



## **HPNA Position Statement** **The Ethics of Opiate Use within Palliative Care**

### **Background**

Pain management is integral to quality palliative care.<sup>1-2</sup> While ensuring effective pain management should be a primary objective in every clinical setting, it is especially important in those settings that provide care to dying patients.

Although experts agree that palliative care must focus on the prevention and relief of pain and suffering; clinicians, patients, and families may be reluctant to use opioids to achieve this goal. This reluctance often stems from the fear that administering opioids may depress respirations, thereby hastening death. However, there is no convincing scientific evidence that administering opioids, even in very high doses, accelerates death.<sup>3-5</sup> Numerous clinical studies demonstrate no significant association among opioid use, respiratory depression, and shortened survival<sup>6-18</sup> Respiratory depression and other changes in breathing are part of the dying process and are more likely to result from disease and multi-system organ failure than from opioids.<sup>7,19</sup>

Despite the lack of evidence that opioids hasten death, many clinicians continue to believe that administering opioids can accelerate the dying process.<sup>20-22</sup> For this reason, they seek moral justification for providing aggressive pain management using opiates. The rule of double effect<sup>23</sup> provides ethical justification for the use of opioids in dying patients, even if there is a risk of hastening death. According to the rule of double effect, four conditions must be satisfied to establish a clinician's act as morally permissible:

- The act must be morally good or neutral, regardless of its consequences; relief of pain and suffering by administering opioids is a priority in hospice and palliative care and therefore is a "good act."
- The clinician must intend the good effect (relief of the patient's pain and suffering); although the bad effect (i.e., death) may be foreseen and permitted, it is not the clinician's intended effect.
- The bad effect must not be the means by which the good effect is achieved; in other words, the patient does not need to die in order to be relieved of pain.

- The benefits of the good effect must outweigh the burdens of the bad effect; in this case, the benefits of achieving pain relief outweigh the minimal risk of hastening death.<sup>23</sup>

There is broad consensus among professional groups, ethicists, courts, and many state legislatures that clinicians have a duty to administer opioids for pain relief to patients at the end of life.<sup>2, 24-26</sup> Moreover, fear of hastening death as a result of opioid administration does not justify the withholding of pain medication.<sup>24,27-28</sup>

Education and support are needed to ensure that clinicians in all settings understand their obligation to relieve pain and suffering and to achieve skill and confidence in the clinical activities that are necessary to meet this goal.<sup>24, 27-28</sup>

### **Position Statement**

This is the position of the HPNA Board of Directors:

- Hospice and palliative care nurses and organizations must affirm that comprehensive and effective pain management is a fundamental standard of care of all hospice and palliative care providers.
- Hospice and palliative care nurses and organizations must affirm that pain management should continue throughout the illness experience, including the final hours, days, and weeks of life.
- Hospice and palliative care nurses and organizations must affirm that receiving adequate pain relief is a right of all patients in every clinical setting, including older adults, infants, and children, nonverbal patients, non-English-speaking people, and those with active or a history of substance abuse.
- Hospice and palliative care nurses must recognize that the risk of hastening death by administering opioids to patients with life-limiting, progressive illnesses is minimal, particularly when administration occurs by or under the supervision of clinicians skilled in pain and symptom management and is consistent with established pain management guidelines.
- Hospice and palliative care nurses and organizations must recognize that the administration of opioids to alleviate pain at the end of life is consistent with widely accepted ethical and legal principles.
- Hospice and palliative care nurses and organizations must advocate for education across healthcare settings to help clinicians recognize their responsibility to relieve pain at the end of life. This education should include information about the lack of empirical evidence that opioids shorten life as well as the ethical and legal acceptability of administering opioids in doses sufficient to relieve pain.
- Healthcare organizations should develop policies regarding the administration of opioids for pain relief at the end of life. Clinicians who

regularly care for dying patients must achieve skill in providing aggressive pain management.

### Definition of Terms

*Rule of Double Effect.* A bioethical concept that provides moral justification for an action that has two foreseen effects: one good and one bad. The key factor is the intent of the person performing the act. If the intent is good (e.g., relief of pain and suffering) then the act is morally justifiable even if it causes a foreseeable but unintended result (e.g., hastening of death).<sup>23</sup>

### References

1. Hospice and Palliative Nurses Association. HPNA Position Statement: Pain Management. Available at [www.hpna.org/DisplayPage.aspx?Title=Position%20Statements](http://www.hpna.org/DisplayPage.aspx?Title=Position%20Statements). Accessed December 10, 2007.
2. National Consensus Project. Clinical Practice Guidelines for Quality Palliative Care, 2004. Available at [www.nationalconsensusproject.org](http://www.nationalconsensusproject.org). Accessed December 12, 2007
3. Fohr S. The double effect of pain medication: Separating myth from reality. *J Palliat Med.* 1998;1:315-328.
4. Wall PD. The generation of yet another myth on the use of narcotics. *Pain.* 1997;73:121-122.
5. Portenoy RK, Sibirceva U, Smout R, Horn S, Connor S, Blum RH, Spence C, Fine PG. Opioid use and survival at the end of life: a survey of a hospice population. *J Pain Sympt Manage.* 2006;32:532-540
6. Wilson WC, Smedira NG, Fink C, McDowell JA, Luce JM. Ordering and administration of sedatives and analgesics during the withholding and withdrawal of life support from critically ill patients. *JAMA.* 1992;267:949-953.
7. Grond S, Zech D, Schug SA, Lynch J, Lehmann KA. Validation of World Health Organization guidelines for cancer pain relief during the last days and hours of life. *J Pain Sympt Manage.* 1991;6:411-422.
8. Walsh TD. Opiates and respiratory function in advanced cancer. *Recent Results Cancer Res.* 1984;89:115-117.
9. Bruera E, MacEachern T, Ripamonti C, Hanson J., Subcutaneous morphine for dyspnea in cancer patients. *Ann Intern Med.* 1993;119:906-7.
10. Campbell ML, Bizek KS, Thill M. Patient responses during rapid terminal weaning from mechanical ventilation: a prospective study. *Crit Care Med.* 1999;27:73-77.
11. Citron ML, Johnston-Early A, Fossieck BE, Krasnow, SH, Franklin, R, Spagnolo, SV, Cohen, MH. Safety and efficacy of continuous intravenous morphine for severe cancer pain. *Amer J Med.* 1984;77:199-204.
12. Walsh T, Rivera N, Kaiko R. Oral morphine and respiratory function amongst hospice inpatients with advanced cancer. *Support Care Ca.* 2003;11:780-784.

13. Morita T, Ichiki T, Tsunoda J, Inoue S, Chihara S. A prospective study on the dying process in terminally ill cancer patients. *Amer J Hospice Palliat Care*. 1998;15:217-222.
14. Morita T, Tsunoda J, Inoue S, Chihara S. Effects of high dose opioids and sedatives on survival in terminally ill cancer patients. *J Pain Sympt Manage*. 2001;21:282-289.
15. Bercovitch M, Waller A, Adunsky A. High dose morphine use in the hospice setting. A database survey of patient characteristics and effect on life expectancy. *Cancer*. 1999;86:871-877.
16. Sykes N, Thorns A. The use of opioids and sedatives at the end of life. *Lancet Oncol*. 2003;4:312-318.
17. Bercovitch M, Adunsky A. patterns of high-dose morphine use in a home-care hospice service Should we be afraid of it? *Cancer*. 2004;101:1473-7.
18. Partridge JC, Wall SN. Analgesia for dying infants whose life support is withdrawn or withheld *Pediatr* 1997;99:76 -79.
19. Buchan ML, Tolle SW. Pain relief for dying persons: dealing with physicians' fears and concerns. *J Clinic Ethics*. 1995;6:53-61.
20. Solomon MZ, Sellers DE, Heller KS, Dokken DL, Levetown M, Rushton C, Truog RD, Fleischman AR. New and lingering controversies in pediatric end-of-life care *Pediatr* 2005;116:872-883.
21. Bendiane MK, Bouhnik AD, Favre R, Galinier A, Obadia Y, Moatti JP, Peretti-Watel P. Morphine prescription in end-of-life care and euthanasia: French home nurses' opinions. *J Opioid Manage*. 2007;3(1):21-6.
22. Bilsen J, Norup M, Deliens L, Miccinesi G, van der Wal G, Löfmark R, Faisst K, van der Heide A;. Drugs used to alleviate symptoms with life shortening as a possible side effect: end-of-life care in six European countries. *J Pain Symptom Manage*. 2006;31:111-21.
23. Beauchamp TL, Childress JF. *Principles of biomedical ethics*, 5th ed. New York: Oxford University Press; 2001.
24. American Nurses Association. Position Statement: Pain Management and Control of Distressing Symptoms in Dying Patients. Available at [www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/ANAPositionStatements/](http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/ANAPositionStatements/). Accessed December 12, 2007.
25. American Pain Society. Treatment of Pain at the End of Life. 2006. Available at [www.ampainsoc.org/advocacy/statements.htm](http://www.ampainsoc.org/advocacy/statements.htm). Accessed December 12, 2007.
26. Natural Death Act. *Revised Code of Washington*. Vol RCW 70.122.010; 1992.
27. Pierce SF, Dalton JA, Duffey M. The nurse's ethical obligation to relieve pain: actualizing the moral mandate. *J Nurs Law*. 2001;7(4):19-29.
28. Kennedy-Schwarz J. Pain management. A moral imperative. *Amer J Nurs*. 2000;100(8):49-50.

**Related HPNA Position Statements:**  
*Pain Management*, approved April 2008

**Originally developed in 2004 by:**

Mary Ersek, PhD, RN, FAAN  
Barbara Wagner, MS, BSN, CHPN®  
Betty R. Ferrell, PhD, RN, FAAN  
Judith A. Paice, PhD, RN, FAAN  
Colleen Scanlon, JD, RN  
Peg Nelson, MSN, APRN, BC-PCM

**Revised by:**

Mary Ersek, PhD, RN, FAAN  
Barbara Wagner, MS, BSN, CHPN®  
Betty R. Ferrell, PhD, RN, FAAN  
Judith A. Paice, PhD, RN, FAAN  
Colleen Scanlon, JD, RN  
Peg Nelson, MSN, APRN, BC-PCM

Approved by the HPNA Board of Directors  
April 2008

This position statement reflects the bioethics standards or best available clinical evidence at the time of writing or revisions.

Copyright © 2008 by the Hospice and Palliative Nurses Association

To obtain copies of HPNA Position Statements, contact the National Office at  
One Penn Center West, Suite 229, Pittsburgh, PA 15276-0100  
Phone (412) 787-9301  
Fax (412) 787-9305  
Website: [www.HPNA.org](http://www.HPNA.org)