.
- But should ADs not concern **only treatments and health care**, or may they address other questions relating to the organisation of care and the patient's living conditions?
- More generally, in order to be validated, must they be **specific and precise**, or general in scope? Both propositions have pitfalls: ADs are either too precise, leaving no room for medical interpretation with a view to their adaptation, or too general, precluding any certainty that the wish expressed will really be complied with.
- In any case, however precise they may be, there is a limit: **they cannot be contrary to law** (a request for euthanasia in a country that would not countenance it, for example).

2°) Should a term of validity, a requirement of periodic restatement, be prescribed?
Depending on the pathologies, the answers may differ in this respect. The closer to reality the intentions are, the more valid they seem, hence the desirability of arrangements for periodic renewals and limited terms of validity. However, with neurodegenerative diseases, it must be possible to invoke wishes expressed well before, prior to the deterioration of the patient's mental condition making the valid restatement of his/her will impossible for him/her.
On the other hand, reversibility is accepted by all.

3°) Connected with the foregoing point, **how can one evaluate the capability or incapability** of the patient resulting in recourse to ADs? This question has two implications for the issue under discussion:

- **when ADs are drawn up:** if drawn up out of context and in the abstract, when the person is still in possession of his/her full capabilities, what indeed is their value? On the contrary, if drawn up while the patient is admittedly in a position to grasp the consequences of his/her illness but his/her faculties may already be affected by it, likewise, what is their value? The possible instances of application are extremely varied, ranging from chronic illness each stage of which the patient can grasp and accommodate, and in respect of which he or she can decide in full knowledge of the facts (but there are also contingencies that can only have been envisaged in the abstract) to neurodegenerative illnesses that impair the cognitive faculties, as with Alzheimer's disease: here, the absence of expression of will may alter with time. Another complex question is mental illness; severe depression does indeed affect the will of sufferers.

- At which stage are ADs to be consulted and implemented? The patient is not always unconscious (coma, vegetative state), his/her will may simply be impaired by the illness. Are they to take precedence over every other opinion? In opposition or in combination? Who is to assess their relevance and according to which criteria: the doctor, the judge, or a board?

These questions about the value of the wishes expressed, be they immediate or anticipated, are definitely of central concern in the problems relating to respect for the dignity of a person in an end of life situation. They were brilliantly handled by Professor Jochen Vollmann (a German psychiatrist) at the symposium.

4°) Preference as to degree of formalism: the stipulation of **writing** often recurs in the debates; the more we assign a binding value, the more circumscribed the form is, some demanding in addition validation by the doctor, countersignature by two witnesses, etc. Is it a document kept by the person, entrusted to the doctor in attendance, to the hospital administration, or even recorded in a **national register**?

The answers to this set of questions point to the legal nature of the ADs and in particular their binding or non-binding character. In this respect, schematically, two viewpoints seem to coexist: either an AD presents itself as **a clinical tool** contributing to the decision-making process in order to offer the patient the appropriate care (France), or it is an "**administrative" document** which, once the criteria of validity are fulfilled, is binding on the doctor. Between these two 2 schematic viewpoints, there is a whole range of intermediate situations.

Conclusion:

The issue of “wishes previously expressed”, as a guarantee that the terminal ill person’s dignity will be respected by due consideration of his/her will, a goal unanimously endorsed, is actually **complex**. It seems straightforward as an instrument allowing patients to be given their place in the end of life decision-making process. However, it encounters **a major pitfall** in the difficulty for each person to conceive their future life as a patient, their dependence, their death, and thus to anticipate lucidly and pertinently that one day’s truth may not still be tomorrow’s, that the situation may have changed, the personal position too.

To get over this pitfall, the symposium debates let us glimpse solutions: if advance directives were given absolute value, accountability for the decision would be shifted to the patient alone, so balancing devices would need to be introduced. ADs might be regarded as an **instrument conducive to dialogue** between the patient and the doctor or the team of care providers (closer to the treatment protocol concept); they might be **a substantive element in the preparation of the decision in a collective process** also incorporating the testimony of the family and close friends, and the carers’ opinion.

While the symposium allowed worthwhile avenues to be opened up, it also emphasised the need for greater availability of data **on end of life conditions, decision-making arrangements, and especially implementation of the existing advance directive mechanisms**: it would be of special interest to analyse their application in countries which have legislated specifically and in particular where they have given ADs binding effect: how are they applied, followed up, and for what reasons are they disallowed?

List of presence/*Liste de présence*

The names of the members and alternates present at the meeting appear in bold
Les noms des membres et de leurs suppléants présents à la réunion sont indiqués en gras

Chairperson/ *Présidente* :		
Mme Liliane MAURY PASQUIER	Switzerland */ Suisse*	M. Arthur LOEPFE
Vice-Chairpersons/ *Vice-Président(e)s*		
Ms Pernille FRAHM	Denmark / *Danemark*	Ms Pia CHRISTMAS-MØLLER
M. Bernard MARQUET	Monaco	Mme Sophie LAVAGNA
Mr Pieter OMTZIGT	Netherlands / *Pays-Bas*	Mrs Wassila HACHCHI
Members / *Membres*		**Alternates / *Remplaçants***
Mme Lajla PERNASKA	Albania / Albanie	ZZ …
Mme Maria Pilar RIBA FONT	Andorra / Andorre	M. Joan CARTES IVERN
Mr Armen MELIKYAN	Armenia / Arménie	**Mr Gagik BAGHDASARYAN**
Mr Karl DONABAUER	Austria / Autriche	Mr Franz Eduard KÜHNEL
Ms Christine MUTTONEN	Austria / Autriche	Ms Sonja ABLINGER
Mrs Sevinj FATALIYEVA	Azerbaijan / Azerbaïdjan	Ms Ganira PASHAYEVA
Mr Fazil MUSTAFA	Azerbaijan / Azerbaïdjan	Mr Aydin ABBASOV
Mme Cindy FRANSSEN	Belgium / Belgique	M. Philippe MAHOUX
M. Stefaan VERCAMER	Belgium / Belgique	M. Dirk Van der MAELEN
ZZ…	Bosnia and Herzegovina / Bosnie-Herzégovine	ZZ…
Mr Desislav CHUKOLOV	Bulgaria / Bulgarie	ZZ...
Ms Dzhema GROZDANOVA	Bulgaria / Bulgarie	Mr Yanaki STOILOV
Ms Karmela CAPARIN	Croatia / Croatie	Mr Mirando MRSIĆ
M. Fidias SARIKAS	Cyprus / Chypre	Ms Athina KYRIAKIDOU
Mme Daniela FILIPIOVÁ	Czech Republic / République tchèque	Mr Rom KOSTŘICA
Ms Kateřina KONEČNÁ	Czech Republic / République tchèque	Mr Pavel LEBEDA
Mr Indrek SAAR	Estonia / Estonie	Mr Silver MEIKAR
Ms Sirpa ASKO-SELJAVAARA	Finland / Finlande	Ms Tuulikki UKKOLA
M. Roland BLUM	France	M. Laurent BÉTEILLE
Mme Claude GREFF	France	Mme Muriel MARLAND-MILITELLO
M. Denis JACQUAT	France	**Mme Françoise HOSTALIER**
Mme Marietta KARAMANLI	France	M. Jean-Paul LECOQ
Ms Magdalina ANIKASHVILI	Georgia / Géorgie	Mr Rati SAMKURASHVILI
Ms Viola von CRAMON-TAUBADEL	Germany / Allemagne	Mr Manuel SARRAZIN
Mr Andrej HUNKO	Germany / Allemagne	Mr Thomas NORD
Ms Marlene RUPPRECHT	Germany / Allemagne	Ms Doris BARNETT
Mr Bernd SIEBERT	Germany / Allemagne	Ms Gitta CONNEMANN
Mr Konstantinos AIVALIOTIS	Greece / Grèce	Ms Charoula KEFALIDOU
Mr Michail KATRINIS	Greece / Grèce	Ms Sophia GIANNAKA
Mr Péter HOPPÁL	Hungary / Hongrie	Mrs Melinda SZÉKYNÉ SZTRÉMI
Ms Virág KAUFER	Hungary / Hongrie	Mr Gábor HARANGOZÓ
Mr Birkir Jón JÓNSSON	Iceland / Islande	Ms Eygló HARÐARDÓTTIR
Mr Peter KELLY	Ireland / Irlande	Ms Maureen O'SULLIVAN
Mr Mario BARBI	Italy / Italie	Mr Paolo GIARETTA
Mr Roberto Mario Sergio COMMERCIO	Italy / Italie	M. Giacomo STUCCHI
Mr Oreste TOFANI	Italy / Italie	Mr Giuseppe CIARRAPICO

Mr Luca VOLONTÈ	Italy / Italie	Mr Vannino CHITI
Ms Ingrida CIRCENE	Latvia / Lettonie	M. Andris BĒRZINŠ
Ms Doris FROMMELT	Liechtenstein	Mr Leander SCHÄDLER
Ms Arūnė STIRBLYTĖ	Lithuania / Lituanie	Ms Birutė VĖSAITĖ
M**. Marc SPAUTZ**	Luxembourg	**M. Jean HUSS**
Mr Francis AGIUS	Malta / Malte	**Ms Marie-Louise COLEIRO PRECA**
Mr Valeriu GHILETCHI	Moldova	ZZ...
Mr Obrad GOJKOVIĆ	Montenegro/ Monténégro	Ms Snežana JONICA
Mrs Khadija ARIB	Netherlands / Pays-Bas	Mrs Tineke STRIK
Ms Karin ANDERSEN	Norway / Norvège	Ms Ingjerd SCHOU
Ms Bożenna BUKIEWICZ	Poland / Pologne	**M. Zbigniew GIRZYŃSKI**
Mr Mariusz KAMIŃSKI	Poland / Pologne	Mr Maciej ORZECHOWSKI
Ms Anna SOBECKA	Poland / Pologne	Mr Ryszard BENDER
Mme Cecília HONÓRIO	Portugal	ZZ …
ZZ...	Portugal	ZZ...
Mr Cristian DAVID	Romania / Roumanie	Ms Ana Adriana SĂFTOIU
M. Cezar Florin PREDA	Romania / Roumanie	M. Iosif Veniamin BLAGA
Mr Mihai TUDOSE	Romania / Roumanie	Mr Florin IORDACHE
Mr Igor CHERNYSHENKO	Russian Federation / Fédération de Russie	Mr Valery PARFENOV
Mr Oleg LEBEDEV	Russian Federation / Fédération de Russie	Mr Nikolay FEDOROV
Mr Valery SELEZNEV	Russian Federation / Fédération de Russie	Ms Svetlana GORYACHEVA
Mr Vladimir ZHIDKIKH	Russian Federation / Fédération de Russie	Ms Tatiana VOLOZHINSKAYA
M. Marco GATTI	San Marino / Saint-Marin	Ms Assunta MELONI
Mr Miloš ALIGRUDIĆ	Serbia / Serbie	Ms Nataša VUČKOVIĆ
Ms Vjerica RADETA	Serbia / Serbie	Mr Mladen GRUJIĆ
Mr Stanislav FOŘT	Slovak Republic	Mr Štefan ZELNÍK
Mr Ljubo GERMIČ	Slovenia / Slovénie	ZZ...
Ms Meritxell BATET LAMAÑA	Spain / Espagne	**Mr Jordi XUCLÀ I COSTA**
Mme Rosa Delia BLANCO TERÁN	Spain / Espagne	Ms Concepción GUTIÉRREZ DEL CASTILLO
Mr Agustín CONDE BAJÉN	Spain / Espagne	Mme Blanca FERNÁNDEZ-CAPEL BAÑOS
Ms Carina OHLSSON	Sweden / Suède	Mr Morgan JOHANSSON
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Mr Victor YANUKOVYCH	Ukraine	**M. Ivan POPESCU**
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Mr Jeffrey DONALDSON	United Kingdom / Royaume-Uni	Mr Michael CONNARTY
Mr Paul FLYNN	United Kingdom / Royaume-Uni	**Mr Michael HANCOCK**
Mr Sam GYIMAH	United Kingdom / Royaume-Uni	Ms Yasmin QURESHI

Special Guests */ **Invités spéciaux***

Mr / *M.* Roberto ANDORNO, Institut d'éthique biomédicale de l'université de Zurich (Suisse) / *Institute of Biomedical Ethics University of Zurich (Switzerland)*
Professeur Andrii BUTENKO, Head of the international scientific relations office of the National Academy of Medical Sciences, Kyiv (Ukraine) / *Chef du Bureau des relations scientifiques internationales de l'Académie nationale des sciences médicales, Kiev (Ukraine)*
Ms / *Mme* Isabelle ERNY, Directorate General of Health, General Secretariat, Rights, ethics and legal support division (DDEAJ) and representative of the Bioethics Division of the Council of Europe (CDBI) / *Direction générale de la santé, Secrétariat général, Division droits, éthique et appui juridique (DDEAJ) et représentante du Comité Directeur pour la Bioéthique du Conseil de l'Europe (CDBI)*
Professeur Pablo SIMON LORDA, Lecturer on Bioethics, Andalusian School of Public Health, Granada (Spain) / *Professeur de Bioéthique, Ecole andalouse de Santé Publique, Grenade (Espagne)*

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Social, Health and Family Affairs Committee */ **Commission des questions sociales, de la santé et de la famille***

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Ms / *Mme* LAMBRECHT-FEIGL, Secretary to the Committee / *Secrétaire de la commission*
Ms / *Mme* GARABAGIU, Secretary to the Committee / *Secrétaire de la commission*
Ms / *Mme* BARTHEL, Principal Assistant / *Assistante principale*