Case Report

Ethics and palliative care: a case of patient’s autonomy

Mamak Tahmasebi

Palliative Medicine Fellowship; Cancer Institute of Iran; Imam Khomeini Hospital Complex; Tehran University of Medical Sciences; Tehran; Iran.

Keywords: *Palliative care; Autonomy; Ethics.*

Introduction:

The objective of palliative care is to provide holistic care to enhance the quality of life by addressing physical, psychological, social and spiritual suffering. In palliative care, the family is part of the team and should be cared for and supported, and communication is the key in the process, especially at the final stage (1).

Maintaining patients’ autonomy at the end of life is a challenging subject that needs to be addressed using a contextualized approach. One alternative demarche in setting care goals and shared decision-making may be "relational autonomy". To this end, the case of an end-stage patient in the need of palliative care and the related ethical challenges are presented below.

***Corresponding Author**
Mamak Tahmasebi

Address: *Cancer Research Center, Cancer Institute, Imam Khomeini Complex, End of Keshavarz Blvd., Tehran, Iran.*
Postal Code*: 1419733141*
Tel: *(+98) 21 61 19 25 30*
Email: *mtahmasebi@tums.ac.ir*

Received: *7 Nov 2022*
Accepted: *13 Dec 2022*
Published: *28 Dec 2022*

Citation to this article:
Tahmasebi M. Ethics and palliative care: a case of patients’ autonomy. J Med Ethics Hist Med. 2022; 15: 16.

Case Presentation:

Mrs. A. was a 40-year-old woman with advanced pancreatic cancer. She was a housewife and the mother of a 10-year-old son. She was admitted to the emergency department for severe abdominal pain. After relative and temporary control of her symptoms, she was transferred to the oncology unit for further evaluation. The surgical team diagnosed malignant bowel obstruction secondary to carcinomatous peritonitis and announced it inoperable. The pain gradually aggregated and remained uncontrollable except temporarily and through morphine injections. The attending oncologist consulted.

Copyright © 2022 Tehran University of Medical Sciences.
This work is licensed under a Creative Commons Attribution-Non Commercial 4.0 International license https://creativecommons.org/licenses/by-nc/4.0/).
Non-commercial uses of the work are permitted, provided the original work is properly cited.

palliative care to assist with managing her severe abdominal pain, stating, "The patient's husband does not allow any opioid injection." Approaching her bedside as a palliative care physician, I noticed that she was agonized and would not even let me touch her abdomen for better evaluation. Her husband was a 45-year-old middle-class worker. He held his wife's hand compassionately when I introduced myself. I asked the patient's permission to give her a morphine injection so that we could have some qualified time for talking and physical examination.

Immediately, her husband responded, "No! You have permission only for a non-opioid medication. I don't want to see her drowsy and confused anymore." In situations like this, we are faced with the following questions:

1. *Does the spouse have the right to make decisions about the patient's pain management?*

2. *Are there ethical issues relating to morphine prescriptions?*

3. *Do health-care providers (physicians and nurses) have the right to prescribe and use medications without informing patients and/or their families?*

Discussion

When discussing the right to make decisions, we are actually talking about respect for autonomy, one of the fundamental principles of medical ethics. There are three types of autonomy in the literature: isolated autonomy, voluntary diminished autonomy, and relational autonomy.

As a concept, isolated autonomy is connected to self-interest, independent of relational or other considerations (2). The voluntary diminished autonomy approach is common among patients who evade their responsibility to make decisions because they are concerned about being harmed by excessively candid diagnostic or prognostic information. Some patients may not wish to know in detail the nature, extent and likely prognosis of their disease (3). Finally, since most people live in cultural and familial contexts, they voluntarily consider the impact of their decisions on valued relationships and seek the counsel of family members or other significant stakeholders in their lives; this is referred to as relational autonomy (4). Sometimes patients' autonomy is compromised due to severe physical decline, cognitive impairment, and/or emotional distress. In these situations, decision-making is automatically

resigned to other people, such as a family member, a surrogate or a health-care team member (5, 6).

Mrs. A.'s autonomy was compromised, partly due to severe physical decline and partly secondary to the specific bond between the couple. Mrs. A. respected her husband's values despite the high cost of tolerating severe physical pain, but accepted morphine injections when her husband was not around.

In decision-making situations, human beings are inseparable from their sociocultural identities, including notions of gender and power (7). Whether Mrs. A. decided to set aside personal wishes for the good of her husband or as a means to maintain peace and harmony with her loved one is a subject that needs to be explored. It can also be argued that the same scenario could happen if the husband were in bed instead of her.

In this case we need to answer a couple of important questions, such as: "Did he realize that she would be dead in a few days?" and "Did he want her to be comfortable?"

There are some myths and misconceptions about morphine and other opioids, for instance that they cause addiction or hasten death (8). A properly titrated dose of morphine does not cause respiratory depression, the most concerning side effect of opioid drugs. Terminally ill patients are especially at risk for opioid-induced sedation, cognitive impairment, and delirium. Some of these neurological side effects are self-limiting, especially in opioid naïve patients, and some are frequently managed by correction of identifiable and reversible factors such as rehydration.

We should find out the reason why Mrs. A.'s husband fears his wife receiving morphine or being sleepy; if she loves him and knows that he cares for her, it may be that they simply wish to communicate with each other. The mental pain of loss is another explanation in this situation: the husband is afraid of his own confusion and dependence on his wife, but this has become, by proxy, the issue of morphine. These questions could be answered through an honest conversation between Mrs. A.'s husband and the physician. In an empathic atmosphere, Mrs. A.'s and her husband's care goals should be explored and aligned with the existing reality. In any case, relief from physical suffering is usually the most achievable intervention at the end of life.

All things considered, nothing but the truth is acceptable, even when the aim is to bring temporary comfort to the patient. In this case, Mrs. A. is a competent person who does not want a

morphine injection for whatever reason, for instance to avoid conflict with her husband or to maintain peace and harmony with her loved ones. Her decision may cause moral distress in health-care providers and consequently amoral action; for example, they may hide the morphine injection from her husband. In this situation, support should be provided to health-care team members to help them comprehend the patient's decision to align with the family (9).

Conclusion

Physicians concentrate mostly on the disease rather than patients and their families. With the exception of psychologists maybe, health-care team members are mainly focused on relieving physical symptoms as a means to provide optimal care. *Patients have a right to adequate relief of their pain and this right is derived from the principles of beneficence, non-maleficence, justice and specifically respect for patient autonomy. At the same time, respect for relational autonomy should be seen as a part of patient autonomy and noted in decision-making.* The concerns of patients and their families need to be addressed, and any intervention (from prescribing antibiotics to analgesics like morphine) should be fully explained if necessary. Recognition of and respect for patients' values, wishes and preferences are part of health-care providers' duties. As a final point, it should be mentioned that interprofessional communication is the best way to avoid moral distress and align all team members' care goals.

Acknowledgements

There are no Acknowledgements

Conflicts of Interests

There are no conflicts of interests.

Reference:

1. Laryionava K, Winkler EC. Dealing with Family Conflicts in Decision-making in End-of-Life Care of Advanced Cancer Patients. Current Oncology Reports. 2021 Nov;23(11):1-6.
2. Gillon R. Ethics needs principles—four can encompass the rest—and respect for autonomy should be “first among equals." J Med Ethics. 2003; 29:307-12.
3. Helft PR. Necessary collusion: prognostic communication with advanced cancer patients. J Clin Oncol. 2005; 23:3146-50.
4. Ho A. Relational autonomy or undue pressure? Family's role in medical decision-making. Scand J Caring Sci. 2008; 22:128-35
5. Tonelli MR, Misak CJ. Compromised autonomy and the seriously ill patient. Chest. 2010;137(4):926-931.
6. Lewis J. Does shared decision making respect a patient's relational autonomy? Journal of Evaluation in Clinical Practice. 2019 Dec;25(6):1063-9.
7. Quill TE and Miller FG. Palliative Care and Ethics. Oxford University Press; 2014
8. Bemand-Qureshi L, Gishen F, Tookman A. Opioid use in palliative care: new developments and guidelines. Prescriber. 2019;30(4):25-31.
9. Blackler L. Compromised autonomy: when families pressure patients to change their wishes. Journal of Hospice & Palliative Nursing. 2016 Aug 1;18(4):184-91.