



HPNA Position Statement **Providing Opioids at the End of Life**

Background:

Pain management is integral to quality hospice and palliative care.^{1, 2} Experts advocate for adequate analgesia to be provided to all patients in pain, including older adults, infants and children, nonverbal patients, non-English-speaking people and those with active or a history of substance abuse.¹⁻⁶ Providing effective pain management should be a primary objective in every clinical setting — especially those settings that provide care to dying patients.

Although there is agreement that the goals of 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 in patients who are dying.^{7, 8} This hesitancy may stem from the fear that administering opioids depresses respirations, thereby hastening death. However, there is no convincing scientific evidence that administering opioids, even in very high doses, accelerates death.⁹⁻¹³ In fact, numerous clinical studies demonstrate no significant association among opioid use, respiratory depression, and shortened survival.^{10, 12, 14-20} Respiratory depression and other changes in breathing are part of the dying process and are more likely to be from disease and multi-system organ failure than from opioids.^{16, 21}

Despite the lack of evidence that opioids hasten death, some clinicians continue to believe that administering opioids can accelerate the dying process; for this reason, they seek moral justification for providing aggressive pain management. The rule of double effect²² 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 good or morally 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.²³

Professional organizations, state lawmakers, and the U.S. Supreme Court have asserted their support for administering opioids at the end of life by explicitly or implicitly invoking the rule of double effect.^{2, 24-26} Thus, fear of hastening death as a result of opioid administration does not justify the withholding of pain medication. In contrast, assisted suicide and euthanasia are not generally seen as moral acts under the rule of double effect because the primary, explicit intent in these cases is to cause death. The difference between these acts (i.e., assisted suicide and euthanasia) and administering opioids for pain relief is that causing death, even for the relief of suffering, is usually not seen as a good or a morally neutral act.²⁷

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.^{2, 26, 28} Education and support are necessary to ensure that clinicians in all settings understand their obligation to relieve pain and suffering and to achieve skill and comfort in the clinical activities that are necessary to meet this goal.^{2, 29-31}

Position Statement:

The Hospice and Palliative Nurses Association (HPNA) is committed to compassionate care of persons at the end of life. It is the position of the HPNA Board of Directors that:

- Hospice and palliative care nurses and organizations must affirm that pain management should continue throughout the dying process
- Hospice and palliative care nurses and organizations must affirm that comprehensive pain management is a hallmark of excellent hospice and palliative care
- Hospice and palliative care nurses and organizations must affirm that patients in all clinical settings have the right to receive adequate pain relief throughout their illness experience
- 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 recognize that administering opioids to relieve pain in dying patients is ethically and legally different from assisted suicide and euthanasia; the intent of the former is to relieve pain, while the intent of assisted suicide and euthanasia is to cause death as a means of alleviating suffering

- Hospice and palliative care nurses and organizations must advocate for education across health care settings to enable clinicians in recognizing 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.
- Health care professionals and organizations must support nurses and other clinicians in discerning between ethically justifiable, legally permitted palliative care interventions and those interventions which may not be ethically justifiable and/or legally permitted
- Health care organizations should develop policies regarding the administration of opioids for pain relief.
- 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.
- Clinicians across clinical settings must reflect on their responsibility to alleviate pain and suffering. This reflection must include careful deliberation regarding standards of practice and the array of interventions that are essential to meeting the goals of palliative care.
- Clinicians who regularly care for dying patients must achieve comfort and skill in providing aggressive pain management.

Definition of Terms:

Assisted Suicide: Making a means of suicide (for example, providing lethal doses of medications) available to a patient with knowledge of the patient's intention to kill him or herself.²²

Euthanasia: An act that is performed by a clinician with the intent to end the patient's life (for example, administering a lethal injection); also called "mercy killing."³²

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).^{22, 23, 25} Also referred to as the "doctrine of double effect."

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Related HPNA Position Statements:
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