Opioid use at the end of life: working out the physician's intentions

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Opioid use at the end of life has been a matter of debate among some doctors because of its perceived life-shortening effects (1). Opioid medications such as Morphine, Tramadol, Codeine, Oxycodone and Fentanyl are effective in relieving pain, but can also cause death through respiratory depression (1). Because of this possibility, it has been argued that doctors utilise such medications at the end of life if the premature death of the patient is intended (1). Because of this claim and the fact that euthanasia and physician-assisted suicide are illegal in most countries, many physicians are reluctant to use these medications for fear of having their intentions questioned (1). The result is that physicians fail in their duty of care because patients suffer unnecessarily though effective and proven treatments exist.

This is a concern, given that studies have discounted the fear that the use of opioids at the end of life always or almost always precipitates death (2,3). Physicians using opioids in end-of-life care may find their decisions questioned even when the justification for the use of these medications is documented, the drugs are used in accordance with established guidance, and a review of opioid administration and the events leading to it makes the physician's intention clear (4,5). The problem, therefore, is to make sure that the physician's intentions are beyond reproach. Yet understanding intention continues to be a thorny problem as evidenced by the continued debates on euthanasia in the courts.

Intention

To be clear, this paper is about the ethical import of intention. Nevertheless, the intricacy of clinical decision-making has become inseparable from attitudes to medical law. To understand the issue at hand, therefore, we find it necessary to approach the circumstances of opioid use both from an ethical and legal direction. To begin with, Beauchamp and Childress have argued that intention depends on deliberation, reasoning, planning, volition and acting upon a premeditated blueprint (5). While this describes the characteristics of an intentional act, questions persist regarding whether it is possible to "know" the motive of the agent. While the actor may be outwardly clear as to what his or her intention is, this is not definitive, and indeed, may be used to shield real intentions. In this respect, Quill has argued that "... clinical intentions may be complex, ambiguous and often contradictory"(6). Moreover, ethical and medical considerations in specific cases may introduce further complications (7). However, challenges are likely in respect to an intention which has no clear outcome (i.e. there is more than one possibility) and especially when the stakes are high, such as decisions made at the end of life. In this respect, we pick up on just one point: it is possible to have more than one intention. For example, if the physician intends to ameliorate suffering as well as hasten death, escalating the dose of opioids would serve both purposes. Such has been the basis of a number of legal cases in which there is an allegation of euthanasia (here we do wish to expand the definition of euthanasia beyond the basic idea that a physician, through his or her actions, has hastened the death of the patient). Only by understanding the physician's real intent can the legality of the action be ascertained, and it is in this judgement that ethical import becomes crucial. Our basic parameter for discussion is therefore understanding the true intention when it is alleged that two diametrically opposite objectives are in play (pain relief and killing a patient), but which are concealed through a single clinical action.

This can be illustrated by the British case of *R v Moor* (reported in *The Times*, May 12, 1999). David Moor, a general practitioner, was charged with the murder of his patient, George Liddell. Moor administered diamorphine, an opioid, to relieve his pain (8). But witnessing Liddell's deteriorating state, Moor instituted a continuous infusion of diamorphine. The patient passed away 20 minutes later. The judge in the case, Justice Hooper, directed the jury in a particular way: the evidence about the amount of morphine administered was not to be relied on. Instead, the "causation question" should be read as the actions of the doctor had "contributed significantly" to the death of his patient. Nor should it be further inquired whether Liddell was terminally ill at the time: Moor clearly believed this to be the case (8,9). In fact, the jury was to confine itself to two questions specific to intention: 1) whether Moor had intended to relieve the patient's pain; and 2) whether the injection was intended to kill. Hooper in essence asked the jury whether they could be certain that Moor had intentionally administered the drug as a means to kill his patient (10,11). Thus, Moor's intentions and his motivations became central to the elucidation of his guilt.

Moor's arrest was subjected to intense media attention that heightened public concerns regarding opioid use at the end of life and its apparent life shortening effects (12,13). The prosecution at least believed that he had intended to kill Liddell. In the ensuing court case a verdict of "not guilty" was recorded, thus indicating that the jury could not be certain of his intent to administer a lethal dose and therefore must acquit him of murder. On the facts of the case (Moor admitted that he had administered a lethal dose of drug in many other patients),

it appeared that Moor acted primarily to alleviate pain, even while it was accepted that a foreseeable, but unintended effect of such an action was to hasten the death of the patient (8,9). There was no evidence that he had intended euthanasia, and given the clinical circumstances, Moor's actions were in keeping with pain control measures. These would support his explanation that pain relief was his primary intention; that is, he appeared to truly believe that Liddell's pain could be medically treated with opioids. His actions therefore resonate within the idea of the "doctrine of double effect" - that an intention to cause evil can be separated from foreseeing evil to be a consequence of one's actions. In this case, the doctor was not seeking the death of the patient through his actions because his goal was to relieve suffering. He may or may not have acknowledged that the possible adverse effect of symptom amelioration is premature death (14,15). Dr Moor was therefore judged to have intended to ameliorate the patient's suffering (any other decision would have indicated his guilt); death was merely the foreseen but unintended effect of the action taken to realise this primary intention.

Can we really know another's intentions?

But this is the question that arises out of similar accusations of euthanasia: can the doctor really be naive, indifferent or oblivious to these consequences? Is it enough that he acknowledges the possibility of death to absolve his true intention from critical judgement? Quill and Bycock state that although intention cannot always be as easily identified, it may be inferred from the actions themselves and the sequence of events preceding them (6,16). Anscombe states that the notion of "unknowability" of intent is "absurd" and argues that the intent behind an action can be learnt from the action itself (17). Sulmasy adds that simple clinical acumen, and reflection on a particular action and the manner by which it was carried out, can clarify the intent behind an action (14). This is to say that an agent acts in such a way as to realise his intention. Tannjso adds that intent can be further understood by asking the physician whether, if there had been another way of treating these symptoms and which entailed fewer risks, he or she would have taken it (18). An affirmative answer indicates that the focus is on ameliorating suffering; a negative response would cast doubts on the true intent of the physician. An affirmative response would also indicate that the physician had visited all other treatment options before utilising the option deemed the safest and most appropriate to the specific clinical scenario. In *Cox*, another infamous British case, the doctor was found guilty of attempted murder because his intention was clearly laid out by the administration of a tranquilliser and potassium chloride, which could only have been meant to hasten the death of his patient (a terminally ill woman in extreme pain). In the case of Cox, the physician would have to (hypothetically) accept that there were effective measures to relieve pain, proportionate to the situation, and which had not (apparently) been even considered (19).

Within a common law system - one in which ethical principles come to the fore because they are used as the basis of argument and redress - it would seem that the doctor's intentions could be at least partially revealed by reviewing the relevant case notes and associated clinical documentation in any patient's treatment. Even though the fact of a patient's death is palpable for the jury, they have to go a long way to work out the circumstances that brought this about. The accuser or defendant's advocate would look for information to ascertain the justification, proportionality and propriety of a questionable action, and provide a means of establishing whether the intention underlying the action was acceptable within the given clinical scenario. This could then be corroborated by the members of the palliative medical team and a review of the decisions made at multidisciplinary meetings on the case. To put it another way, it is an enquiry as to whether the physician had good (meaning justified or ethical) reasons for acting in the way he or she did. It is only on the basis of this probe that his or her intentions can be properly judged.

In *Moor*, the use of a known analgesic to relieve suffering did not itself justify the physician's actions, let alone shed light on his intentions. This became possible only through an appreciation of the clinical scenario: clinical corroboration and the associated documentation demonstrated proportional titration and appropriate monitoring in keeping with clinical guidelines. Only then was Moor's true intent elucidated and his actions deemed by the jury as justified. Additionally, given that Moor's intervention was in keeping with the practice of his peers within the same specialty, further confidence in his actions was provided (20). The fact that he had not recognised that the patient's worsening pain was caused by an undiagnosed heart condition rather than terminal cancer did not undermine his intention. What it does show, perhaps, is that doctors should act with confidence in their diagnosis and prognosis, discuss with their peers before acting, and record their reasons for acting in each case. It is only through meeting these conditions in their entirety that the rationale for an action be clinically and ethically justified.

This is pertinent to two points of practical clinical consideration for any use of opioids for any pain relief. First, the physician's actions are scrutinised by peers, audited through clinical practice reviews, and judged within a defined legal framework. "Accepted practice" is in turn defined by clinically sensitive and ethically relevant evidence-based guidelines, such as the WHO analgesic ladder (4, 21). Physicians are obliged to show that their actions are in keeping with these standards of clinical practice through a review of clinical records that will further illuminate their intentions. Any digression from established treatment protocols will need justifying and failure to do so may cast doubt on their clinical decisions and intentions (20).

Second, the availability of clinical records precludes the falsification of documentation or concealment of one's actions. This ensures probity, accountability and maintenance of clinical standards and governance. These factors, when considered together, provide a basis for dependence on clinical records as a means of elucidating clinical intent. Such measures may

even go some way towards clarifying the true intention of the physician and remove any question of acceptability and accountability with regard to the intervention (20).

This is important because there are those patients who, despite the best palliative care support and interventions, warrant rapidly escalating doses of opioids with significant risks. In these patients, there is an equivocal risk-benefit ratio, and, in the presence of diametrically opposing intentions that can be resolved through the same intervention, the intentions of the physician become important. It is here that the doctrine of double effect remains relevant, and ascertaining intention is of significance when determining the validity of an intervention.

Conclusion

The use of opioids at the end of life continues to be an area of controversy. Though their use is justified in medically indicated circumstances, when they are used at the end of life the physician risks initiating an unwelcome enquiry into his /her intentions. Accepted practice needs to therefore be based on exemplary recording and monitoring frameworks that allow clinicians to provide the best care for their patients without unnecessarily calling into doubt their intentions. Given that there are significant data attesting to the safety of this treatment modality and, more significantly, given the proven efficacy in ameliorating suffering at the end of life without an impact on life expectancy, it is imperative that physicians do not feel inhibited when utilising opioids -- so long as they do so in a proportional and monitored, well documented manner that is in accordance with established guidelines. This should put an end to any lingering concerns regarding a physician's motivations and the customary invoking of the doctrine of double effect. At stake are the best interests of the patient and the duty of the physician to provide the best possible care of his / her patients within the specific conditions of terminal care.

This paper asserts that vigilance also ought to be maintained in the more routine of cases whence options are not attenuated and suffering not intractable. Indeed, when questioned, intentionality can be ascertained through adherence to established clinical guidelines and the maintenance of exhaustive medical records detailing clinical indications and justifications for the treatment options adopted, and wherever possible corroborated by a multidisciplinary team. This goes some way towards creating a medical fraternity that is above reproach. However, it is within the realms of truly risky cases and where there is a high chance of hastening death, or where there are suspected opposing (and undisclosed) intentions, that the difficulty of ascertaining intentionality remains a judgement of "facts".

References

1. Pargeon KL, Hailey BJ. Barriers to effective cancer pain management: a review of the literature. *J Pain Symptom Manage*. 1999 Nov;18(5):358-68.
2. Krishna LKR, Poulose JV, Tan BS, Goh C. Opioid use amongst cancer patients at the end of life. *Ann Acad Med*. Singapore. 2010 Oct;39(10):790-7.
3. 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 Feb 10; 163(3): 341-4.
4. World Health Organization. WHO's Pain Ladder [Internet]. Geneva:WHO; © WHO 2011[cited 2011 Jan 6]. Available from: http://www.who.int/cancer/palliative/painladder/en/
5. Beauchamp TL, Childress JF. Nonmaleficence. In: Beauchamp TL, Childress JF, editors *Principles of biomedical ethics*. 6th ed. New York: Oxford University Press; 2001: 149-97.
6. Quill TE. The ambiguity of clinical intentions. *N Eng J Med*. 1993 Sep 30; 329(14):1039-40.
7. Quill TE. Principle of double effect and end-of-life pain management: additional myths and a limited role. *J Palliat Med*. 1998 Winter;1(4):333-6.
8. Arlidge A. The trial of Dr Moor. *Crim Law Rev*. 2000;31- 40.
9. R V Moor (1999) *Crim Law Rev.* 2000;568-90. See also N.L.J. 1999, 149 (6891) 863-4.
10. Smith SW. Fallacies of the logical slippery slope in the debate on physician assisted suicide and euthanasia. *Medical Law Review.* 2005;13(2):224-43
11. Huxtable R. Get out of jail free. In: *Euthanasia, ethics and the law*. London: Routledge-Cavendish; 2007; p. 84-114
12. Dr Moor: landmark verdict.. BBC News [Internet]. 2000 Nov 28 [cited 2010 Dec 9]. Health: [about 4 screens]. Available from: http://news.bbc.co.uk/2/hi/health/background_briefings/euthanasia/331263.stm
13. BBC Online Network. Euthanasia GP: I would do it again.BBC News [Internet]. 1999 May 13 [cited 2010 Dec 9]. Health: [about 2 screens]. Available from: http://news.bbc.co.uk/2/hi/health/343257.stm
14. Sulmasy DP, Pellegrino ED. The rule of double effect: clearing up the double talk. *Arch Int Med*. 1999 Mar 22;159 (6):545-50.
15. Fohr SA. The double effect of pain medication. *J Palliat Med*. 1998 Winter:1(4):315-28.
16. Quill TE, Bycock IR. Responding to intractable terminal suffering: the role of terminal sedation and voluntary refusal of fluids and food. ACP-ASIM End-of-Life Care Consensus Panel. American College of Physicians-American Society of Internal Medicine. *Ann Intern Med*. 2000 Mar 7; 132(5):402-14.
17. Anscombe GEM. Intention. *Intention*. Oxford: Blackwell, 1957. 2nd ed, 1963.
18. Tannsjo T. Terminal sedation: a substitute for euthanasia? In: *Terminal sedation: euthanasia in disguise.* Kluwer Academic Publishers; 2005.
19. R v Cox (1992) 12 BMLR 38
20. Bolam v Friern Hospital Management Committee [1957] 1 WLR 583.
21. Verkerk M, van Wijlick E, Legemaate J, de Graeff A. A national guideline for palliative sedation in the Netherlands. *J Pain Symptom Manag*. 2007 Dec;34(6):666-70.

Acknowledgements: *Dr A Yee, Prof Cynthia Goh and the reviewers whose comments greatly improved this paper; Ms Nur Irwati for the preparation of this manuscript. There are no grants or competing interests to be declared.*