

all cases a referral to social services would be appropriate.

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#### References

- 1 Hawton K, Roberts J, Goodwin G. The risk of child abuse among mothers who attempt suicide. *Br J Psychiatry* 1985;146:486–9.
- 2 Royal College of Paediatrics and Child Health. *Child protection companion*. London: RCPCH, 2006.

#### A personal view of assisted dying

Over my ten years in palliative medicine the accusations levelled against morphine have been a constant feature and, with the passing years, the frequency of such accusations does not seem to change. Relatives' misperceptions are common and are perhaps understandable with comments such as: 'starting morphine, well that means the end doesn't it?'. Often patients tend to be more trusting, with an understanding driven by a need to obtain relief from their unpleasant symptoms. Colleagues often share these misperceptions: 'now that we know we can't make you better, we can start morphine' – suggesting that while you may still be cured you do not require effective pain relief. For those still in training it is a regular topic in education sessions and informal discussion. Among senior colleagues, especially those who influence policy, such gaps in knowledge are far less acceptable or understandable.

Frustration among colleagues is common. Accusations that although using opioid analgesics effectively to control pain we bring about an earlier death cause unnecessary fear for patients and families. With a need to reassure myself, and hopefully colleagues, that these accusations were misplaced I invested time in research and writing.<sup>1,2</sup> Clearly this is a difficult area to research but there is no evidence that using opioids in line with usual palliative medicine practice shortens life either in cancer or neurological disease.<sup>3,4</sup>

Two examples came to me recently that led me to write this letter. Firstly, a senior doctor writing to a relative of a patient in a hospice explaining that morphine doses would now be increased resulting in the

shortening of her life – implying this was normal practice in the hospice environment. The patient died peacefully 15 days later on the same dose of morphine.

Secondly, the recent article in *Clinical Medicine* (November/December 2006 pp 412–13). My sincerest sympathies go out to the author. Every day people go through similar battles to get good end-of-life care in acute hospitals. It is a hard task for acute units when faced with so many other demands on their time and it is genuinely challenging for the professionals involved to switch from providing acute, curative medicine to a focus on comfort and end-of-life medicine. All hospital palliative care teams work hard to try to improve this transition, and I am grateful to my local colleagues who are considerate of dying patients' needs. I am relieved that the hospice provided the last few hours of comfort – though it is a shame it was only for such a short time. But again morphine gets blamed for shortening a life with a suggestion that this is usual practice in a hospice to help the person on their way. Perhaps an alternative explanation is that this was clearly a frail lady dying from prolonged vomiting and advanced malignancy. The medication she received on her transfer purely made her more comfortable during this last phase of her life.

I have seen the blissful relief when morphine starts to work in reducing pain or breathlessness that all too often had been chronic and unrelieved. It is one of the most satisfying achievements in medicine to effectively remove a patient's pain. I know also that if morphine doses go too high the side effects can be unpleasant. In my early days as a senior house officer I increased a dying patient's morphine day after day believing her to be in pain. In fact she was agitated, not in pain, and all the morphine did was to increase this agitation, making her more uncomfortable and certainly not shortening her life. With my consultant's intervention, a low dose of the appropriate anxiolytic soon improved her agitation, ensured her comfort and the morphine dose came back down.

A huge amount can be achieved by palliative care despite the very short time periods we are often left to work in. Perhaps people (professional and non-professional)

do not realise this and we need to do more to broadcast our successes. Palliative care practice is more than just about the use of morphine, or other drugs. The skills of the team members, the approach to the patient and family, the attention to other issues than just the physical – in particular the psychosocial and spiritual – and the environment are all vital.

We cannot resolve all problems; it would be unprofessional to suggest we can. Occasionally, despite the efforts of the multidisciplinary team and the pharmacological approaches at our disposal, symptoms remain intransigent and intolerable. In these situations we can, and do, turn to sedation. This raises an ethical debate in itself and much work has examined this area.<sup>2,5</sup> But on the rare occasions when a patient meets the criteria and sedation is the only way to relieve their distress, midazolam is far more effective than morphine in making their time before death less distressing.

End-of-life care for many people could be significantly improved by changing opinion about the appropriate use of morphine. With all the discussion around assisted dying, one thing is clear: there is a need for a greater understanding of the evidence that guides practice around the end of life. If laws are to be changed then we need to start from a position of common understanding and accurate information.

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#### References

- 1 Thorns A, Sykes NP. Opioid use in last week of life and implications for end-of-life decision-making. *Lancet* 2000;356:398–9.
- 2 Sykes N, Thorns A. The use of opioids and sedatives at the end of life. *Lancet Oncol* 2003;4:312–8.
- 3 Neudert C, Oliver D, Wasner M, Borasio GD. The course of the terminal phase in patients with amyotrophic lateral sclerosis. *J Neurol* 2001;248:612–6.
- 4 Oliver D. Opioid medication in the palliative care of motor neurone disease. *Palliat Med* 1998;12:113–5.
- 5 Sykes N, Thorns A. Sedative use in the last week of life and the implications for end-of-life decision making. *Arch Intern Med* 2003;163:341–4.