Ethical problems of palliative care in the period of its evolutionary transformation

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ABSTRACT

Our long-time experience in palliative care allowed us to notice changes in ethics of palliative medicine. In the handbook of palliative medicine, its authors R.G.Twycross and D.Frampton in 1995 did formulate the following ethical postulate: respect for life, acceptance of death of a patient as an unavoidable event, respect for a patient as a person, beneficence, nonmaleficence, justice. In addition, they stressed prohibition of euthanasia as a rule. Nine years later, however, in the Oxford handbook of palliative care, its authors: M.S.Watson, C.T.Lukas, M.A.Hoy and J.N.Back described their ethical basis, which were slightly different but quite similar to those of T.L.Beauchamp and J.F.Childers: autonomy of a patient, beneficence, nonmaleficence, justice and the trust. Their set of principles may induce controversy because of unlimited patient's autonomy and absence of physician's autonomy. Further, it may permit euthanasia, which is excluded by palliative medicine.

Key words: palliative care, ethics, euthanasia

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INTRODUCTION

Since the moment of its origin in the 6th decade of the XXth century, paradigms of palliative-hospice care have included, apart from pharmacological treatment of physical symptoms, necessity of analysis of psycho-social, intellectual, moral and ethical problems of patients during their terminal period of incurable diseases.

The 18-year-long experience of the Cracow Palliative Care Centre has given us the possibility of observing transformation of this type of therapy and care. The changes that followed its development were noted not only in pharmacotherapy of pain, cachexia and other physical symptoms but also in psycho-social, intellectual, moral and ethical problems of the patient in his/her last phase of the illness.

It seems these changes, ethic ones, in particular, may cause some controversy and change of paradigms of the palliative care in near future. Quite often, ethical and philosophic changes are strictly related with social and political state of a country. In Poland, secular and liberal tendencies have been experienced recently. Thus, the following question seems to be essential: do the ethical evolution changes are good and advantageous for patients, for medicine and the whole society now and in the future?

DISCUSSION

The question of bioethics in palliative medicine relates mainly to ethical problems of so-called "terminal situations," particularly to problems of mental suffering caused by agony and approaching death. They are the most remarkable and of model character in this medical specialization and as such can serve as a pattern of behavior and material for analyses in other branches of clinical medicine.

Some of these issues are given below:

- Autonomy of a patient; its scope, in particular
- Autonomy of a physician (therapist)
- Welfare and good standing of a patient
- Dignity of a patient and a therapist
- Quality, value and sanctity of life
- Selection of the model of physician-patient relations
- Selection of the model of clinical medicine and its current "autonomy"
- Influence of these problems on society.
- These problems may be interpreted in various ways at the patient's bed. Differences in this area come mainly from different ethical theories, which determine our medical behavior and selection of a model of mutual relation between a physician and patient.

From among several ethic "theories," the most popular are:

- Consequentialism
- Deontonomism
- Personalism
- So-called "colloquial ethic" which is, to some extent, a "relic" of ethical discussions, which had been carried on before a scientific bioethics originated. It is worth stressing here that the election of an ethical model is most of all related to the philosophy of life accepted by an individual.

From this point of view, it is essential to distinguish differences in understanding of such ideas as a person, his/her dignity and autonomy, absolute good (welfare, well-being) of a patient and of a person in general meaning, ethos of the clinical medicine, etc.

Consequentialism which includes utilitarianism of acts and of rules says the **good** of an individual or society – derived out of our activity and being its consequence – is the base of an ethical valuation. When a conception of a person is discussed, its approach is of relative character because it says we are becoming persons gradually during our lives. However, we can be excluded from the category of persons in some circumstances. The above-mentioned statement is based on the enunciation that a person must have and show some specific attributes of which consciousness and possibility of deciding of his or herself are dominant (J. Fletcher – 15 indicators of humanity) [2]. Individuals who are deprived of these dominant and deciding attributes have been called - somewhat strangely - "moral subjects" or "past persons" by followers of the utilitarianism. Human fetus as well as young children who have not acquired these attributes are denominated as "future persons" [3,5].

Leaving the merits of the conception for future discussion, it may be stated here that these facts undoubtedly **depersonalize** some members of humanity and may deprive them of the rights and protection which have been guaranteed by, among others, the Universal Declaration of Human Rights voted by the U.N.O. in 1948.

In the future, this specific terminology may bring negative results for clinical medicine since it may be understood as a scientific base for change of present critical attitude to legalization of euthanasia. The palliative-hospice movement is firmly against such postulates because of its paradigms, which absolutely exclude the possibility of each and all forms of euthanasia. It

says the value of life of a patient must not depend on quality of his or her life.

Utilitarianism says a person's **quality of life** is essential and defines and qualifies the value of life. If it is low, life "is unworthy of live" according to foundations of utilitarianism (E. Shelep – the principle of minimum of independence). These statements may serve as grounds for legalization of euthanasia in future [2]. Further, they are contrary to postulates of personalism and its rule of **sanctity of human life** even though it is of very low quality.

The trend of ethics which is based on **personalist philosophy** does underline **dignity of the person** from its conception until his or her natural (biological) death. The trend says the existence of a human being does not depend on possessing of attributes (consciousness, for example); it is so because attributes describe and characterize persons but do not create them, they are derivative and secondary to being. The personalist model of ethics says also a human life must not be a medium to achieve any goals, neither particular nor general ones. By this, it supports "the principle of sanctity of human life." All the principles of the personalist philosophy do exclude euthanasia of a patient, nevertheless, the quality of his/her life, the degree of damage of the body as well as the patient's request expressed as his or her own decision [2].

At this point, it is proper to mention those trends of ethics, which are based on deontonomism as well as recall the essence of so-called "ethics colloquial."

Deontonomism (*deon* – duty, obligation) motivates ethical rules by some authority. We distinguish two forms of deontonomism: heteronomous where the rules are imposed on people - by the law, for example – by creation of specific rules or codes (medical code, for instance); alternatively, autonomous where me, myself and my convictions are the authority [2].

Fast development of bioethics since the second half of XXth century made it an important part of philosophy, which does possess its own scientific **base, trends, nomenclature**, etc. Because of said development, so-called "ethics colloquial" - being a set of subjective views that are relatively often based on emotional reactions, which sometimes exclude each other - may not play a significant role in medicine. However, quite often are analyses of ethical problems that are made either out of existing scientific ethical models or with their total omission. Such an ethical judgment – disregarding solutions of these problems by above mentioned ethical theories – must not be a ground for binding conclusions. Among others, we think here of such problems as: legalization of euthanasia, assisted-suicide, falsifying the patient's hope by telling him or her untruth about prognosis, etc.

There is more than one type of relation between a practitioner and a patient. At present, there are three main models of the relation:

- **Paternalism** – patient does fully depend on a physician during the therapy, and the physician can exercise quite a large autonomy.
- That's why a new pattern of practitioner-patient relation has been developed in English-language countries at the end of the XX th century:
- **Principism** (T. L. Beauchamp, J. F. Childres, 1983) with its five ethical rules (principles): autonomy of the patient, beneficence, nonmaleficence justice and the trust [1].

The model seems to be good and meeting expectations of both a physician and a patient. However, the practice has revealed the fact that lack of scientific determination of principles may lead to serious consequences, particularly in palliative-hospice care. Lack of determination of patient's autonomy is one of the possible negative reasons; it sometimes causes faulty understanding of patient's autonomy – as the rule or principle which is absolutely and totally binding a physician. Further, absence of physician's autonomy in his/her relations with the patient quite often makes the physician's autonomy decrease or be completely neglected; it may cause moral dilemmas in a physician's mind when a patient - equipped with an absolute autonomy - requests the physician to act contrary to his or her hierarchy of values. It may strike the ethos of clinical medicine as well. We are talking about, among other's patients, request of euthanasia, abortion, eugenics, cloning, etc.

The model of unlimited autonomy of a patient opens the door to full **commercialization of medicine**. This will lead to the end of Hippocratic model of medicine. Furthermore, such an unrestricted autonomy of patient's decisions may somewhat "anarchic" society by such demands as, for example: "I am free in requesting physician to do everything," "I don't care of what other people will think of such a medicine."

There is also the third model of a physician-patient relation. However, it is disregarded quite often, unjustly in our opinion. It is based on the theory of personalist ethics and is called **beneficence in trust** (E.Pellegrino, 1988). Here, the physician-patient relation is grounded on balance and equilibrium between autonomy of both and on dignity of both as well - which all determine the scope of decisions of the patient and the physician [4].

Sometimes, ethical problems are resolved by amicable settlement (agreement) by parties who represent different ethical standpoints. It is called "c**ontractalism**". However, we think such an improvised solution should not be used in palliative care, particularly in issues of shortening of patient's life.

When the ethical ground of palliative-hospice practice is observed from its beginning to the present moment, evolution changes can be noticed. Principles which have been formulated by its originator Madame Cicely Saunders were generally adopted by the World Health Organization when "palliative medicine," a new clinical specialization, came into existence.

According to "Palliative Care of a Patient in Agony" by R.G.Twycross and D.Framptom, 1996, ethical grounds of the specialization were as follows:

- Respect for life
- Acceptance of inevitability of death
- Respect for the patient who is a human being.
- Doing good
- Not doing evil
- Reasonable division of available means [6].

When the above rules were discussed in details, the paradigm of prohibition of euthanasia of the patients was underlined.

However, a handbook of palliative care that was published nine years later (in 2005) by S.M.Watson. C.F.Lucas, A.M.Hoy, J.N.Back [7] enumerates main ethical rules in slightly different way: respect for autonomy of the patient, beneficence, nonmaleficence, justice

As can be seen, the acceptance of inevitability of death and definition of a patient as a human being are omitted. It is easy to note these rules are nearly the same as ethic postulates regarding mutual relations between a physician and a patient that were given by T.L. Beauchamp and J.F. Childress in 1983 – same as those of so-called principism. Significant is that they were known in the days of creation of the new medical specialization (palliative medicine) but were not taken into account by its founders [1].

The present model of palliative care system does underline the inevitability of death but does not accept legalization of euthanasia of a patient – neither active nor passive or hidden one. Also, existing limitation of autonomy of a patient by physician's autonomy influences the now existing ethos of clinical medicine of discussed specialization.

Reasons of the attempts to change ethical grounds by some authors are not quite clear. We suppose they may be the result of widening of scope of palliative medicine by patients suffering from non-tumor diseases and being in their last period, whose therapy in English-language countries is based on principism of Beauchamp and Childress. The model, as it was stated before, stresses the patient's autonomy and may, in some circumstances, permit euthanasia.

Controversial situations may arise when physicians of palliative medicine meet employees of health centres in Holland and Belgium where euthanasia is legally permissible. In said countries, the practice of resignation of "special extraordinary therapeutic methods" in palliative care centers in Great Britain or Poland for example is seen – wrongly in our opinion – as a sort of passive euthanasia. Similarly, "terminal sedations" are considered by them (by Holland and Belgium's centres) to be a hidden form of the active euthanasia which is actually performed in those countries where euthanasia is not allowed.

At this point, it seems to be necessary to explain that decrease of suffering of a patient – not shortening of his or her life – is **the intention** of both stopping of special therapeutic methods and terminal sedation. So, speaking of euthanasia is quite inadequate here. Returning to the discussion about causes of changes in main ethical problems of palliative care, it should be noted that global tendencies to make clinical medicine become a commercial might be the reason of the changes. Said changes need wide autonomy of a patient who in turn brings withdrawal of the autonomy of a physician who otherwise, based on his or her conscience, may block extreme ideas of some consumers of the "commercial" medicine which – apart from its traditional tasks – performs such controversial "services" as change of sex, abortion, prenatal eugenics and euthanasia [2].

CONCLUSIONS

1. There comes a question: whether the attempt to change ethical principles by acceptance of the model of Beachamp and Childress (principism) is aimed at creation of ethical, supposed to be scientific, grounds for acceptance of euthanasia in the future? The question, although in Poland, it is a problem of far future rather, seems to be of some importance.
2. If so it happens, the main paradigm of the palliative movement – ban of euthanasia – will have to be withdrawn. But would it still be the palliative-hospice medicine?
3. On the other hand, development of palliative care must undergo some evolution-type changes. At the moment, questions about changes that would be good for a patient, for ethos of medicine and for the society as well, seems to be well grounded.

Conflicts of interest
We declare that we have no conflicts of interest.

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