End-of-Life Pain Management: a Criminal Offense?

Robert A. Weitzel, M.D.

In June 1999 I was about to fly to the Cayman Islands for a week of scuba diving when I got the call from my attorney. He told me I'd better sit down.

He said it had just been announced on the news that I was being investigated in the deaths of five of my patients, years before, and there was talk of charging me with murder.

At that moment I could barely remember the details of the deaths, but I did remember the general circumstances. I was incredulous. I had treated patients in the manner taught in medical school and residency.

I thought my care was state of the art. I had worked in a pain clinic and read the medical literature in the palliative care and pain treatment fields. I had always been interested in the issues of medical ethics, and I studied assiduously when we had our required senior year medical ethics course.

I had done volunteer work with acquired immune deficiency syndrome (AIDS) patients in Dallas during my first years after medical school, and I had become familiar with the then nascent hospice care movement.

Now the Davis County Attorney claimed that I'd been practicing "active euthanasia."

What Is Euthanasia?

Active euthanasia means intentionally causing the death of a person, albeit generally in a manner that is meant to be kind, non-painful, and even pleasant. The word euthanasia comes from the Greek, with roots meaning "good" – "eu," and "death" – "thanatos." Euthanasia is a "good" death, rather than the painful, undignified, sometimes degrading death that is often the outcome of chronic illness. When a loved pet is "put down," this is euthanasia, and it is "active"–the veterinarian administers a drug, or in some other manner ends life.

I had no intention to practice euthanasia. I had, if anything, let nature take its course. There is a world of difference.

Generally when we are vigorous and healthy, we want to have treatment if there is a reasonable hope of a good outcome from the medical care. But at some point even the most sophisticated care is virtually useless. It might keep a person alive for a little while longer, but at a huge cost. Side effects are intolerable, financial expense unbearable, pain and suffering from the disease are not completely treatable, and the whole process sometimes becomes a hellish extension of dying, rather than living.

Patients must determine for themselves when and if they want to end futile attempts at treating illness and accept the inevitable death that approaches. If the patient is incompetent to make this decision because of unconsciousness or dementia, it is the right and responsibility of the family members or other surrogate to decide. Competent patients always have the right to refuse any and all treatments. It is legally an assault and battery to continue to treat against the patient's wishes. We must respect the patient's right to autonomy, and transfer care to another if we cannot abide by the decisions made by the patient or the incompetent patient's surrogate.

If and when a patient opts to stop interventional attempts at cure, and asks for palliative care, it is the medical profession's duty to ensure that the dying process is, if possible, pain-free and dignified. The emphasis now is not cure, but comfort. Treatment is not completely withdrawn: one might even resect a tumor mass that is causing problems, but in an attempt to palliate discomfort, not to cure the disease. More commonly, simple nursing care is emphasized, and the use of opiate pain medications becomes almost universal.

Use of opiates is never meant to *cause* the death of the patient. The patient is being *allowed* to die. This is the crucial difference. In the first case, death is caused and intended. In what has been called "passive" euthanasia, the process of death is allowed to run its course, and the dying person is afforded every technique we have to prevent pain and suffering. Hospice workers give this type of care every day in every hospital in America, in nursing homes, in freestanding hospice centers, and in the homes of patients. It is mainstream medicine.

Many in the hospice movement object to the phrase "passive euthanasia" because of the connotations and overlapping identification with the active type. Assisted suicide as practiced in Oregon and in Kevorkian's ultimately irresponsible acts have tainted the word "euthanasia." Physicians prefer the term "palliative care," and nurses speak of "comfort care."

Opiate dosage is not stinted when one is practicing palliative care. The proper dose is the dose required to control pain. Patients and families often need to be counseled about the fallacy of the irrational fear of addiction.

The ethical principle of "double effect" justifies continuing assertive, even aggressive use of potent opiates, even if their use might conceivably hasten death. This is because the opiate's intended effect is to ameliorate pain and suffering. If it should have the effect of somehow shortening life, the primary intent to treat pain overrides this secondary and unintended effect.

Of course, it is almost impossible to prove that a certain blood level of opiates actually caused the death of a dying patient. Respiratory depression might be cited, but this occurs universally in dying patients. Pain is a potent antagonist to this effect.

What is the Correct Dose of Opiates?

The correct dose of opiates is, again, the dose that controls the pain.

Very importantly, there is little concern by palliative care physicians for the overblown concerns that opiates might be very dangerous. This misconception has been proven incorrect, but often leads to woefully inadequate pain control. When given alone, not mixed with one or more of the "three Bs" of booze, benzodiazepines, or barbiturates, the opiates are in fact very safe. (This caveat does not apply to the judicious use of benzodiazepines with opiates when prescribed by a physician. Frequently the two are necessary, for instance, in the case of a patient with both post-surgical pain and fulminant alcohol withdrawal. The warning refers to recreational use.)

Research on the LD_{50} for morphine, the lethal dose for 50 percent of test subjects, was done in the 1920s. Monkeys intentionally given lethal overdoses of intravenous morphine required what extrapolated to a minimum of approximately 500 mg of the drug in a 70 kg human. A 1929 study of morphine addicts demonstrated that the intravenous injection of up to 30 grains (1,950 mg) caused "insignificant changes in respiratory rate, pulse, and behavior."[1]

If tolerance develops through a long course of palliative treatment, doses can seem huge, equivalent to grams of morphine in a day, but this is entirely appropriate. Unfortunately, through a long history of substandard education about pain control, and the insidious effect of the government's current "War on Ourselves," many practitioners hold outmoded opinions about opiates that have no basis in fact, and severe pain is under-treated.

Although the government in sensational and often hysterical press releases frequently cites thousands of "heroin overdoses," it is in fact very difficult to overdose on opiates alone. For this reason, physicians in Oregon who choose to participate in physician-assisted suicide have been warned to not attempt this with morphine. Instead, they use a fast-acting barbiturate like secobarbital.[2]

The Facts in My Case

My patients were terminal. Their minds and brains ravaged by severe dementia, and their lives seemed a living hell. They had been transferred to the geriatric psychiatry unit for treatment of severe and intractable agitation that made it impossible for them to reside in the nursing homes from which they all came.

I was treating them with psychiatric medications: antidepressants, anxiolytics, antipsychotics, and mood stabilizers. When they developed an acute medical illness, with such serious problems as renal failure, sepsis, GI bleed, pneumonia, and stroke, I offered their families a transfer to an internist in the ICU, for full work-up of the new problems and whatever treatment interventions they wanted.

I also offered an alternative. Given their irreversible and end-stage dementia, I offered a switch to simple palliative care. I told them I would stop intervening, give opiates for any pain and suffering, have the nurses provide comfort care, and let them die a natural death.

All the families chose the second option, and they signed advance directives making this clear in the cases in which no medical treatment plan had yet been accomplished.

Nevertheless, an overzealous prosecutor was calling me a murderer. It seemed like a bad dream. None of the families of my patients had ever complained to anyone about the care I had rendered. How could a politician, completely untrained in medicine, drag me into court and prosecute me over issues he knew nothing about?

The answer is: with ease, using the enormous power and resources of the county, state, and federal governments–unfairly, unethically, and illegally.

The end result was my imprisonment, impoverishment, and unemployment. I have not worked in my chosen field to this day, although I was acquitted on all charges in a second trial granted because the prosecution had withheld exculpatory testimony.

Full information is posted at www.weitzelcharts.com.

Robert A. Weitzel, M.D., is a board-certified psychiatrist. E-mail address: raw1md@weitzelcharts.com.

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