

Pain control for dying patients: Hastening death or ensuring comfort?

Marshall B. Kapp, JD, MPH

Engaging in affirmative acts to intentionally hasten another human being's death may leave a physician open to state prosecution for homicide under the specific legal theories of murder, attempted murder, and/or voluntary manslaughter. Apprehension about the risk of such criminal prosecution has likely inhibited many physicians from responding adequately (in other words, humanely) to the pleas of dying patients for relief from their terrible and unremitting pain. The unfortunate consequence of this legal anxiety-induced inadequacy in medical care has been unnecessary emotional and physical suffering on the part of a substantial number of dying patients and their families, who have watched and shared in that suffering.

A proper understanding of the legal and ethical character of pain control in the end-of-life context should address that negative consequence by encouraging different, more positively responsive behavior on the part of physicians caring for dying patients. In particular, health-care professionals, state prosecutors and law enforcement officers, and the general public need to better understand the fundamental legal and ethical distinction between proper pain control on the one hand and the prohibited practice of euthanasia on the other.

Euthanasia is the carrying out of an affirmative act, such as the administration of a lethal injection, by one person for the precise purpose of hastening another person's death, with the cognizant expectation and actual result of accomplishing that objective. Whether undertaken with (voluntary euthanasia) or without (involuntary euthanasia) the permission or request of the ultimately euthanized individual, this kind of act is presently legally and ethically condemned in every American jurisdiction and most of the rest of the world. By contrast, providing adequate pain medication for a dying patient is a qualitatively different act than euthanasia. Therefore, it should be treated quite distinctly under the law, for at least two reasons.

First, the purpose of prescribing sufficient pain medication for a suffering patient in the final stage of life is to provide palliation for that patient. Unsurprisingly, physical pain is the primary motivation for patients who ask

their physicians to provide relief through prescription drugs.¹ In such cases the patient's death is a foreseeable and expected event, but bringing about that death is not, per se, the physician's goal in prescribing pain medications. Although it is not necessarily unwelcome, the patient's death in this situation is, at most, an accompaniment to or byproduct of humane palliative care. Thus, the philosophical principle of "double effect" (engaging in an act for a morally good purpose even while realizing the act may also contribute to a morally bad effect) would excuse, if not applaud, the prescribing of pain medications for suffering end-of-life patients.

Second, and more importantly, it may not even be necessary for proponents of the prescription of adequate pain medications for dying patients to resort to the double-effect principle for moral vindication and legal protection. This is because the physician's palliating action may not really contribute to a hastening of the patient's death. There is substantial evidence that even when it sedates a patient so deeply as to render him or her unconscious or stuporous until death has occurred, the administration of pain medication may not have any deleterious effect on the patient's life span.

As put by one legal scholar,² "Since deep sedation is administered to patients who are gravely deteriorated and unavoidably dying, it may be almost impossible to know whether the underlying disease process or the effects of sedation caused the death." Regarding the administration of pain relievers to a point short of inducing terminal sedation, the same commentator notes, "In the context of a debilitated, fatally afflicted patient, it is difficult to establish whether the analgesics actually hasten death. That evidentiary difficulty helps explain why very few criminal prosecutions [for homicide] have involved physician administration of analgesics."

The medical literature overwhelmingly agrees that "[o]pioids, which are recognized worldwide as the most appropriate drugs to treat severe pain, can be taken in large doses without having a lethal effect" and that "fears over the perceived life-shortening side effects of higher doses of opioids (known as 'opiophobia'), the risk for

abuse of opioids and possible legal consequences” are “probably often unrealistic.”³ Internationally, there appears to be a “growing notion that the effect of opioids on survival might be much smaller than frequently thought”⁴ and that “opioids are safe [that is, not death hastening] in the terminally ill when their doses are titrated against the symptom response”⁵

As is true elsewhere in clinical medicine, maintaining ethical practice while effectively managing legal risks depends on both behaving properly at the time and being able to prove you have done so afterwards. Proper physician behavior in this arena consists of prescribing opioids and other analgesic medications for dying patients only when clinically indicated to treat the effects of specific pain symptoms, and only to the extent (but certainly to the full extent) necessary to alleviate those symptoms.² Then, the factual basis for the physician’s clinical judgment and conduct should be documented fully and honestly in the patient’s medical record, as a safeguard in anticipation of a subsequent challenge to the physician’s reasoning. Assuming good professional practice that is properly documented, a compassionate physician should not

realistically fear adverse legal consequences for hastening the comfort of patients, even (or perhaps especially) at the ends of their lives.

Marshall B. Kapp, JD, MPH, Garwin Distinguished Professor of Law and Medicine, Southern Illinois University, Carbondale, Illinois.

REFERENCES

1. Rietjens JAC, van Delden JJM, van der Heide A, et al.: Terminal sedation and euthanasia: A comparison of clinical practices. *Arch Intern Med.* 2006; 166: 749-753.
2. Cantor NL: On hastening death without violating legal and moral prohibitions. *Loyola Univ Chicago LawJ.* 2006; 37: 407-431.
3. Bilsen J, Norup M, Deliens L, et al.: Drugs used to alleviate symptoms with life-shortening as a possible side effect: End-of-life care in six European countries. *J Pain Symptom Manage.* 2005; 31: 111-121.
4. Onwuteaka-Philipsen BD, Fisher S, Cartwright C, et al.: End-of-life decision making in Europe and Australia: A physician survey. *Arch Intern Med.* 2006; 166: 921-929.
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: 341-344.