Morphine And Hastened Death

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Categories: Ethics; Pain: opioids

Question: What is the distinction between the use of morphine at the end of life to control symptoms and euthanasia/assisted suicide?

Case Scenario: An 83 year old former industrial worker has been hospitalized because of severe pain. He has pancreatic cancer with metastases to liver and lung. He has severe abdominal pain, and opioid therapy with morphine is recommended for pain relief.

Main Teaching Points

1. Many physicians inaccurately believe that morphine has an unusually or unacceptably high risk of an adverse event that may cause death, particularly when the patient is frail or close to the end of his or her life. In fact, morphine-related toxicity will be evident in sequential development of drowsiness, confusion, then loss of consciousness before respiratory drive is significantly compromised.

2. Many physicians inappropriately call this risk of a potentially adverse event, a double effect, when it is in fact a secondary, unintended consequence. The principle of double effect refers to the ethical construct where a physician uses a treatment, or gives medication, for an ethical intended effect where the potential outcome is good (eg, relief of a symptom), knowing that there will certainly be an undesired secondary effect (such as death). An example might be the separation of conjoined twins knowing that one twin will die so that the other will live. Although this principle of “double effect” is commonly cited with morphine, in fact, it does not apply, as the secondary adverse consequences are unlikely.

3. When offering a therapy, it is the intent in offering a treatment that dictates whether it is ethical medical practice:
   1. If the intent in offering a treatment is desirable or helpful to the patient and the potential outcome good (such as relief of pain), but a potentially adverse secondary effect is undesired and the potential outcome bad (such as death), then the treatment is considered ethical.
   2. If the intent is not desirable or will harm the patient and the potential outcome bad, the treatment is considered unethical.

4. All medical treatments have both intended effects and the risk of unintended, potentially adverse, secondary consequences, including death. Some examples are total parenteral nutrition, chemotherapy, surgery, amiodarone, etc.

5. Assisted suicide and euthanasia are not examples of “double effect.” The intention in offering the treatment in assisted suicide and euthanasia is to end the patient’s life.

6. If the intent for using morphine in the scenario is to relieve pain and not to cause death, and accepted dosing guidelines are followed:
   1. the treatment is considered ethical,
   2. the risk of a potentially dangerous adverse secondary effects particularly hastening death is minimal, and
   3. the risk of respiratory depression is vastly over-estimated.

References


**Version History:** This Fast Fact was originally edited by David E Weissman MD. 2nd Edition published July 2005. Current version re-copy-edited March 2009; additional references were added.

Fast Facts and Concepts are edited by Sean Marks MD (Medical College of Wisconsin) and associate editor Drew A. Rosielle MD (University of Minnesota Medical School), with the generous support of a volunteer peer-review editorial board, and are made available online by the Center to Advance Palliative Care (www.capc.org). Fast Facts and Concepts are editorially independent of the Center to Advance Palliative Care, and the authors of each individual Fast Fact are solely responsible for that Fast Fact’s content. The full set of Fast Facts are available at https://www.capc.org/fast-facts/ along with contact information, and how to reference Fast Facts.

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**Morphine myths and facts**

Fact: Morphine should be titrated according to efficacy and toxicity.

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Myth: Morphine or other opioids hasten death.
Fact: Morphine does not hasten death if used correctly, and in fact appropriate analgesia can increase life expectancy (Temel et al., 2010).

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Myth: Morphine is only used when death is imminent.
Fact: Morphine should be used when a person’s pain is severe enough to warrant it; use does not imply that death is imminent.

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Myth: There is a limit to the dose of morphine that can be used.
Fact: Morphine has no upper limit dose, though in practice if increasingly higher doses are required, consideration should be given to opioid switching.

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Myth: Use of morphine will interfere with what other treatment options may be used.
Fact: Morphine use will not limit other treatment options.

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Myth: Morphine has intolerable side effects.
Fact: Morphine rarely has intolerable side effects if titrated correctly.

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Myth: A person taking morphine should not be driving a car.
Fact: Taking morphine does not exclude a person from driving if the dose is stable.
Pain Control: Dispelling the Myths
by Dr. Joel Potash, MD.

Hospice strongly advocates good pain control for terminally ill patients, even to the point of using narcotic drugs (we call them opiates) such as morphine as they are needed. With all the concern about drug abuse, patients and their families and friends sometimes question this use of narcotics. Are we pushing “dope”? Or are we practicing good medicine? Let’s explore some of the myths about the use of narcotics for pain control.

Myth #1: Morphine is offered to patients only when death is imminent.
It is not the stage of a terminal illness, but the degree of pain that dictates which medicine to use. We start with the mildest medicine and if it works, stop there. If it doesn’t we move on, to morphine when it’s appropriate. Some people never need morphine, while others will require it for quite a while. You can live for a long time on morphine.

Myth #2: People who take morphine will become addicted.
Drug addicts are people who are driven by their needs for narcotics; they may commit crimes or harm others to get their needs met. Hospice patients usually don’t have drug-seeking behavior. When their pain is in good control, they don’t desire more opiates. Sometimes we can even decrease the dosage. If patients take morphine for a while, their body does become used to it and it should not be suddenly stopped, because side effects could occur. However, hospice patients on morphine are not considered to be addicts.

Myth #3: People who take morphine will become so sedated (sleepy) that they can’t function.
When patients start to take drugs like morphine, they often feel drowsy for a few days. But their bodies usually will very quickly build up a resistance to the sedating effects. Most patients whose pain is well controlled on morphine are not bothered by unusual sleepiness. Some people, however, notice a difference in their alertness and might choose somewhat less than perfect pain control as a tradeoff.

Myth #4: People who take morphine die sooner because morphine causes them to stop breathing.
Fortunately, patients quickly adjust to any effect that morphine may have on their breathing. We prescribe a small initial dose, gradually increasing it if needed. So rarely do breathing problems occur, they are usually not even listed as side effects. In fact morphine is a drug of choice for breathing distress in people with end-stage heart or lung disease: it makes their breathing more comfortable.
Myth #5: I’m allergic to morphine: once I had a shot of morphine after an operation and I felt very strange.
Of course you can be allergic to morphine just like any other medicine. But feeling strange is not a sign of morphine allergy usually. Some people may have unpleasant mental sensations temporarily when they start to take morphine. But that is not an allergy; and it might never recur. There are other opiates available for those people who are truly allergic to morphine.

Myth #6: Morphine must be given by injection.
We used to think that opiates were not effective unless administered by injection. But Hospice has been a leader in demonstrating the effectiveness of morphine and other opiates taken orally. Even people who required injections of morphine in the hospital (the most common way of giving morphine there) will probably be able to be well controlled on oral morphine at home. There are also long-acting preparations of morphine which can be given every twelve hours, or opiate skin patches which can be applied every 72 hours, to simplify the routine of pain control.

Myth #7: People should wait until their pain is bad to take morphine so it will be effective when it’s really needed.
There is no upper dose limit to the use of morphine or other opiates. If pain increases we can increase the dose; this is true of very few other medications. Using it when it’s needed early in the course of a terminal illness does not mean that it won’t continue to work later in the disease.
Morphine, one of the oldest drugs in existence, has found a well-deserved place in the new field of palliative care: the relief of pain and other symptoms. We recommend opiates for pain control only if they are needed. When they are needed, they are often successful in controlling the pain and suffering of terminal illness.