

ARTICLE

Ethical issues in palliative care

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Physicians should act in their patients' best interests. They should also respect their patients' wishes—which may not be in their best interests. For example, a patient may be in the ICU and nearing death with no chance of survival. Yet, he wants to continue active treatment. In such cases, patients' wishes have to be respected. Caring for patients in a palliative care setting requires physicians to make particularly difficult decisions.

Certain issues must be remembered when treating patients with advanced, incurable disease. First, their treatment is primarily symptomatic. Second, they may be weak, confused and not very alert, thus vulnerable to inappropriate influence by others. Third, as they approach death, they may have fears and anxieties that they may or may not reveal to their caregivers; this may cause certain behavioural changes which call for sensitive emotional and spiritual support. Fourth, dying is a process and not a sudden event. Relatives can be a support to the patient in this process, and aid the physician in ethical decision-making. The physician thus has a responsibility to see that relatives are given their due place in caring for the dying patient.

We must also justify the value judgements behind our decisions. When a weak, almost moribund, patient gets a chest infection, how should the physician respond? Should antibiotics be administered? My own first response is to treat to relieve physical distress. If there is no distress, I will wait and watch perhaps for up to 48–72 hours. If the patient starts improving on his own, then I might give treatment. If not, I will let nature take its course. But what if relatives want active treatment, saying that one has no right to let a person die?

Patient care and comfort

The patient is entitled to expect a good standard of medical care, which includes proper assessment, diagnosis and treatment. When curative treatment is withdrawn, the reasons for doing so should be fully explained to the patient, so that he/she does not feel abandoned. Patients should be made to understand that 'care' is possible even though 'cure' is impossible. Symptoms should be controlled and side-effects anticipated and treated.

What if the patient's relative acts against the patient's wishes? Some time ago, we had a case of a young woman with terminal breast cancer. She also had paraplegia due to spinal metastases. She was admitted to the hospice for pain relief, which was achieved with morphine. Though sad, she was content with her care. One month later, her father wanted to try alternative therapy on her, and wanted to take her home. She was against this and pleaded with us not to send her home. Yet in front of her father, she could not maintain her stand. He was adamant, despite all our counselling, and one day he brought an ambulance and took her home. This case still troubles me. Although it is the patient who is important, in India, women usually defer to the men in the family. This is one kind of dilemma we often face in India.

Consent and confidentiality

Personal consent to any medical procedure should be voluntary, competent and informed. Since palliative care patients are in a weakened state, they may give consent without fully understanding the situation. The doctor should seek consent from the patient in a responsible, sensitive and caring manner.

Confidentiality is a vital element in a doctor–patient relationship, though it can be broken under certain circumstances. Other team members may need to be informed to provide better patient care, or if the patient is a source of infection and a danger to others. Yet it is difficult to decide how much to tell.

Prolonging life

In palliative care, the issue of prolongation of life will occur in certain circumstances. Should one treat dying patients who suddenly get bronchopneumonia? How should one react when the secondary illness becomes more life-threatening than the primary disease? In cancer of the oesophagus an otherwise healthy patient is starved due to obstruction. Are we justified in performing a gastrostomy or jejunostomy for feeding? These issues need to be resolved keeping the patient's condition in mind. Also, symptom relief is important to make the patient comfortable. Whatever the decision, patients' wishes must be respected, and terminally ill patients must be allowed

to die with dignity and in peace. Resuscitation is rarely justified in palliative care.

Withholding or withdrawing treatment

Patients rarely ask for termination of life if they can be provided relief from pain and distressing symptoms. We must remember that the care is for relief of symptoms that are not only medical but also physical, mental and spiritual.

A study of cancer patients in the intensive care unit showed a high burden of pain and other symptoms. Some clinicians consciously provide inadequate treatment for pain, even when withdrawing life support, because they fear hastening death. However, current guidelines recommend placing a high priority on adequate symptom control using a combination of morphine or other narcotic with a benzodiazepine, barbiturates or haloperidol.

Conflicts about withholding or withdrawing treatment are common between clinicians and families. Negotiating these conflicts requires good communication skills. A standardised multidisciplinary family conference led by the attending physician, focusing on the goals and outcomes of life support as opposed to symptomatic treatment, often enables an earlier transition to a palliative care setting. This not only improves the quality of end-of-life care but also reduces the guilt of relatives who find it difficult to make this decision. We also need to emphasise that palliative care does not mean withdrawal of medical and nursing care, and that pain and other symptoms continue to be monitored and treated.

We need to explain that high-quality medical care is that which results in an improvement in health; when improvement is not possible it should ensure comfort. We must remember that withdrawal of active treatment is a clinical procedure that requires good medical skills, cultural sensitivity, attention to ethical principles and close collaboration with patients' families. Improved communication about goals, prognosis and treatment options will successfully resolve most conflicts. It may also minimise unrealistic requests by patients and families.

The ability to treat disease and sustain life by artificial means is continually advancing. However, there comes a

time when we need to acknowledge that limits have been reached in a patient and continued treatment is not longer in his or her best interests.

While it is unlawful to give a medicine with the primary intent of hastening death, giving medicine to relieve suffering which may, as a side-effect, hasten death is lawful and appropriate. When an action is intended to have a good effect, and can be achieved only at the risk of producing a harmful effect, then it is ethically permissible. This is true only when the action is good and there is sufficient reason to allow the bad effect—the possibility of causing death.

Conclusion

It is ethical to withdraw life-sustaining treatment from those unable to decide for themselves, only when treatment can no longer achieve its intended clinical purpose and cannot provide any benefit. Such decisions should be made on the basis of what is right for that particular individual. The quality of life after treatment is a relevant consideration.

Often we have no right answer to such dilemmas. The boundaries within which our decisions must lie should be learned. A knowledge of the relevant laws helps, as does having a framework for ethical decision-making. There is also a need to recognise cultural influences on decision-making. Finally, honesty to oneself is important; when all is said and done, we need to live with the consequences of our decisions. In the words of Hippocrates, 'The purpose of medicine is to do away with the sufferings of the sick, to lessen the violence of the disease and to refuse to treat those who are overmastered by their disease.'

Suggested reading

1. Way J, Back AL, Curtis JR. Withdrawing life support and resolution of conflict with families. *BMJ* 2002;**325**:1342–5.
2. Royal College of Paediatrics and Child Health. *Withholding or withdrawing life-saving treatment in children: a framework for practice*. London, 1997.
3. Dickenson DL. Are medical ethicists out of touch? Practitioner attitudes in the US and UK towards decisions at the end of life. *J Med Ethics* 2000;**26**:254–60.
4. Ethical debate. *BMJ* 2001;**323**:388–91.
5. BMA. *Withdrawing or withholding life-prolonging treatment: guidance for decision-making*. London: BMJ Books, 2001.