

PHARMACY LAW AND ETHICS

End-of-life law and ethics: grey areas around homicide and assisted suicide

A session organised by the Pharmacy Law and Ethics Association on 24 September discussed the legal and ethical issues in palliative care pharmacy

In view of the ability nowadays to preserve life in situations where previously the patient would have died, health care professionals can find themselves faced with difficult challenges. As suppliers of palliative care drugs, it is important that pharmacists understand some of the legal and ethical principles that surround care for terminally ill patients, said Professor JOY WINGFIELD, University of Nottingham and chairman of PLEA, as she opened the seminar.

LEGAL ISSUES

Doctors and those who assist them in administering pain relief, may be working under a cloud of possible prosecution, said Dr JOHN KEOWN, senior lecturer in the law and ethics of medicine, University of Cambridge.

The two main areas of law relevant to end-of-life decision-making are homicide and assisted suicide. To convict somebody of murder, the prosecution must prove that the defendant unlawfully caused the death of the victim, and that he or she did so with the intention of causing death, or at least grievous bodily harm. Previously, it was accepted that if diamorphine was administered with the sole purpose of easing pain, and the drug's effect of shortening life was foreseen, but not intended, there was no criminal liability.

However, the precise meaning of the word "intent" has been brought into question and a recent case in the House of Lords appears to have removed the distinction between intentional life-shortening and merely foreseen life-shortening. It was held that in the crime of murder, intention goes beyond its ordinary meaning of purpose, goal or objective, and includes consequences which are either foreseen as certain or virtually certain to happen.

This is significant for health care professionals because when caring for patients at the end of life, they may perform an act that has the foreseen effect of hastening a patient's death even though that is not the purpose of the act, and this could be seen as murder. Dr Keown said that he did not think that the judges in the case had turned their minds to the effect that conflating intention and foresight would have on palliative care. "I think if they had done so, it would have made them rethink," he said.

Which case law takes precedence is a rather vexed issue. "The law is rather unclear and this is unfortunate because how are health care professionals supposed to carry out their duty to patients in the con-



John Keown: the law relating to assisted suicide is even more unclear than the law relating to homicide

text of such serious legal uncertainty? It is a matter of urgency that the courts revisit this issue," Dr Keown said.

However, Dr Keown went on to say that he thought if a health care professional were prosecuted for following established medical practice with the sole intention to ease distress and pain, he or she would either be acquitted (following previous case law) or the judge would be very keen to find a way of enabling acquittal, such as inventing a defence of necessity.

Similarly, there are grey areas in the law of assisted suicide, where assistance could mean simply advising someone about how to kill him- or herself. To be convicted of assisted suicide, again, legal authority is contradictory and whether the prosecution has to prove intention is debated.

MIALI JAMES, prescribing advisor for Billericay, Brentwood and Wickford Primary Care Trust, commented that it is not unknown to come across medication records during nursing home inspections, that indicate a necessary medicine is no longer being given because the patient refuses to take it. The pharmacist is often asked by care staff what he or she thinks about this. Mr James asked where this left the care worker, nurse or pharmacist in relation to assisted suicide.

Dr KEOWN replied that the courts have held patients have an absolute right to refuse treatment, even if the refusal amounts to suicide. This need not imply though, that the health care worker is intentionally assisting suicide. The position might be that those responsible for the patient do not force the patient to take his or her medication (that would constitute assault), but at the same time have no intention that the patient should commit suicide. However, it

would not do any harm to keep documentation so that it is clear that there has been no complicity in the suicidal refusal of treatment, Dr Keown added.

ETHICAL ISSUES

Dr PIERS BENN, lecturer in medical ethics, University of London, gave an overview of the ethical issues surrounding the end of life and euthanasia. According to Dr Benn, there are three common situations in which a health care professional might be implicated in a patient's death:

- 1 Through respecting the legal and, arguably, moral right of a competent adult to refuse life-saving treatment.
- 1 Through a refusal to embark on "heroic measures", for instance, where it is recognised that cardiopulmonary resuscitation may not benefit, and may in fact traumatise, the patient.
- 1 Through the double effect, where a drug used to alleviate pain also has the effect of hastening death.

"The legal and ethical responsibilities of pharmacists still have to be teased out and there is a relative dearth of information and research that has been done in pharmacy practice" said TIM HANLON, senior pharmacist, British Forces, Germany. Mr Hanlon told the session that he had conducted a study of community pharmacists' attitudes to the position of assisted suicide and found that more than a quarter of those surveyed would rather not know the purpose of the prescription presented to them. "That is significant for a profession that is moving forward and wants to engage in ethical issues," Mr Hanlon said. "The British Medical Association has looked at consensus opinion. We have not. I think that the Royal Pharmaceutical Society has an ostrich mentality on certain ethical issues," he added.

PALLIATIVE CARE PHARMACY

People think of pain as the most distressing symptom experienced by palliative care patients, but studies involving patients in their last year of life show that symptoms of weakness and fatigue head the list, said MARGARET GIBBS, senior pharmacist at St Christopher's Hospice, south London, as she described what being a palliative care pharmacist in a hospice involved.

Palliative care tries to offer the patient as much choice as possible and in terms of medication, is a question of balancing benefits against risks: sometimes patients prefer

be more alert at the cost of tolerating a little nausea or pain.

In contrast to primary care, where prescribing of the more expensive slow-release preparations is being reduced, in palliative care, "if a patient who is feeling nauseous has to swallow two tablets twice a day rather than three tablets three times daily, we feel it is worth the cost," Ms Gibbs said. However, budgeting is tight. In 1995, it was decided that drugs for hospices should not be funded by charitable means and Government monies were allocated for this purpose and the budget was set according to the number of hospices in 1995.

Since then, the money has gone into a big pot and it is up to each hospice to negotiate with their PCT. If the hospice overspends, it has to find the money from somewhere else. For example, Ms Gibbs explained, "last year we did well, but the year before, we had just four or five patients who needed expensive drugs over four to seven weeks and we ended up nearly £30,000 over budget".

Community pharmacists can play a big part in palliative care. Ms Gibbs said that they often know the patient before they are diagnosed with disease and can provide continuous support. A major issue though, is the provision of palliative care drugs in the community. From a procedural point of view, good symptom control cannot be achieved without a good supply system in place, she explained.

A further issue of concern pointed out is that out-of-hours services are patchy. There are teams covering some areas, but other areas have no such provision. Ms Gibbs said that this is an area being looked at by the Department of Health.



*Margaret Gibbs: Palliative care
neither hastens nor postpones death*

Ms Gibbs also called for a stronger evidence base for the use of drugs outside their product licence. "We do it because everyone else does. Unfortunately that is how things go in palliative care," she said.

Having previously worked in hospital pharmacies, Ms Gibbs noted that teams in hospices were "truly multidisciplinary": meetings are attended by doctors, nurses, a physiotherapist, a social worker, a

chaplain and the day centre leader as well as the pharmacist, and everyone is listened to.

As for the future of hospices, "The Care Standards Act that came into force in April has reclassified hospices as independent hospitals and we are having to work hard to comply with these care standards," she said.