Opiates and the Removal of Life Support

A Moral Obligation of Health Care Providers

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Abstract. Medical and nursing personnel have an obligation to provide the medication necessary for every patient's pain relief. This includes patients whose life-supporting mechanical ventilation is being removed, who may not exhibit traditional signs of pain or dyspnea. The purpose of this paper is not to argue a position on withdrawing life support. Rather, it argues that nurses and physicians have an obligation to provide pain-relieving medication, such as opiates, when life support is removed, to ensure that those entrusted to their care do not experience pain or significant distress. This is based on the principle of double effect, by which two actions, one intended and one unintended, may be permissible if there is a proportionate reason. The goal in these situations is never to hasten death intentionally but to make patients' pain and suffering tolerable as a matter of compassionate and loving care. *National Catholic Bioethics Quarterly* 17.3 (Autumn 2017): 409–415.

Some health care providers hesitate at the thought of administering a medication like morphine to alleviate pain and dyspnea in a patient who is to be removed from life-supporting mechanical ventilation when they know that the medication may hasten the patient's death. What is the obligation of the medical community? How can the administration of opiates at the end of life not be perceived as euthanasia? What is the Catholic Church's position on providing medication that may hasten

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death? What is the role of medical and nursing staff for ordering and administering these medications?

Among critically ill patients in an intensive care unit (ICU), death most commonly results from withholding or withdrawing ventilator support. However, this decision is difficult for patients, families, and clinicians. It is influenced by many factors, including the patient's prognosis, values, and treatment preferences as well as their cultural, philosophical, and religious beliefs.[1]

Removing a patient from mechanical ventilation, including one who is actively dying, is ethically acceptable when the patient no longer benefits from its continuation. When the family or surrogate decision maker concludes that the benefits of continuing treatment have become disproportionate to the burdens, they may decide to discontinue treatment and remove ventilator support. Often, an individual cannot be weaned from the ventilator, and the surrogate feels that proceeding with a tracheostomy would not be in line with the patient's wishes. Most patients in this situation are being cared for in an ICU or other critical care setting, and staff must be technically and ethically prepared to care for them properly after the decision to discontinue ventilator support has been made.

What is the duty of health care personnel when providing relief from pain and suffering to these patients? Must they provide medications that may potentially decrease respiratory drive and hasten death? Would this be considered euthanasia? How aggressive can the pain-relief efforts be? How aggressive should these efforts be? What if the patient does not appear to be in pain? In the provision of pain-relieving therapies, what is too much or too little?

Whether or not the patient exhibits symptoms, health care providers have an obligation to prevent and relieve suffering by providing opiates or other medications that are appropriate to the patient's condition. I also contend that in order to provide the necessary medication for symptom management, medical and nursing staff must have a solid understanding of the principle of double effect and must be able to explain this principle to family members when questioned about whether their actions constitute euthanasia.

Obligation to Provide Pain Relief

Medical personnel have an obligation to provide medication that will alleviate or minimize a patient's pain and suffering when mechanical ventilation is removed. This mandate includes patients who may not exhibit traditional signs of pain or other distress[2] and is supported by the ethical principle of beneficence, which obligates practitioners to act in the best interests of their patients.

1. J. Randall Curtis and Jean-Louis Vincent, "Ethics and End-of-Life Care for Adults in the Intensive Care Unit," *Lancet* 376.9749 (October 16, 2010): 1347–1353, doi: 10.1016/S0140-6736(10)60143-2.

2. US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB, 2009), dir. 61.

Insertion of a temporary breathing tube through the mouth and into the trachea is painful, and the tube cannot remain in place indefinitely. Most patients are already receiving intravenous medications to help dull their senses so that they do not try to remove it. In addition, a doughnut-shaped balloon is inflated around the base of the tube to help keep it in position and prevent oral secretions and vomitus from entering to the lungs. Even though patients may appear relaxed while receiving sedation and pain medication, often they are not.[3] Intubation and ventilator support are markedly unpleasant, and many patients need to be restrained with soft wrist restraints or pharmacological agents.

For those who have experienced being on a ventilator, the sensations of drowning, gasping, and choking invoked feelings of helplessness, vulnerability, and fear. Their descriptions of horror, misery, and torture provide an insight into how extreme and traumatic intubation can be, and it has been argued that leaving a person in avoidable pain is a breach of fundamental human rights.[4] Not surprisingly, many patients who receive ventilator assistance in the ICU also receive continuous medication for pain and anxiety. The most common medication for ICU patients on ventilator support is the opiate morphine, given its low cost and the predictability of its effects.[5]

If a patient is unable to make his or her own health care decisions, a surrogate may advocate for that individual and make decisions about care. If the prognosis becomes poor and recovery is unlikely, there will probably be a discussion about the goals of care, which may include removing life support and allowing the patient to die. If recovery is not possible, a dignified and peaceful death becomes the paramount goal.[6]

The surrogate may decide that the burdens of continued treatment, including use of the ventilator, are either disproportionate to its expected benefits or, perhaps, not in line with the goals of care previously expressed by the patient verbally or in a living will. This decision is sometimes made when the individual cannot safely be weaned from the ventilator and has previously expressed an aversion to having life artificially prolonged without the likelihood of recovery. This decision is consistent with Catholic moral theology, as "a person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's [or surrogate's] judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community. . . . The free

3. Lory Clukey et al., "Discovery of Unexpected Pain in Intubated and Sedated Patients," *American Journal of Critical Care* 23.3 (May 2014): 216–220, doi: 10.4037/ajcc2014943.

4. M.A. Somerville, "Death of Pain: Pain, Suffering and Ethics," in *Proceedings of the 7th World Congress on Pain: Progress in Pain Research and Management,* vol. 2, ed. Gerald F. Gebhart, Donna L. Hammond, and Troels S. Jensen (Seattle: IASP Press, 1994): 41–58.

5. H.M. Soliman, C. Mélot, and J.L. Vincent, "Sedatives and Analgesic Practice in the Intensive Care Unit: The Results of a European Survey," *British Journal of Anaesthesia* 87.2 (August 2001): 186–192, doi: 10.1093/bja/87.2.186.

6. F.J. Tasota and L.A. Hoffman, "Terminal Weaning from Mechanical Ventilation: Planning and Process," *Critical Care Nursing Quarterly* 19.3 (November 1996): 36–51.

and informed judgment made by a competent adult patient [or surrogate] concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching."[7]

The role of communication cannot be overstated when discussing end-of-life decisions, especially when considering whether to remove a patient from life support.[8] Withdrawing life-sustaining treatment is a process that merits the same meticulous preparation and expectation of quality that clinicians provide when they initiate it. Attention should be devoted to making it clear that care is not being withdrawn.[9] Although the endotracheal tube will be removed and ventilator support withdrawn, providers will continue to manage the symptoms associated with the patient's ineffective or deficient respiratory system.

Once the decision has been made to discontinue life support and remove the endotracheal tube, the patient may be expected to breathe for a period of time. In these circumstances, the staff are obligated to continue providing compassionate care, including minimizing pain and dyspnea, often through the use of opiates and benzodiazepines, and always respecting the dignity of the individual. Although death may be an anticipated outcome, relief of suffering is the priority. This may cause some uneasiness among health care professionals, because it has long been established that opiates can depress the respiratory drive. Because of these potentially fatal consequences, opioid-induced respiratory depression is a major limiting factor for the provision of effective analgesia.

Nonetheless, "medical fear of respiratory depression means that pain is often under-treated and patients experience unnecessary suffering."[10] According to the principle of double effect, it is ethically appropriate and acceptable for patients to receive medications that may unintentionally hasten death if the medication is required for a proportionately serious, medically indicated reason.

The Principle of Double Effect

The principle of double effect "is grounded in the ethical principle of proportionality. It originated from Thomas Aquinas in the 13th century. This doctrine asserts that an action in the pursuit of a good outcome is acceptable, even if it is achieved through means with an unintended but foreseeable negative outcome, if that negative outcome is *outweighed* by or equal to the good outcome."[11] In its basic form, the double effect allows for a bad effect as long as it is not intended and the action that

7. USCCB, *Ethical and Religious Directives*, dir. 57, 59.

8. Sharon M. Valente, "End-of-Life Challenges: Honoring Autonomy," *Cancer Nursing* 27.4 (July–August 2004): 314–319.

9. Sharon Reynolds, Andrew B. Cooper, and Martin McKneally, "Withdrawing Life-Sustaining Treatment: Ethical Considerations," *Thoracic Surgery Clinics* 15.4 (November 2005): 469–480, doi: 10.1016/j.thorsurg.2005.06.002.

10. K.T.S. Pattinson, "Opioids and the Control of Respiration," *British Journal of Anaesthesia* 100.6 (June 2008): 747, doi: 10.1093/bja/aen094.

11. Molly L. Olsen, Keith M. Swetz, and Paul S. Mueller, "Ethical Decision Making with End-of-Life Care: Palliative Sedation and Withholding or Withdrawing Life-Sustaining

causes it has a proportionately good effect. The double effect allows the medical community to provide appropriate patient care and pain relief as long as the following four conditions are met:

1. The action of itself, and considered in its object, is good or, at least, indifferent (that is, neither good nor bad).
2. The good effect and not the bad effect is intended.
3. The good effect is not produced by means of the bad effect.
4. There is a proportionately grave reason for permitting the bad effect.[12]

All four of the conditions must be met. If any one of the conditions are not met, the action is unacceptable.

The challenge for many caregivers is recognizing their responsibility to provide medications for pain and dyspnea to a patient who may develop respiratory compromise as a result. Dyspnea is a symptom perceived by the patient; there are no physiological or physical signs that indicate the level of dyspnea, and patients without physical signs of shortness of breath may experience severe subjective dyspnea. Therefore, it must be assumed that the patient may have dyspnea, which must be anticipated, expected, and preemptively treated. This sort of preemptive dosing is not euthanasia or assisted-suicide but good palliative care. For patients and relatives, the sensation of breathlessness is one of the most terrifying symptoms of the dying process.[13]

There are times when medical professionals are not comfortable providing some of the medications used to treat dyspnea. They may feel that giving opiates for pain and dyspnea, or benzodiazepines for anxiety, may decrease a patient's respiratory drive and thereby speed up or even cause death. Some may believe that giving these medicines to patients prior to removing the patients from ventilator support constitutes euthanasia. Also, newly practicing nurses may be reluctant because they do not have experience in providing end-of-life care. A survey of more than two thousand nurses showed that basic nursing programs do not teach students about end-of-life care, even though 90 percent of respondents considered it very important.[14] "It is essential that nurses acquire the necessary competencies, through their academic preparation and

Treatments," *Mayo Clinic Proceedings* 85.10 (October 2010): 951, original emphasis, doi: 10.4065/mcp.2010.0201.

12. Edward J. Furton and Albert S. Moraczewski, "Double Effect," in *Catholic Health Care Ethics: A Manual for Practitioners*, 2nd ed., ed. Edward J. Furton, Peter J. Cataldo, and Albert S. Moraczewski (Philadelphia: National Catholic Bioethics Center, 2009), 24.

13. E. J. O. Kompanje, B. van der Hoven, and J. Bakker, "Anticipation of Distress after Discontinuation of Mechanical Ventilation in the ICU at the End of Life," *Intensive Care Medicine* 34.9 (September 2008): 1593–1599, doi: 10.1007/s00134-008-1172-y.

14. B. Ferrell et al., "Beyond the Supreme Court Decision: Nursing Perspectives on End-of-Life Care," *Oncology Nursing Forum* 27.3 (April 2000): 445–455.

continuing education, to effectively guide and advocate for patients and families in end-of-life planning [and] the dying process itself."[15]

Providing end-of-life care to a patient who is to be removed from life support is both a learned behavior and a learned skill. Nursing staff must be trained on the double effect, not only during their formal education but also by their employers. When questioned, health care providers must be able to explain the appropriateness and acceptability of this principle to family members so that they can effectively explain the rationale for providing medications that may hasten death. They must be prepared to explain that the goal is always and only the relief of symptoms. In some instances, they may have to defend their actions against accusations of euthanasia and physician-assisted suicide.

"For family members of dying patients, it is essential that physicians provide assurance that the patient will not be abandoned during the process of withdrawal of life-sustaining measures and that pain and suffering will be minimized."[16] Failure to provide the medication necessary to ensure a patient's comfort violates the patient's dignity; consequently, there is a substantial obligation to treat symptoms related to the removal of ventilator support.

Application of the principle of double effect to decisions about medicating patients who will be removed from life support can be summarized as follows:

1. Providing medication to a patient to treat pain and dyspnea is in itself a good action.
2. Relief from pain and dyspnea is the only intended result of providing the medication. Respiratory depression and the hastening of death are not intended, although their possibility is foreseen.
3. The good effect is not achieved by means of the bad effect; that is, the relief of suffering must not come about by the death of the patient. At the same time, this means that one cannot give an excessive dose of medication to intentionally expedite or cause death and thereby relieve the person of pain. Purposefully hastening death cannot be excused as a side effect of pain relief, and increasing the dosage of medication beyond what is necessary for pain relief cannot be justified under the double effect.[17]
4. From the standpoint of proportionality, if pain, dyspnea, and other distressing symptoms are present and if death is approaching whether or not medication is used, it would be unconscionable and professionally improper not to provide medications for comfort. A patient should never be allowed to die in anguish.

15. American Nurses Association, *Registered Nurses' Roles and Responsibilities in Providing Expert Care and Counseling at the End of Life*, position statement, June 14, 2010, 20. This statement was retired and has not been replaced.

16. Ann C. Long et al., "Time to Death after Terminal Withdrawal of Mechanical Ventilation: Specific Respiratory and Physiologic Parameters May Inform Physician Predictions," *Journal of Palliative Medicine* 18.12 (December 2015): 1046, doi: 10.1089/jpm.2015.0115.

17. Susan Anderson Fohr, "The Double Effect of Pain Medication: Separating Myth from Reality," *Journal of Palliative Medicine* 1.4 (Winter 1998): 315–328.

The medication necessary for providing comfort is paramount in providing quality care and maintaining the human dignity of patients.

Recognizing the Need to Relieve Symptoms

Medical professionals must recognize that when a patient is allowed to die, "one still upholds the value of a human being's life by not acting with intention to end it."[18] They must be able to understand and explain that "withholding or withdrawing ineffective, futile, burdensome, and unnecessary life-prolonging procedures or treatments does not constitute euthanasia or [physician-assisted suicide], because it is not intended to hasten death, but rather indicate the acceptance of death as a natural consequence of the underlying disease progression."[19] Although they may lack higher brain functions, even patients in a comatose state may have the rudimentary capacity to experience pain and suffering. In these cases, the clinician should err on the side of caution and provide an appropriate level of analgesia and sedation.[20]

Choosing to either continue agonizing life-prolonging treatment or discontinue life support can create a great deal of anguish for family members, who may come to realize that neither choice presents the outcome they want for their loved one. Some may question whether removing life support is permissible or whether it might be considered euthanasia. Good medical and nursing care, as well as open and honest dialogue regarding the prognosis, benefits, and continued risks, must be shared and discussed with patients and their family members.[21]

In summary, the period of life that follows the discontinuation of mechanical ventilation can be very short, but thoughtful anticipation of distressing symptoms takes more time. Given that the patient is suffering from a serious respiratory or ventilatory deficiency, multiple organ failure, extremely diseased lungs, or severe neurological dysfunction, withdrawing mechanical ventilation and subsequently removing an endotracheal tube often induces or hastens death. These actions do not kill the patient but allow the disease to complete its natural course. There is an ethical mandate to both anticipate and treat pain, respiratory distress, and anxiety. "This makes [the process of] withdrawal of mechanical ventilation in ICU patients a thoughtful process, taking palliative actions instead of fast terminal actions."[22]

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18. Daniel P. Sulmasy, "Killing and Allowing to Die: Another Look," *Journal of Law, Medicine, and Ethics* 26.1 (Spring 1998): 62.

19. Liliana De Lima et al., "International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician-Assisted Suicide," *Journal of Palliative Medicine* 20.1 (January 2017): 11, doi: 10.1089/jpm.2016.0290. See also Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (May 5, 1980).

20. R. D. Truog, et al., "Recommendations for End-of-Life Care in the Intensive Care Unit: The Ethics Committee of the Society of Critical Care Medicine," *Critical Care Medicine* 29.12 (December 2001): 2342.

21. Somerville, "Death of Pain."

22. Kompanje et al., "Anticipation of Distress after Discontinuation of Mechanical Ventilation," 1593.