The Use of Opioids and Sedatives at the End of Life

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Introduction

WE OWE A DEBT OF GRATITUDE to Fr. Austriaco for his fine work on medical ethics. He brings together effortlessly the fruits of his own work in biology, the best of the Catholic moral teaching on medical issues, pastoral sensitivity, an awareness of the challenges that our tradition faces in a secular society, including still disputed questions, and a masterful integration of the cardinal and theological virtues that doctors, nurses, and patients ought to bring to bear on the practice of medicine at the beginning of the twenty-first century.

While Austriaco is nearly exhaustive in his approach, here and there he hints at the need for further research in some areas. An example of this is the use of opioids and sedatives at the end of life. He writes, "(Incidentally, there is now data that suggests that the use of opioids and sedatives for various medical indications during a patient's last days of life is not associated with shortened survival.)"[1] It is this issue that I wish to explore more fully.

[1] Nicanor Pier Giorgio Austriaco, O.P., *Biomedicine and Beatitude: An Introduction to Catholic Bioethics* (Washington, DC: The Catholic University of America Press, 2011), 139.

Palliative Care at the End of Life

The use of opioids and sedatives at the end of life is a firmly established teaching in Catholic medical ethics. In the *Catechism*, we read the following:

> Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the suffering of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable. Palliative care is a special form of disinterested charity. As such it should be encouraged.[2]

Catholic teaching encourages the use of opioids and sedatives during the dying process, even if their use could hasten death. Such use has been generally covered by the principle of double effect. The use of opioids and sedatives is good in that they relieve the dying person of undue suffering and pain. It had been thought that the side effect of such use was the shortening of the person's life through respiratory depression. But as long as painkillers were used for that end, and not for the direct killing of the patient, such use could be tolerated as a foreseen and inevitable side effect of opioid and sedative use. On the other hand, to administer opioids and sedatives *in order to* hasten death would be considered illicit, as it would, in effect, be an act of active euthanasia. So the evil of shortening the patient's life would be acceptable as long as the ends and the means of opioid and sedative use were purely palliative.[3]

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[2] *CCC* 2279.

[3] A growing concern among ethicists, left untreated by Austriaco, is the rise of the number of cases of "stealth euthanasia" in which death is imposed (usually without the patient's consent) under the guise of pain relief. This issue is itself worthy of further discussion. See, for example, Ralph A. Capone, Kenneth Stevens, Jr., Julie Grimstad, and Ron Panzer, "The Rise of Stealth Euthanasia," *Ethics & Medics* 38 (June 2013): 1-4; Ron Panzer, "Contrary to Some, Medical Killings are Occurring in End-of-Life Care Settings," *Hospice Patient Alliance*, (April 29, 2012) n.a., "Actual Reports of Involuntary Euthanasia Cases in Hospice Settings—(Eleven Letters)," *Hospice Patients Alliance* (http://www.hospicepatients.org/actual/hosp-euth-cases.html).

This received wisdom has been challenged in recent years by studies that show that the *proper use* of opioids and sedatives does not, in fact, shorten life. We will examine these studies below. If this is, indeed, the case, the traditional use of the principle of double effect in such scenarios would be rendered virtually otiose. Let us examine the evidence.

Opioid and Sedative Use Does Not Shorten a Patient's Life

It has almost become a truism in the literature dealing with pain relief at the end of life that such relief almost inevitably hastens death. According to many authors, the use of opioids and sedation in terminally ill patients may "hasten death,"[4] "'potentially' hasten death,"[5] "actually speed up the process of dying,"[6] or "indirectly and unintentionally contribute to the patient's death,"[7] etc.[8] But studies that have been conducted since the 1980s have consistently shown that this is not the case.[9]

In their article "Sedative Use in the Last Week of Life and the Implications for End-of-Life Decision Making,"[10] Nigel Sykes and Andrew Thorns report that even though more than 50 percent of patients receive sedation at the end of life for symptoms such as pain, breathlessness and, more commonly, delirium,[11] sedation is usually brief and there is no evidence that it precipitates death. Rather, the use of sedation is a response to features of the dying process that have already begun. For

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[4] Cf. Kevin O'Rourke, "Pain Relief: the Perspective of the Catholic Tradition," *Journal of Pain and Symptom Management* 7 (1992): 485-491.

[5] Cf. S.H. Wanzer, D.D. Federman, S.J. Adelstein, et al., "The Physician's Responsibility Toward Hopelessly Ill Patients," *New England Journal of Medicine* 320 (1989): 844-849.

[6] Cf. S.C. Klagsburn, "Physician-assisted Suicide: A Double Dilemma," *Journal of Pain and Symptom Management* 6 (1991): 325-328.

[7] Cf. F. G. Miller, T.E. Quinn, H. Brody, et al., "Regulating Physician-assisted Suicide," *New England Journal of Medicine* 331 (1994): 119-123.

[8] For this information, I am indebted to Susan Anderson Fohr, "The Double Effect of Pain Medicine: Separating Myth from Reality," *Journal of Palliative Medic*ine 1/4(1998): 315-327.

[9] Cf. ibid., 316-319.

[10] Nigel Sykes and Andrew Thorns, *Archives of Internal Medicine* 163 (February 10, 2003): 341–44.

[11] Cf. V. Ventafridda, C. Ripamonti, F. De Conno, M. Tambutini, and B. R. Cassileth, "Symptom Prevalence and Control During Cancer Patients' Last Days of Life," *Journal of Palliative Care* 6 (1990): 7–11.

patients in need of such treatment, it is possible to use ongoing sedation at a level that is both therapeutically effective and safe.[12] The same, they argue, is true for the use of opioids.[13] Sykes and Thorns looked at seventeen studies and the effect of opioid use and survival.[14] Regardless of the kind of opioid used, these studies indicate that their use had not shortened a patient's life. The same results obtained even when opioids were used in conjunction with sedatives.[15]

There are two consequences that result from believing the myth that

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[12] Cf. Sykes and Thorns, "Sedative Use in the Last Week of Life," 344.

[13] See Sykes and Thorns, "The Use of Opioids and Sedatives at the End of Life," *Lancet Oncology* 4 (May 2003): 312–18.

[14] See M. Bercovitch, A. Waller, and A. Adunsky, "High Dose Morphine Use in the Hospice Setting: A Database Survey of Patient Characteristics and Effect on Life Expectancy," *Cancer* 86 (1999): 871–77; T. Morita, T. Ichiki, J. Tsunoda, et al., "A Prospective Study on the Dying Process in Terminally Ill Cancer Patients," *Journal of Palliative Care* 15 (1998): 217–22; T. Morita, J. Tsunoda, S. Inoue, and S. Chihara, "Effects of High Dose Opioids and Sedatives on Survival in Terminally Ill Cancer Patients," *Journal of Pain and Symptom Management* 21 (2001): 282–89; S. Grond, D. Zech, S.A. Schug, et al., "Validation of World Health Organization Guidelines for Cancer Relief During the Last Days and Hours of Life," *Journal of Pain and Symptom Management* 6 (1991): 411–22; F. J. Brescia, R. K. Portenoy, M. Ryan, et al., "Pain, Opioid Use and Survival in Hospitalized Patients with Advanced Cancer," *Journal of Clinical Oncology* 10 (1992): 149–55; R. Fainsinger, M. J. Miller, and E. Bruera, "Symptom Control During the Last Week of Life on a Palliative Care Unit," *Journal of Palliative Care* 7 (1991): 5–11; R. Fainsinger, K. Louie, M. Belzie, and E. Bruera, "Decreased Opioid Doses Used in a Palliative Care Unit," *Journal of Palliative Care* 12 (1996): 6–9; N. Coyle, J. Adelhardt, K. Foley, and R. Portenoy, "Character of Terminal Illness in the Advanced Cancer Patient: Pain and Other Symptoms During the Last Four Weeks of Life," *Journal of Pain and Symptom Management* 5 (1990): 83–93; I. Lichter, and E. Hunt, "The Last 48 Hours of Life," *Journal of Palliative Care* 6 (1990): 7–15; S. Mercadante, "Pain Treatment and Outcomes for Patients with Advanced Cancer Who Received Follow Up Care at Home," *Cancer* 85 (1999): 18–58; R. Goldberg, V. Mor, M. Viemann, et al., "Analgesic Use in Home Hospice Patients: Report from the National Cancer Study," *Journal of Chronic Disease* 39 (1986): 37–45; A. McCormack, D. Hunter-Smith, Z. Piotrowski, et al., "Analgesic Use in Home Hospice Patients," *Journal of Family Practice* 34 (1994): 160–64; K. Boyd, "Short Terminal Admissions to a Hospice," *Palliative Medicine* 7 (1993): 289–94; K. Turner, R. Chye, G. Aggarwal, et al., "Dignity in Dying: A Preliminary Study of Patients in the Last Three Days of Life," *Journal of Palliative Care* 12 (1996): 7–13; S. Mercadante, G. Dardanoni, L. Salvaggio, et al., "Monitoring of Opioid Therapy in Advanced Cancer Patients," *Journal of Pain and Symptom Management* 13 (1997): 204–12; D. Zech, S. Grond, J. Lynch, et al., "Validation of World Health Organization Guidelines for Cancer Pain Relief: A Ten Year Prospective Study," *Pain* 63 (1995): 65–76.

[15] See Sykes and Thorns, "The Use of Opioids and Sedatives at the End of Life."

opioid and sedative use at the end of life almost inevitably hastens death: the non-use of such treatments, or their under-use.[16] Leaving patients with untreated symptoms, by failing to use sedatives and by holding onto a misguided "opiophobia,"[17] which results in inadequate pain relief at the end of life, are not ethical choices.

The Principle of Double Effect is a helpful tool in analyzing many situations that can occur in the medical setting. It helps doctors, nurses, patients, and ethicists to choose options that those not acquainted with the principle might otherwise be reluctant to make. For example, the removal of a cancerous uterus from a pregnant woman is ethically permissible, according to the Principle of Double Effect. The removal of a cancerous organ is a good thing. Even though the baby will die as a result, the death of the baby, while foreseen, is not the means to cure the mother of cancer. The removal of the cancerous uterus is. The death of the baby, while sad, is *praeter intentionem*. The use of opioids and sedatives at the end of life, however, is a different matter. As the above studies show, the use of opioids and sedatives at the end of life should no longer be the subject of a Principle of Double Effect analysis. Their use is good. Their intended use is the relief of pain and the alleviating of some symptoms associated with the dying process. If used *properly*, opioids and sedatives do not hasten the death of the dying person and so can be used, if warranted, with peace of mind. No patient should needlessly suffer because of the unfounded fear of the use of opioids and sedatives at the end of life. N&V

[16] See I. Higginson and M. McCarthy, "Measuring Symptoms in Terminal Cancer: Are Pain and Dyspnoea Controlled?" *Journal of the Royal Society of Social Medicine* 82 (1989): 264–7; M. Boisvert and S Cohen, "Opioid Use in Advanced Malignant Disease: Why Do Different Centres Use Vastly Different Doses? A Plea for Standardizing Reporting," *Journal of Pain and Symptom Management* 10 (1995): 632–8.

[17] The use of the word "opiophobia" is found in Robert Maccauley, "The Role of the Principle of Double Effect in Ethics Education at US Medical Schools and Its Potential Impact of Pain Management at the End of Life," *Journal of Medical Ethics* 38 (2012): 174–8, especially 174.