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Ethics and Palliative Care: Autonomy vs. Beneficence

This case study presents Mrs. A, a 40-year-old woman with advanced pancreatic cancer who presented to the ED for severe abdominal pain. On admission to the oncology floor, she was diagnosed with an inoperable malignant bowel obstruction secondary to carcinomatous peritonitis. The only temporary relief of her pain came from morphine injections, which her husband opposed due to the side effects of drowsiness and confusion. When the palliative care physician observed that the patient was in too much pain to undergo a physical exam, and asked her for permission to administer morphine, her husband quickly interjected, stating, “No, you have permission only for a non-opioid medication…”

This case represents an ethical dilemma of autonomy vs beneficence. In regard to autonomy, the patient has the right to make her own healthcare decisions, including accepting morphine for pain relief. Her autonomy is being compromised by her husband’s values. In regard to beneficence, the physician has a duty to do good for the patient, which includes relieving her suffering by controlling her pain. I believe that beneficence should take precedence in this case, and the patient should receive morphine, as her last few days of life should not be spent in agonizing pain. Denying her relief of pain based solely on her husband’s preferences not only undermines Mrs. A’s autonomy, but subjects her to avoidable pain in which the physician has the professional and ethical responsibility to resolve. Further, Mrs. A’s pain is preventing her from receiving appropriate medical evaluation, as she won’t allow the physician to examine her abdomen (which can pose further complications).

Although I believe that Mrs. A should be given morphine, this doesn’t mean the physician should disregard her husband’s concerns, which is why a conversation with him is warranted. First, the reasoning behind Mrs. A’s husband's wish to cut off morphine supply should be explored with a simple conversation. Maybe he is fearful of her loss, and thinks that morphine will hasten her death, in which he should be educated that when morphine is correctly dose-adjusted to the patient, it does not shorten life. I would also add that morphine’s sedative effects of which he is apprehensive about, wear off quickly (NIH, 2007). Further, and with much empathy, the physician should explain that patients with MBO secondary to

carcinomatous peritonitis have a short life expectancy and on average, have 3 episodes of MBO until death, with short time intervals between each episode. These episodes consist of severe pain, inability to eat, and intractable nausea and vomiting (IJGC, 2024). This distress could be avoided with the application of one simple medication. Additionally, I think there could also be a gap in communication between Mrs. A and her husband; they should be given time to talk about each of their concerns and hopefully come to a conclusion that involves Mrs. A being in a pain-free and peaceful state.

The case presentation implies that Mrs. A was approving morphine injections when her husband wasn't around, as her pain was "...uncontrollable except temporarily and through morphine injections." Mrs. A, although in a terminally ill state, has the mental capacity to make her own healthcare decisions, and understands the risks of receiving morphine, which includes drowsiness and confusion. It is evident that she prefers to alleviate her pain at the cost of temporary sedation. Others may argue that if Mrs. A is in such pain that she's not even able to tolerate a physical exam, her ability to make decisions is temporarily impaired by her unrelieved pain, which would raise concern for her decision-making capacity. At that point, her husband's insistence on only giving non-opioid pain medications implies that he thinks he is the surrogate decision maker. In this circumstance, given the ambiguity around Mrs. A's mental capacity and her husband's interference, a formal decision making capacity assessment, as well as involvement of the ethics team, would help ensure that the patient's rights are being protected. Even so, Mrs. A's husband would have to respect his wife's previous preferences, and not substitute them for his own.

In conclusion, the principle of beneficence, or relieving suffering, should guide care decisions in the case of terminally ill patients, such as Mrs. A. The physicians on this case have a duty to alleviate Mrs. A's suffering and honor her decisions regardless of her husband's objections, as it is implied that she has the mental capacity to do so and that her previous wishes, evident by her previous approvals, was to receive morphine. In doing so, and while engaging in empathic and educational communication with her husband, the care team in this case would demonstrate both ethical responsibility and adherence to the core values of PA practice.

References

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