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ETHICS ROUNDS

Appropriate Palliative Care?

Health care providers have an ethical obligation to provide effective pain management for patients, including at the end of life. Yet determining what constitutes appropriate palliative care raises several complex ethical dilemmas.

Consider the fictionalized case of a patient admitted to a VAMC for coronary artery bypass surgery. Initially the operation is a success, but while the patient is in the surgical intensive care unit recovering, severe complications develop. Over time, it becomes increasingly apparent that the patient will not survive. Despite aggressive medical management and life support, the patient proceeds to multi-system failure.

The surgeons and family in collaboration decide to discontinue mechanical ventilation. High dose opioids and sedatives (morphine and midazolam) are administered "to make sure the patient does not suffer" when the ventilator is withdrawn. The patient expires almost immediately. The next day, a nurse involved in the case expresses concerns about the dosages of medication the patient was given. Specifically, the nurse believes that the dosages prescribed by the surgeon were much higher than the dosages required to prevent suffering. In fact, the nurse is convinced that the amount administered was a fatal dose. She wonders whether this is a case of active euthanasia - which is illegal in VA and throughout the US.

The use of opioids (such as morphine) and benzodiazepines (such as midazolam) to prevent suffering in the setting of ventilator withdrawal is considered a standard part of appropriate palliative care.[1] In fact, analgesia and sedation sufficient to relieve dyspnea and anxiety during and after ventilator withdrawal are generally appropriate even in cases where the drugs may shorten the patient's life. In contrast, the practice of active euthanasia is prohibited by law. When does the use of opioids and benzodiapines cross the line to become euthanasia? The definition of "euthanasia" hinges on ***intent*** - were the drugs administered with the intent to cause death or with the intent to control symptoms? In other words, was death an intended consequence or an unintended side effect? [2,3] The Supreme Court has noted the centrality of intent in this distinction, emphasizing the importance of appropriate palliative treatments to relieve suffering.[4,5,6,7] However, this distinction is inherently subjective and based in part on the word of the physician.

In this case the physician's intent was not to cause death. Therefore, this is not properly considered a case of active euthanasia. But was it appropriate palliative care? Were the dosages of medications used in fact excessive, as the nurse suggests?

As a general rule, for medications of this type, the correct dosage is the minimal amount that can reasonably be expected to relieve suffering. The dosage of medication should then be titrated to the patient's symptoms - that is, it is appropriate to administer a larger dosage only if the starting dosage proves ineffective. The general wisdom among palliative care experts is that when these drugs are titrated according to the patient's actual symptoms, they are very rarely the cause of death.

The starting dosages that are generally recommended to prevent or relieve suffering in the setting of ventilator withdrawal are 2-10 mg of morphine and 1-2 mg of midazolam,[8] although patients who receive opioids and/or benzodiazepines on a regular basis may require much higher doses.

In the case described here, the prescribed dosages of morphine and midazolam were 100 mg and 40 mg, respectively - many times higher than the usual starting dose. Unless there was a clear reason why such high dosages were needed (e.g., lower doses had been shown to be ineffective), the doctor's actions - even though they did not constitute euthanasia - were outside of accepted standards for palliative care.

Unfortunately, this type of situation is neither surprising nor unusual. It is known that current knowledge of appropriate palliative care practices among physicians is often inadequate.[9] This case should serve as a reminder that despite VHA's impressive victories in the improvement of end-of-life care, there is work to be done to assure that practice is consistent with the highest quality standards. Every physician should have basic competence in end-of-life care - including knowledge of both clinical standards and ethical standards that guide end-of-life decisions. Information about educational opportunities and other useful resources are available on the following web sites:

VA Faculty Leaders Project for Improved Care at the End of Life:
    http://www.va.gov/oaa/flp/
Education for Physicians on End-of-life Care (EPEC) Project:
    http://www.ama-assn.org/ama/pub/category/2910.html
End of Life Physician Education Resource Center (EPERC):
    http://www.eperc.mcw.edu/

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1. AMA's *Education for Physicians on End-of-life Care Project*. Participant's handbook-Module 11: Withholding, Withdrawing Therapy. Available at: http://www.ama-assn.org/ethic/epec/download/module_11.pdf. Accessed May 10, 2001.

2. Quill TE, Dresser R, Brock DW. The rule of double effect-a critique of its role in end-of-life decision making. *N Engl J Med*. 1997; 337:1768-1771.

3. Garcia JLA. Double effect. In: Reich WT, ed. *Encyclopedia of Bioethics*. Revised edition. New York, NY: Simon & Schuster Macmillan; 1995:636-641.

4. *Washington v Glucksberg*, 521 US 702 (1997).

5. *Vacco v Quill*, 521 US 793 (1997).

6. Burt RA. The supreme court speaks-not assisted suicide but a constitutional right to palliative care. *N Engl J Med*. 1997; 337:1234-1236.

7. Luce JM, Alpers A. End-of-life care: What do the American courts say? *Crit Care Med*. 2001;29:N40-N45.

8. AMA's *Education for Physicians on End-of-life Care Project*. Participant's handbook-Module 11: Withholding, Withdrawing Therapy. Available at: http://www.ama-assn.org/ethic/epec/download/module_11.pdf. Accessed May 10, 2001.

9. American Pain Society. Position Statement: Treatment of pain at the end of life. Available at: http://www.ampainsoc.org/advocacy/treatment.htm. Accessed April 22, 2001.