WHAT MAKES FOR GOOD PALLIATIVE CARE?

Speaking at the CMA Conference in London in March, Dr Philip Howard pointed out that ordinary care was best defined by Pope Pius XII. "Normally one is held to use only ordinary means – according to circumstances of persons, places, times and culture - that is to say, means that do not involve any grave burden on oneself or another. A stricter obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health and all temporal activities are in fact subordinated to spiritual ends (Pope Pius XII 24/11/57. Address to Anaesthetists). According to John Paul II (2004), artificial nutrition and hydration are ordinary care and may not be denied. To quote; "I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act. Its use, furthermore, should be considered in principle ordinary and proportionate, and as such morally obligatory insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering."

The principle of double effect has caused difficulty for some. All medical treatment has benefits, disadvantages and side effects. We are justified in treatment where it is necessary and where there are no other reasonable alternatives and where there is sufficient proportionality between the good effects and the side effects. So in palliative care you do not kill the patient to kill the pain. It is always necessary to use medicines with side effects having balanced the risks and benefits.

In fact double effect almost never applies in palliative care with opiates as in the correct doses they are almost always safe. But the wrong doses may be and are harmful and opiates can be used inappropriately.

CAN OPIATES BE USED TO SHORTEN LIFE?

Pius XII was asked in the 1950s if opiates could be used, even if they shorten life. Clearly, not as the primary purpose; Dr Howard pointed out, quoting Dr Margaret McKerrow, that with a little experience and knowledge, you know what you intend.

Pope John Paul II set out that nutrition and hydration are ordinary care except at the very end of life where hydration and nutrition may become physiologically irrelevant in the last few days of life. Throughout the history of medicine, even in pre Christian times, doctors have always recognized the value, dignity and worth of their patients. The Hippocratic Oath is predicated on the dignity of the individual. We learn that even in Hippocratic times, there were always physicians who would not abandon the city in times of plague. In more modern times, Victor

Frankl who survived Auschwitz, explained the dignity of the individual even in the most appalling circumstances of the concentration camp.

As Victor Frankl said, "Fundamentally, therefore, man can, even under such circumstances decide what shall become of him both mentally and spiritually. He may retain his human dignity even in a concentration camp. Dostoevsky said once, "There is only one thing that I dread: not to be worthy of my sufferings." These words frequently came to my mind after I became acquainted with those martyrs whose behaviour in camp, whose suffering and death, bore witness to the fact that the last inner freedom cannot be lost. It can be said that they were worthy of their sufferings: the way they bore their suffering was a genuine inner achievement. It is this spiritual freedom- which cannot be taken away- that makes life meaningful and purposeful."

We can of course translate that suffering away from the concentration camp to those who suffer severe medical illness, as Frankl himself did. When we see how some of our patients bear the great suffering they face, it is an inspiration and can be one of the greatest rewards of our work.

Our job is to see the value of all our patients especially in the event of incurable and terminal illnesses. Our patients do carry crosses and it is our job to help and support them as they carry that cross, reducing their suffering. John Paul II tells us that we can suffer with, for and on behalf of Christ because He wills it, we are invited to share with him in His cross so that we may rejoice with Him in heaven. Our lives become extraordinary precisely because we participate in the redemptive actions of Christ himself.

CURRENT PROBLEMS IN PALLIATIVE CARE

At the CMA Conference in London last March, Dr Philip Howard suggested that palliative care has been transformed by the secular world around us in the last few years. On the wards there has been a change in attitudes with the introduction of terminal care pathways, the most familiar of which is the Liverpool Care Pathway (LCP).

We know that prognosis is not accurate and we often get our predictions of prognosis wrong. A tool based upon prognosis is therefore dangerous as it may become a decision that a person will die. Often on such pathways triple therapy is used (with morphine, midazolam a sedative and a hyoscine which is a drug to dry secretions). This means that the patient, who may or may not be dying, is given drugs that may hasten or even cause death. This is particularly true if hydration is also withdrawn. On such a regime the patient cannot survive. Sedation towards the end of life can also take away the freedom of the individual to see their families, set their affairs in order and attend to their religious duties and spiritual preparation for death. Deprivation of consciousness removes the moral freedom of the individual. Pius XII stated that this might be used in exceptional circumstances when other means to relieve extreme suffering were not available. But to do this routinely is wrong. In Holland deep sedation is used as a substitute for euthanasia and it may also be used where for legal reasons, the legal requirements for euthanasia are absent or the process of certification is regarded as too lengthy or difficult. We now see relatives sitting around the bed in the expectation of death. Where death does not occur soon, it may be a cause of complaint.

So we must return to the view that all persons are of worth while they live. There seems little doubt that lives are being shortened. The median time of patients on the LCP is 33 hours for cancer and 30 for non-cancer diagnosis. That is a matter of concern especially if we know that we do not know the precise prognosis in non cancer diagnoses.

Increasingly, in Holland, Belgium, the Netherlands and the States of Washington Montana and Oregon, we see moves towards euthanasia and physician assisted suicide (PAS). Increasingly even in jurisdictions that do not permit euthanasia and PAS, there is a move to terminal sedation which may be used a substitute for euthanasia.

References

Address to an International Congress of Anesthesiologists, Official Documents. Pope Pius XII, November 24, 1957, L'Osservatore Romano, November 25-26, 1957

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