

Palliative care: Preventing misconceptions

To the Editor: McQuoid-Mason's statement that 'Doctors who hasten the termination of the lives of their patients by withholding or withdrawing treatment or prescribing a potentially fatal palliative dose of medication satisfy the elements of intention and causation of a charge of murder against them'^[1] is of great concern. It highlights a disconnect between the professions of law and medicine and misconceptions regarding the practice of palliative care. Such statements influence professional and public perceptions and create barriers to patient and family access to quality end-of-life care that focuses on relief of suffering and improving quality of life.

The World Health Organization definition of palliative care includes affirming life, regards dying as a normal process, and intends neither to hasten nor postpone death. The palliative care approach aims to improve quality of life and assist patients to live as actively as possible. It may aim to prolong life where there is expectation of fair quality of life, but not to prolong dying. Clinical skill and experience assist the doctor and the palliative care team in identifying where quality of life can be improved and when patients are dying without likelihood of improvement.

Excluding those who die suddenly, many people are under medical care when they die. Doctors do not cause the death, which results from the disease process. When treatment is futile, is refused or has no benefit, it should not be given just because treatment is available. 'Consideration of withholding or withdrawing treatment as a sound clinical decision developed as a consequence of the availability of advanced medical technology and the resultant ability to prolong life that in some cases is in fact unwanted prolongation of the dying process.'^[2]

Focusing on death, which is common to end-of-life care and to euthanasia, is 'a reductionist philosophy that does not reflect clinical reality'.^[3] Euthanasia is an active intervention intending to cause the person's death. Palliative care advises that the decision to withhold or withdraw treatment should only be taken after careful consideration by the care team and discussion with the patient (if competent) and the family. Withholding or withdrawing treatment is a sound clinical decision under these circumstances. The statement that the doctor 'legally has the eventual intention to kill the patient'^[1] highlights the disconnect between the legal and medical professions on this point, and lack of understanding of clinical reality.

It is a misconception that 'prescribing a potentially fatal palliative dose of medication'^[1] is part of medical practice, in particular palliative care. Responsible prescribing of medicine by doctors is reinforced in palliative medicine training, where doctors use sedatives and analgesics, titrating the dose to the patient's response so that the symptoms are controlled without threatening the patient's life. This misconception stems from the 'Doctrine of Double Effect' first described by Thomas Aquinas in the 13th century. Advances in medical knowledge and skill enable doctors to provide quality care without shortening life. Palliative care integrated into cancer care can increase life expectancy.^[4] That using opioids or sedatives may shorten life is a myth; 'there is no evidence that the use of opioids or sedatives in palliative care requires the doctrine of double effect as a defence', and 'although the doctrine is a valid ethical device, it is, for the most part, irrelevant to symptom control at the end of life. To exaggerate its involvement perpetuates a myth that satisfactory symptom control at the end of life is inevitably associated with hastening death. The result can be reluctance to use medication to secure comfort and failure to provide adequate relief to a deeply vulnerable group of patients.'^[5]

The Hospice Palliative Care Association of South Africa urges doctors to improve their knowledge and skills in palliative care and pain management, and to refer patients to hospice, or to a palliative care or pain service if they lack the knowledge and skills to address their patient's suffering. Legal and ethics specialists must also update their understanding of palliative care and not perpetuate misconceptions that deprive patients of quality palliative care.

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Prof. McQuoid-Mason responds: Gwyther's 'great concern' about the fact that two of the four elements necessary for a charge of murder may be satisfied is understandable, but unfounded. The law is clear – unless all four elements are satisfied there is no question of a crime or a civil wrong being perpetrated (see my example in 'Definition of euthanasia' above, concerning surgeons in the operating theatre).

I do not understand the statement that 'Such statements influence professional and public perceptions and create barriers to patient and family access to quality end-of-life care that focuses on relief of suffering and improving quality of life.' Surely doctors explain to patients and their families that when treatment is withheld or

withdrawn in cases of futility, it will hasten the patient's death and not prolong their dying? The doctors know that their act or omission will allow the underlying condition to cause death, but that they are protected by the law because their conduct is regarded as lawful; they may have what the law calls 'eventual intention', but their conduct is not unlawful. This is because the law recognises that, in Gwyther's words, 'When treatment is futile, is refused or has no benefit, it should not be given just because treatment is available.' There is no disconnect between the law and medicine on this point, as the law regards such conduct as lawful.

I stand corrected if it is a 'misconception' that the drugs used in palliative care may reduce a patient's life expectancy, and in Gwyther's words, that 'symptoms are controlled without threatening the patient's life'. However, the principle regarding the hastening death might apply in other situations – unless such treatment is also no longer practised. Presumably, in the past, when certain drugs did reduce a patient's life expectancy this was fully explained to patients (and to their families) to ensure that such conduct was lawful.

I agree with Gwyther's statement that 'Legal and ethics specialists must also update their understanding of palliative care and not perpetuate misconceptions that deprive patients of quality palliative care.' I also agree with the statement by Mason and McCall Smith that prompted me to write the article and is quoted at the end: 'When, however, a treatment is discontinued solely by reason of its futility, there is nothing to be lost – and much to be gained by intellectual honesty – in attributing death, correctly, to "Lawful withdrawal of life support systems which were necessitated by [the disease]"'^[1]

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S Afr Med J 2014;104(4):260-261. DOI:10.7196/SAMJ.8093